

State of California  
State and Consumer Services Agency

**MEDICAL BOARD OF CALIFORNIA**

October 27-28, 2011



<b>Panel A</b>	<b>October 27</b>	<b>9:00 a.m. - 12:00 p.m.</b>
<b>Panel B</b>	<b>October 27</b>	<b>9:00 a.m. - 12:00 p.m.</b>
<b>Presentation</b>	<b>October 27</b>	<b>1:00 p.m. - 2:00 p.m.</b>
<b>Access to Care Committee</b>	<b>October 27</b>	<b>2:00 p.m. - 3:00 p.m.</b>
<b>Licensing Committee</b>	<b>October 27</b>	<b>3:00 p.m. - 4:00 p.m.</b>
<b>Executive Committee</b>	<b>October 27</b>	<b>4:00 p.m. - 5:00 p.m.</b>
<b>Application Review Committee</b>	<b>October 28</b>	<b>8:30 a.m. - 9:00 a.m.</b>
<b>Full Board</b>	<b>October 28</b>	<b>9:00 a.m. - 3:00 p.m.</b>

MEDICAL BOARD OF CALIFORNIA  
BOARD MEETING SCHEDULE

Doubletree by Hilton – San Diego Mission Valley  
7450 Hazard Center Drive  
San Diego, CA 92108

**October 27-28, 2011**

**Thursday, October 27**

- 9:00 a.m. – 12:00 p.m. **Panel A –Brickstones Room**  
*(Members: Duruisseau, Carreon, Diego, Salomonson, Yaroslavsky)*
- 9:00 a.m. – 12:00 p.m. **Panel B – Sonoma Room**  
*(Members: Chang, Levine, Low, Schipske)*
- 12:00 p.m. – 1:00 p.m. **Lunch Break**
- 1:00 p.m. –2:00 p.m. **Presentation on Diagnosis of Substance Abuse Disorders and Criteria for Determining When a Physician is Fit to Practice - Brickstones Room**  
*(All Members)*
- 2:00 p.m. –3:00 p.m. **Access to Care Committee – Sonoma Room**  
*(Members: Schipske, Chang, Carreon, Duruisseau, Yaroslavsky)*
- 3:00 p.m. –4:00 p.m. **Licensing Committee – Brickstones Room**  
*(Members: Salomonson, Carreon, Chang, Diego, Duruisseau, Schipske)*
- 4:00 p.m. –5:00 p.m. **Executive Committee – Brickstones Room**  
*(Members: Yaroslavsky, Chang, Duruisseau, Levine, Schipske, Salomonson)*

**Friday, October 28**

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



## MEDICAL BOARD OF CALIFORNIA

### Executive Office



#### MEMBERS OF THE BOARD

*Barbara Yaroslavsky,*  
President  
*Janet Salomonson, M.D.,*  
Vice President  
*Gerrie Schipske, R.N.P., J.D.,*  
Secretary  
*Hedy Chang*  
*Jorge Carreon, M.D.*  
*Silvia Diego, M.D.*  
*Shelton Duruisseau, Ph.D.*  
*Sharon Levine, M.D.*  
*Reginald Low, M.D.*

### QUARTERLY BOARD MEETING

**October 28, 2011**

Doubletree by Hilton – San Diego Mission Valley  
Brickstones Room  
7450 Hazard Center Drive  
San Diego, CA 92108  
619-297-5466 (directions only)

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

## AGENDA

Friday, October 28, 2011  
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

1. 9:00 a.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 July 28-29, 2011 meeting
4. Access to Care Update - Ms. Schipske
5. Physician Assistant Committee Update – Dr. Low
6. Enforcement Committee Update – Dr. Low

*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.*

7. Special Faculty Permit Review Committee Update and Consideration of Applicants and Committee Member Change– Dr. Low
  - A. 2168 Applicants
  - B. Stanford University Committee Member Change Request
8. Licensing Committee Update – Dr. Salomonson
9. Federation of State Medical Boards Update - Ms. Chang
10. Health Professions Education Foundation Update – Ms. Yaroslavsky and Dr. Duruisseau
11. Board Member Communications with Interested Parties – Ms. Yaroslavsky
12. President’s Report - Ms. Yaroslavsky
13. Executive Director’s Report – Ms. Whitney
  - A. Staffing and Administrative Update
  - B. Budget Overview – Ms. Kirchmeyer
  - C. BreZE Update – Ms. Kirchmeyer
14. Consideration of Modified Text for Polysomnographic Technologist Regulations – Mr. Worden and Mr. Heppler
15. Licensing Chief’s Report – Mr. Worden
  - A. Staffing
  - B. Program Statistics
  - C. Status of International Medical School Program
16. Licensing Outreach Report - Mr. Schunke
17. Midwifery Advisory Council Update
  - A. Licensed Midwife Annual Report Statistics and Update – Ms. Ehrlich
18. 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
19. Vertical Enforcement Program Report – Mr. Ramirez
  - A. Status Report on VE Manual
  - B. Presentation on Statistics
  - C. HQE Organization and Staffing

20. Legislation/ Regulation – Ms. Simoes
  - A. 2011 Legislation Wrap-Up and Implementation Schedule
  - B. 2012 Legislative Proposals
  - C. Status of Regulatory Action – Mr. Schunke

***11:45 Lunch Break***

21. Discussion and Consideration of Draft Strategic Plan Presented by the Executive Committee – Ms. Yaroslavsky
22. Discussion of Strategic Plan Objective 5.4 Annual Review of Committees; Establishment of Board Committees – Ms. Yaroslavsky
23. 2012 Board Meeting Dates – Ms. Yaroslavsky
24. Agenda Items for February 2-3, 2012 Meeting in San Francisco
25. 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](mailto: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.*



**MEDICAL BOARD OF CALIFORNIA**  
Executive Office



Marriott Courtyard Cal Expo  
Golden State Room C/D  
1782 Tribute Road  
Sacramento, CA 95815

July 28-29, 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 July 28, 2011 at 1:09 p.m. A quorum was present and notice had been sent to interested parties.

**Members Present:**

Barbara Yaroslavsky, President  
Hedy Chang, Secretary  
Jorge Carreon, 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.

**Staff Present:**

Eric Berumen, Enforcement Program Manager  
Anna Caballero, Secretary, State Consumer Services Agency  
Ramona Carrasco, Enforcement Manager  
Janie Cordray, Research Analyst  
Andrew Hegelein, Supervising Investigator  
Tamiko Heim, Budget Analyst  
Kurt Heppler, Staff Counsel  
Kimberly Kirchmeyer, Deputy Director  
Ross Locke, Business Services Staff  
Mark Loomis, Supervising Investigator  
Natalie Lowe, Enforcement Analyst  
Armando Melendez, Business Services Staff  
Kelly Montalbano, Enforcement Analyst  
Valerie Moore, Enforcement Program Manager

Regina Rao, Business Services Staff  
Letitia Robinson, Licensing Program Manager  
Paulette Romero, Enforcement Manager  
Anthony Salgado, Licensing Program Manager  
Teresa Schaffer, Enforcement Analyst  
Kevin Schunke, Outreach Manager  
Anita Scuri, Department of Consumer Affairs, Supervising Legal Counsel  
Jennifer Simoes, Chief of Legislation  
Laura Sweet, Deputy Chief of Enforcement  
Cheryl Thompson, Administrative Assistant  
Renee Threadgill, Chief of Enforcement  
Linda Whitney, Executive Director  
Curt Worden, Chief of Licensing

**Members of the Audience:**

Yvonne Choong, California Medical Association (CMA)  
Paul Costa, Department of Consumer Affairs  
Dean Crow, M.D., Member of the Public  
Karen Ehrlich, L.M., Midwifery Advisory Council  
Julie D'Angelo Fellmeth, Center for Public Interest Law  
Stan Furmanski, M.D., Member of the Public  
Dean Grafillo, CMA  
Dan Leacox, Greenberg Traurig  
Margaret Montgomery, Kaiser Permanente  
Elberta Portman, Physician Assistant Committee, Department of Consumer Affairs  
Carlos Ramirez, Office of the Attorney General  
Romero Reyes, Member of the Public  
Rehan Sheikh, Member of the Public

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

Dr. Stan Furmanski stated the orders issued by the Board indicate that a doctor shall be tested in his or her specialty or subspecialty. However, the Board often does not have tests for the ordered topic, nor does it have objective published standards that would be used to grade such a test. Public Records Act requests have verified that no test exists for nuclear magnetic resonance imaging, which is Dr. Furmanski's specialty. He stated the Board is issuing orders that are impossible to comply with and recommended establishing an administrative pathway to have the orders for radiologists, chemotherapists, and anesthesiologists voided by administrative staff, and creating a pathway that would allow doctors to come directly to the Board to have orders eliminated.

Ramiro Reyes expressed concern over cannabis clinics that operate via the internet and dispense marijuana without a true physician examination. He questioned the legality of a physician conducting a physical examination via the internet prior to issuing a cannabis recommendation and called for a thorough investigation of this practice.

Dr. Deane Crowe stated he issues cannabis recommendations but is careful to follow the practice guidelines set forth by the Medical Board. He expressed concern over medical corporations that are not physician owned but merely employ physicians to issue marijuana recommendations. Recently, one of these corporations, after learning it was in violation, appointed a physician to its board and was issued a fictitious name permit by the Medical Board. He requested that the Board investigate this particular corporation and offered to provide supporting documentation.

**Agenda Item 3      Approval of Minutes from the May 6, 2011 Meeting**  
*Dr. Salomonson made a motion to approve the minutes from the May 6, 2011 meeting; s/Levine; motion carried.*

Ms. Yaroslavsky appointed Dr. Salomonson to serve on the Application Review Committee for the Thursday, July 29, 2011 meeting.

**Agenda Item 24      Presentation: CMA California Physician Workforce Report**  
Yvonne Choong, Associate Director, Center for Medical and Regulatory Policy, CMA, and Dean Grafilo, Associate Director, Government Relations, CMA, delivered a presentation entitled "Five Issues Facing California's Physician Workforce". Physician workforce analysts have projected the United States will be face a shortage of approximately 91,000 physicians by 2020. California physician shortages are projected to be 17,000 by 2015. These projections were issued before the enactment of federal health care reform, likely making the physician shortage much higher as California's insured patient population is projected to increase by 10%. The composition and distribution of physicians in California, as well as the state's capacity to train and recruit the next generation of physicians, present additional concerns.

Bottlenecks exist in California's physician training pipeline. Last year, California's eight allopathic medical schools received over 45,000 applications for 1,000 positions. Only 41% of medical school students from California are able to attend an in-state medical school, compared to a national average of 62%, minimizing the benefit California receives for having the highest retention rate for medical students in the country. Only 26% of active patient care physicians in California were educated in-state.

The situation is similar for graduate medical education (GME), with a high retention rate and few positions available. The primary source of funding for graduate medical education is Medicare, accounting for approximately 70% of all GME dollars. However, the number of funded positions and their distribution across the country has been frozen since 1997. At that time, the majority of residency slots existed in New York and New England, hence, that geographical bias was institutionalized. While Medi-Cal also provides a significant funding stream for GME, this, too, has problems as the funding is both undersized and unreliable.

These shortcomings in the physician training pipeline make California particularly dependent upon attracting doctors from out of state, thus, maximizing the appeal of California as a medical practice environment is a major issue. However, California's Medicaid (Medi-Cal) rates are the fourth lowest in the US, paying on average 56% of the Medicare fee schedule. This does not include the 10% cut under former Governor Schwarzenegger that is scheduled to go before the US Supreme Court or the new 10% cut that Governor Brown just signed into law. Also

detracting from the fiscal appeal is the fact that CA has the fourth highest cost of living in the country, at 132% of the national average. This results in narrow margins for maintaining the financial viability of a medical practice. The pending implementation of federal health reform makes matters even worse; PPACA is expected to add as many as three million newly insured Californians to the existing patient population without any corresponding increase in the number of physicians. It's difficult to predict the impact such an increase in demand will have upon an already over-stretched health care system. One positive note is that the medical liability insurance premiums in California are low compared to those in other states, largely due to MICRA and the limits placed on non-economic damages.

Specialty distribution is another major issue for the physician workforce, with an immense need for more primary care physicians. Currently, 74% of California's counties have an undersupply of primary care physicians. Primary care residencies draw lower levels of interest among graduating medical students compared to other specialties. While there is on-going debate over why interest in primary care is waning, the AMA is beginning to find links between medical school debt and medical students pursuing higher paying specialties. Between 2001 and 2006, public medical school tuition increased 11% annually and continues to grow. As a result, 86% of medical school students are now graduating with outstanding loans, with an average debt at \$156,456 in 2009. With primary care physicians making on average only 70% of the median income for all doctors, higher debt has a particular impact on specialty choice.

The geographical distribution of physicians throughout the state is extremely uneven. The urban centers of Sacramento, San Francisco, San Diego, and Los Angeles all have a considerable advantage over less metropolitan areas such as the San Joaquin Valley, Northern and Sierra regions, the Central Coast, and the Inland Empire. There are over 200 distinct areas and populations in California designated as medically underserved, with 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.

The final issue is the shortcoming in the ethnic and racial diversity of California's physician workforce. Latinos (which make up 37% of California's population but only 5% of the physician workforce) and African Americans are underrepresented, as are Samoan, Cambodian, and Laotian ethnicities. Minority physicians are far more likely to practice in primary care and work in low income and underserved communities. Diversity is also important for patient care and access, with studies indicating that ethnic physicians are more attuned to screening and treating health risks associated with their own race and ethnicity.

Ms. Choong presented on potential solutions to the issues discussed. CMA recommends increasing medical school enrollment in California, both by expanding class sizes at existing schools and building new schools. However, California's current financial landscape has presented challenges to building new schools, such as those at UC Riverside and UC Merced.

The number of residency slots in California should also be expanded in order to attract medical students from other states. This, too, becomes difficult as California's current budget deficit leaves few options outside of looking for private sources of GME funding. In the long term,

change is required at the federal level in the way residency programs are funded through Medicare. CMA is sponsoring SB 347 (Rubio) which looks at earmarking a portion of Medi-Cal managed care funding to hospitals specifically for GME training. This is currently a two-year bill.

Another option is to look to foreign medical graduates. Both in California and nationally, many individuals are seeking medical education at foreign medical schools. Since these schools are a significant source of physicians and California has some of the strictest standards for recognizing international medical schools, an option would be to revisit some of these standards and the list of schools eligible for recognition by the Board.

With regard to the practice environment, suggested strategies include upholding the MICRA cap to contain medical liability insurance premiums and increasing Medi-Cal payments. In addition, streamlining the medical licensing processing and reducing the licensing fees would be helpful, particularly for new physicians just beginning their careers.

Primary care physician shortages could be addressed by reducing financial barriers by expanding scholarships and grants to medical students. This would prevent students from accumulating excessive debt that could later drive specialty selection. CMA is sponsoring AB 589 (Perea) which would mirror the Steven Thompson Loan Repayment Program by creating the Steven Thompson Scholarship Program for medical schools, whereupon completion of residency, awardees would practice in highly medically underserved areas. Additional suggestions include increasing compensation for primary care services, improving Medi-Cal payments, cracking down on insurance plan abuses, sufficiently funding public health initiatives such as flu vaccines, and expanding loan repayment programs for primary care physicians. A third option, which has been explored in other states, is to develop a shortened primary care education track. In theory, such a system would reduce the amount of debt primary care physicians accumulate by eliminating a year of their medical schooling. Any plan to condense medical education would have to meet the Board's requirements to ensure that these students would be eligible to practice in California.

With regard to geographical distribution issues, existing state loan repayment programs for primary care physicians and specialists working in underserved areas could be expanded. In 2011, the Steven Thompson Loan Repayment Program will have awarded \$3.1 million in loan repayment scholarships to 34 physicians. The program's funding will be combined with available federal funding to expand awards in the next year. Expanding medical schools' rural training programs and developing rural and community-based residency programs are other options.

The ethnic and racial diversity issue could be addressed by recruiting more students from underserved communities by offering premedical advising services for youths, clinical mentorship opportunities, and post-baccalaureate premedical programs. Financial barriers could be reduced by offering more scholarships and grants to students with ethnically and economically diverse backgrounds. Further, medical education programs and continuing medical education courses could be developed that focus on culturally competent care.

Dr. Low noted there are some new private medical schools that will be opening in California that will help increase the physician pool. He also suggested that pharmaceutical, device, medical insurance companies, and other stakeholders be required to help subsidize the distribution and training issues. Mr. Grafilo indicated that other states already require all stakeholders to contribute toward funding GME.

Ms. Schipske requested a report through the Federation of State Medical Boards (FSMB) that compares California with other states for licensing application processing times and fees. Ms. Chang noted that FSMB has just begun to collect this data from the state boards. Ms. Whitney indicated this information could be requested and presented at the October 2011 meeting.

## **Agenda Item 9      Legislation / Regulation**

### **A.    2011 Legislation**

Jennifer Simoes, Chief of Legislation, referred members to the Legislative Packet and the Tracker List.

#### **Board Sponsored Bills:**

- **AB 1127 (Brownley) Physicians & Surgeons: Physician Interview**  
This bill will make it a violation of unprofessional conduct for a physician who is the subject of an investigation by the Board to repeatedly fail, absent good cause, to attend and participate in an interview scheduled by mutual agreement between the physician and the Board. The bill was signed by the Governor and will become law.
- **AB 1267 (Halderman) Physicians & Surgeons: Misdemeanor Incarceration**  
This 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. The bill would allow the Board to disclose the reason for the inactive status on its website. The bill was amended in Senate Business and Professions Committee (B&P) to require the Board to move the physician's license back to its prior appropriate status within five business days of receiving notification. Board staff believes the five day time frame is reasonable and agreed to take the amendment. Regulations to specify this process will need to be developed. The bill passed out of the Legislature with no opposition; it has been enrolled and was sent to the Governor on July 25, 2011.
- **SB 541 (Price) Regulatory Boards: Expert Consultants**  
The Board is co-sponsoring this bill with the Contractor's State Licensing Board. This bill would enable all boards and bureaus in the Department of Consumer Affairs to continue to utilize expert consultants or reviewers in the same manner as in the past 25 years without having to go through the formal contracting process. If the bill passes, all boards and bureaus would be allowed to complete a simplified contract with expedited processing, with delegation to the various boards for contracting authority. Recent amendments were made to prevent the expansion of the scope of practice of an expert providing services. The bill will be heard in Assembly Appropriations Committee during the week of August 17, 2011; so far, there are no opposition votes on this bill.

### Other 2011 Legislation

- **AB 536 (Ma) Physicians and Surgeons: Expungement**  
This bill would have required the Board to remove misdemeanor and felony convictions posted by the Board on the Internet within 90 days of receiving a certified copy of an expungement order from the licensee. At the May 2011 meeting, the Board voted to take an oppose unless amended position. The 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 website within six months of the receipt of the certified expungement.  
  
*Dr. Levine made a motion to change the Board's previous position on AB 536 from oppose unless amended to a support position; s/Moran; motion carried.*
- **AB 584 (Fong) Worker's Compensation: Utilization Review**  
This bill clarifies current law to provide that physicians performing utilization reviews for injured workers must be licensed in California.  
*Dr. Low made a motion to support AB 584; s/Schipske; motion carried.*
- **AJR 13 (Lara) Graduate Medical Education Residency Positions**  
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.  
*Dr. Duruisseau made a motion to support AJR 13; s/Moran; motion carried.*
- **SB 100 (Price) Healing Arts: Outpatient Settings**  
The Board took a support if amended position on this bill at the May 2011 meeting. The bill strengthens oversight of outpatient settings by the accreditation agencies and the Board and increases information sharing between accreditation agencies and the Board. The Board's previous concerns with the bill have all been addressed. 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 record and are required 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 on-site. Further, the amendments require the Board to take action to enjoin an unaccredited outpatient setting when appropriate, through, or in conjunction with, the local district attorney. The amendments make other technical changes. Ms. Simoes provided an overview of the requirements the bill would place on the Board, the accreditation agencies, and the outpatient settings. These are noted in the Legislative Packet.

Dr. Moran asked about the specific verbiage on lasers and intense pulse light devices. Ms. Simoes indicated that existing law requires the Board, in conjunction with the Board of Registered Nursing and in consultation with the Physician Assistant Committee and

other professionals in the field, to review issues and problems relating to the use of laser or intense pulse light devices for elective cosmetic procedures. The bill requires the Board to adopt regulations by January 1, 2013 regarding the appropriate level of physician availability needed within clinics or other settings using certain lasers or intense pulse light devices for elective cosmetic procedures.

Dr. Levine asked for clarification of the Board's requirement to evaluate the accreditation agencies. Ms. Simoes stated the Board has the authority to approve the accreditation agencies. The evaluation would involve verifying whether the accreditation agency was doing the things it is supposed to be doing, such as notifying the Board within the required 24 hour period, providing the information needed for the Board to post on its website, established rules for inspection, etc. Ms. Whitney noted the accreditation agencies must reapply to the Board every three years.

- **SB 380 (Wright) Chronic Disease Prevention: Nutrition /Lifestyle Behavior**  
This bill would have originally required 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. The bill was amended and no longer requires mandated CME. The current version of the bill would 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.

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 to each general acute care hospital in California. The Board would also be required 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 the bill. Ms. Simoes noted this information could be disseminated via the Board's quarterly newsletter and the Board could work with the Department of Public Health to get the information out to general acute care hospitals. The Board previously declined to take a position on the bill. With the amendments, staff suggests a neutral position on the bill.

*Dr. Levine made a motion to take a neutral position on SB 380; s/Chang; motion carried.*

- **SB 824 (Negrete McLeod) Opticians: Change of Ownership**  
The Board previously took a support position on this bill. The bill would require the 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. The 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. The bill has been amended and now only puts the 10 day time

limit on the RDO assuming ownership of the business. Ms. Simoes noted this change will no longer help make the Board's process run more smoothly and effectively; therefore, staff suggests a neutral position on the bill.

*Dr. Duruisseau made a motion to change the Board's previous support position to a neutral position on SB 824; s/Chang; motion carried.*

- **SB 943 (Senate B&P) Healing Arts: Polysom Grandfathering**  
This bill is the vehicle by which omnibus legislation has been carried by Senate B&P. The portion of the bill relating to the Board clarifies the grandfathering provisions in existing law related to polysomnographic technologists. The bill would authorize current practitioners to be grandfathered in by allowing them to apply for registration as a certified 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.

SB 132, which was passed in 2009, established the Polysomnography Program which is to be administered by the Board. The grandfathering provision that was included in the bill was drafted in a manner that is ambiguous and can be interpreted as meaning that there is in effect no grandfathering provision. The clarifying language will reflect the original intent of SB 132 and now 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.

*Dr. Levine made a motion to support the provisions related to the Polysomnography Program in AB 943; s/Chang; motion carried.*

#### **B. 2012 Legislative Proposals**

Ms. Simoes reported the Board's proposed omnibus changes were not included in SB 943. Senate B&P staff has committed to putting the requested language changes related to midwifery reporting terminology and licensing into its 2012 omnibus bill, likely to be introduced in December 2011.

At the May 2011 meeting, Ms. Whitney discussed the UCLA International Medical Graduate Program, founded by Dr. Dowling and Dr. Bholat. It was brought to the Board's attention that legislation may be needed to allow the program participants to obtain clinical experience. This could be accomplished by making the program a pilot project. The Board approved this concept at the May 2011 meeting and agreed to possibly co-sponsor legislation along with the University of California. Board staff has working with the University of California and have jointly decided to go forward with this proposal in 2012. This allows time to fine tune the proposal and move through the legislative process in the normal time frame.

Ms. Simoes indicated that staff requested Senate B&P to change the sunset date of the Vertical Enforcement (VE) Program report to coincide with the sunset report date for the Board. Unfortunately, the request was not successful. Hence, the Board will be completing the VE

report by March 1, 2012. Based upon the outcomes of the report, legislation may be sponsored to extend the program.

The California Medical Association (CMA) recently contacted Ms. Simoes regarding a physician health program that they are working on establishing with their coalition. They have requested for Board staff to meet with them on this issue and a meeting has been scheduled for August 2, 2011. Ms. Simoes stated she assumed the proposal was for 2012 since it so late in the 2011 legislative session. To date, she has not received any specific information or language, but anticipates having more to report at the October 2011 meeting.

Mr. Grafilo stated it was his understanding that the physician health legislation would be for 2012.

### **C. Status of Regulatory Action**

Mr. Schunke directed members to the matrix on page 72 of the packet detailing the status of pending regulations. He noted the regulations pertaining to the Clinical Training Programs for International Medical Students requested by the City of Hope have been finalized and submitted to the Office of Administrative Law for final review on July 15, 2011.

### **Agenda Item 4 Licensing Chief's Report**

Mr. Worden reported staff has been working on the recommendations from the Business Process Re-engineering Report. Revisions to the various forms in the licensing application are underway; some forms are ready for review by management. This project has been somewhat delayed due to the need to process applications for the graduate medical education trainees. Updates and revisions to the licensing section of the Boards' website are on-going. Staff has not yet determined if the PTAL application should be separate from that for a physician and surgeon's license. The new management reports have been completed. The Update to the Policy and Procedures Manual is not moving forward at this time due to staffing shortages.

A Special Faculty Permit Review Committee is scheduled for September 15, 2011. One specialty board application is pending, waiting for a response back from the specialty board on requested information. The Polysomnographic Program Final Statement of Reasons has been reviewed by legal and returned for edits; staff will continue to work on moving these regulations forward.

### **A. Staffing**

Mr. Worden thanked the Licensing Program staff for their work in getting the 2065/ 2066 license exemptions issued in a timely manner. This was accomplished without any overtime from staff. Staff from all areas of the Licensing Program chipped in to help, including the Call Center, Cashiering Unit, Fictitious Name Permit, and front office areas.

Mr. Worden reported there are currently 10.6 vacant positions in the Licensing Program. Three of these vacancies are for Associate Government Program Analysts (AGPA) who perform the more technical, advanced level work dealing with international medical schools, Policy and Procedures Manual revisions, and the training of staff. Mr. Worden anticipates two more Staff Services Analyst (SSA) vacancies in the coming months which will impact international

application processing. The Licensing Program will have a total of 7.5 vacant Office Technician (OT) positions; these individuals perform functions within the cashiering unit, answer consumer and licensee calls in the Consumer Information Unit, process mail and perform other front end duties. These vacancies have a pronounced impact on the program's functioning. When added together, the number of vacancies equate to a 19% vacancy rate in the Licensing Program. This is leading to delays in processing international medical school applications, increasing timelines for processing licensing applications from US medical school graduates, delays in cashiering incoming payments, preparing files, and in answering and returning calls.

#### **B. Status of 7/1/11 Licensing for 2065/2066 Applicants**

Mr. Schunke's outreach to the graduate medical education programs helped create a more even flow of 2065/2066 applications into the Licensing Program, which, in turn, helped eliminate the need for staff overtime. Forty-three hospitals participated in the outreach program, submitting the names of 1,225 applicants requiring licensure by July 1, 2011. Fifty names were removed from the list as these individuals were not true 2065/2066 applicants. The Board received 1,186 applications and reviewed 1,185 of these by July 1. Among these, 1,034 licenses and 41 PTALS were issued by the deadline. As of July 27, 2011, there are six US files and three IMG files that are still incomplete. Hence, of the 1,186 applications received, only nine individuals have not yet been licensed or issued a PTAL. Mr. Worden noted there was one individual needing licensure by July 1, 2011 who did not submit an application until July 13, 2011.

Ms. Yaroslavsky and Dr. Duruisseau commended Mr. Worden and his staff on this accomplishment. They questioned whether these types of results were sustainable. Mr. Worden stated they are not without an adequate number of staff to perform the work of the Licensing Program.

#### **C. Program Statistics**

Mr. Worden directed members to page 47 of the meeting packet for statistics on the Licensing Program. He reported the program received 3,176 more telephone calls, 269 more physician applications, and 1,842 more physician license renewals in FY 2010/2011 than in FY 2009/2010. Page 52 of the packet provides a five year history of the number of physician and surgeon applications received, as well as the number of PTALs received. Referencing the production report on page 53, Mr. Worden noted the number of days needed to review US files has increased to 48 days (which is still within the statutory requirements); IMG file review is at 35 days. The number of days to review mail is at 11 days for US files and 7 for IMG files. More recently, the review time has dropped to 41 days for US files and 34 for IMG files.

There are eight staff positions designated for US file review; of these, five are filled by new individuals who are in training. Mr. Worden reported it takes six months to bring a US file reviewer up to a comfortable speed of reviewing files. A similar situation is occurring among the IMG file reviewers with five new individuals in training; IMG file review training is more complex and takes six months to one year to reach full speed. These developments will influence the review timelines.

Dr. Salomonson stated she would like to see the data on the number of files requiring senior level review in the statistical charts as it provides data on the quality of applications being received.

**D. Status of International Medical School Program**

Mr. Worden directed members to the matrix beginning on page 51.1 of the meeting packet for a status update on the review of international medical schools that have applied for recognition pursuant to CCR §1314.1(a)(1) or §1314.1(a)(2). The schools are divided into two categories: (a)(1) schools which are government owned and operated and whose primary purpose is educating its own citizens to practice medicine in that country; (a)(2) schools which have a primary purpose of educating non-citizens to practice medicine in other countries. The matrix includes (a)(1) schools that were evaluated and determined to have met the requirements for recognition. The Board will review an (a)(2) school at its meeting on July 29, 2011.

Ms. Whitney stated that the matrix now reflects *all* of the international schools in the recognition process, including those (a)(1) schools only requiring an administrative and legal review of the submitted documents. In the past, the Board may only have been aware of those schools that have submitted full applications and require their attention. She noted the heavy workload associated with the international medical school program.

The schedule for the reevaluation of schools that were previously recognized by the Board has been revised and put on hold due to vacancies in the Licensing Program. The schedule is likely to change again if an analyst cannot be hired for the position.

**Agenda Item 5 Licensing Outreach Report**

The Outreach Program provides the opportunity to educate new residents on the licensing process and conduct an early initial review of applications in order to identify problems and deficiencies before they are submitted. Mr. Schunke reported his plans for outreach for the remainder of 2011 include nine overnight trips to participate in licensing workshops and fairs in Northern and Southern California. A request has been submitted to the Department of Consumer Affairs (DCA) for an exemption to the Governor's restriction on travel which would allow attendance at these events. Mr. Schunke has been notified that UCSD and UCSF plan to cancel their licensing fairs if he is unable to attend. The request for the exemption details the results achieved and lack of overtime required within the Licensing Program as a result of the Board's Outreach Program. The costs of supporting this program are significantly less than the cost of overtime hours spent in past years to license 2065/2066 applicants. Staff has not yet received a decision from DCA on whether this travel exemption request will be approved.

Outreach also includes participation in new resident orientation events and during grand rounds where Mr. Schunke serves as a guest speaker providing an introduction to the Board and its mission and roles, outlines the licensing process, and offers notice about licensing deadlines and requirements. He frequently answers questions from applicants on substance abuse or criminal history issues and how it will impact licensure. The travel exemption request to attend new resident orientation events during the months of June and July 2011 was denied by DCA. Mr. Schunke was, however, able to make a teleconference presentation for a portion of the orientation at Loma Linda.

Ms. Kirchmeyer has been working with DCA on the travel waivers requests. Ms. Yaroslavsky reported that she, Ms. Chang, Ms. Whitney, and Ms. Kirchmeyer have met with the State and Consumer Services Agency (SCSA) Secretary and have requested approval of travel for the Outreach Program.

**Agenda Item 6      Midwifery Advisory Council Update and Consideration of Council Recommendations**

**A.      Midwifery Advisory Council Nominations and Approval**

Mr. Worden reported nominations were solicited for two positions on the Midwifery Advisory Council (MAC) whose terms have expired. One position is for a licensed midwife and one for a public member. Five applications for the licensed midwife position and four applications for the public member position were received. At the April 7, 2011 MAC meeting, after learning the Ms. Yaroslavsky and Ms. Sparrevohn would like to continue to serve on the MAC, the other candidates withdrew their applications. The Council voted to recommend that Carrie Sparrevohn, L.M. and Barbara Yaroslavsky be reappointed to the MAC by the Board for a three year term.

*Ms. Chang made a motion to reappoint Ms. Yaroslavsky and Ms. Sparrevohn to the Midwifery Advisory Council for a three year term; s/Moran; motion carried.*

**B.      Update**

Karen Ehrlich, L.M., Chair of the MAC, expressed the Council's pleasure in having Ms. Yaroslavsky and Ms. Sparrevohn's continued service on the MAC. She requested that the Board consider expanding the number of members on the MAC in order to allow a parent who has been cared for by a midwife to sit on the Council and bring a parent's perspective to discussions. This would necessitate the addition of another midwife to the MAC since, by law, half the members must be licensed midwives. This would provide an opportunity to include a midwife from southern California on the Council, as there are some differences in how midwives in the two regions work. Ms. Ehrlich stated she was aware of the current travel issues and said the addition of two members would not have to be immediate.

Ms. Whitney indicated that at the May 2011 Board meeting, the MAC was given permission to consider the expansion of the Council at its next meeting and then bring a plan back to the Full Board.

Ms. Ehrlich expressed her concern over the cancellation of the August 11, 2011 MAC meeting which was cancelled due to staffing constraints. She stated the MAC is not scheduled to meet again until December 2011. As the original mandate was for the MAC to meet four times per year between the Board meetings, she was concerned this reduced schedule delays the ability of the Council to move forward in addressing midwifery issues.

In June, Ms. Ehrlich reported she attended the International Confederation of Midwives (ICM) Triennial Congress in South Africa. She indicated there are changes coming in international midwifery by the ICM with the complete endorsement of the World Health Organization and the International Federation of Gynecologists and Obstetricians. ICM has put forth a set of standards for the education and regulation of midwives throughout the world. One of the ICM's concerns is that midwifery continue to be an autonomous profession with consultation and collaboration with the medical community, as it is in the rest of the world. Ms. Ehrlich reported California is the only place in the world (that she is aware of) that requires physician supervision of midwives.

### **Introduction of Special Guest**

Ms. Yaroslavsky introduced State and Consumer Services Agency Secretary Anna Caballero and invited her to address the Board. Ms. Caballero serves Governor Jerry Brown as a cabinet member and as Secretary of the SCSA. Her responsibility as Secretary includes the oversight of departments charged with civil rights enforcement, consumer protection, and licensure for 2.4 million working professionals. Secretary Caballero was a former member of the California State Assembly, Mayor of Salinas and council member for fifteen years. She is a graduate of UCLA law school and UC San Diego.

Secretary Caballero thanked the members for their service and expressed her desire to be an ally for the Board to the Governor's Office. She noted policies from the previous administration such as the furloughs and hiring freeze have hampered the Board's efforts, as well as that of all Consumer Affairs departments. Her first charge as Secretary has been to encourage the boards to submit freeze exemptions in order to staff up to do the work they are asked to do. To date, the success rate for the approval of freeze exemptions has been very high.

With regard to the budget, Secretary Caballero stated she is aware that the Medical Board is funded separately and does not receive any General Fund money. The Governor proposed extensions of taxes that were increased two years ago in order to be able to begin repaying loans from special funds and other debt obligations. Unfortunately, the required two-thirds vote necessary for the tax extension was unsuccessful. In order to balance the budget, state services were reduced in a fairly significant manner, including the elimination of some commissions and boards. She noted that revenue has been above projections for most months in the 2011 calendar year, allowing the Governor to project these increases over the long term and predict \$4 billion more in revenues than what was originally projected in January 2011. The budget includes a \$400 million unallocated reduction. The Department of Finance is now going through the process of allocating this reduction to the various departments, with all departments likely to see reductions. Prior to the May budget revise, the Secretary had asked all departments under the SCSA to submit a plan for a 5% reduction in order to gather information on which departments have made cuts or could make additional cuts, and what would the impact of such cuts be. In reality, SCSA will only be required to cut around \$2 million, significantly less than the 5% savings drill. These cuts will not affect the boards, only the Department of Consumer Affairs, requiring them to "flatten out" their organization. The existing hiring freeze will probably take care of some of the unallocated reduction. The Secretary will ask the boards to complete the 5% savings drill in case the \$4 billion in projected revenue increases does not materialize. She would like to have a plan in place so any necessary cuts can be made in a way that will not affect the public or impact services. Secretary Caballero stated it's the Governor's intention that, once the unallocated reductions are identified, the hiring freeze and travel restrictions will be lifted. These are, however, executive orders, and until they are lifted, the Agency will continue to follow them.

Ms. Yaroslavsky asked if the 5% savings would involve permanent or temporary cuts. The Secretary noted that for now, the 5% savings is just an exercise.

With regard to travel restrictions, the Agency has authority over in-state travel. She noted that the state has been embarrassed in the past by trips taken by organizations, commissions, and

boards and the amount of money spent on them. This has created a negative perception by the public with regard to the use of public funds. The public does not understand that the Board is fee-supported and tax dollars are not being used. As such, the Secretary urged caution in the destination and the number of staff traveling and has occasionally placed restrictions.

Ms. Yaroslavsky reassured the Secretary that the Board was highly sensitive to these issues, but it is necessary to have the appropriate staff person in attendance at the various meetings in order to be effective.

Ms. Schipske reminded the Secretary that the Board was down to nine members from the mandated fifteen members. This creates a very large workload for the existing members with regard to the disciplinary panels. The funding of the Operation Safe Medicine is also an issue as it provides an important enforcement function for consumer protection yet has not been provided any funding by the administration.

The Secretary reported she is in communication with staff in the Governor's Appointments Unit and they have assured her they are working diligently to move appointments forward.

Ms. Yaroslavsky described the importance of the Licensing Outreach Program, indicating the Board views this work as mission critical. She requested cooperation from the Secretary in approving travel exemptions for Mr. Schunke's outreach work and other mission critical trips.

The Secretary stated she defers to the boards in determining what is mission critical and pledged her cooperation, particularly with regard to the licensing outreach.

Ms. Yaroslavsky adjourned the meeting at 3:27 p.m. in order for the members to tour the UC Davis Medical School and Hospital Pavilion Building/ Emergency Department. Agenda items not covered were held over to Friday, July 29, 2011.

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**Agenda Item 14      Call to Order / Roll Call**

Ms. Yaroslavsky called the meeting of the Medical Board of California (Board) to order on July 29, 2011 at 9:11 a.m. A quorum was present and notice had been sent to interested parties.

**Members Present:**

- Barbara Yaroslavsky, President
- Hedy Chang, Secretary
- Jorge Carreon, 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.

**Staff Present:**

Eric Berumen, Enforcement Program Manager  
Thomas Campbell, Investigator  
Ramona Carrasco, Enforcement Manager  
Janie Cordray, Research Analyst  
Phil Egeston, Licensing Analyst  
Tamiko Heim, Budget Analyst  
Kurt Heppler, Staff Counsel  
Kimberly Kirchmeyer, Deputy Director  
Ross Locke, Business Services Staff  
Mark Loomis, Supervising Investigator  
Natalie Lowe, Enforcement Analyst  
Armando Melendez, Business Services Staff  
Valerie Moore, Enforcement Program Manager  
Cindi Oseto, Licensing Program Manager  
Regina Rao, Business Services Staff  
Paulette Romero, Enforcement Manager  
Anthony Salgado, Licensing Program Manager  
Kevin Schunke, Outreach Manager  
Anita Scuri, Department of Consumer Affairs, Supervising Legal Counsel  
Jennifer Simoes, Chief of Legislation  
Laura Sweet, Deputy Chief of Enforcement  
Kathryn Taylor, Licensing Program Manager  
Cheryl Thompson, Administrative Assistant  
Renee Threadgill, Chief of Enforcement  
Linda Whitney, Executive Director  
Curt Worden, Chief of Licensing

**Members of the Audience:**

Thomas Balsbaugh, MD, UC Davis  
Peter Bell, M.D., American University of Antigua College of Medicine (AUACOM)  
Katherine Besinque, PharmDn, USC School of Pharmacy  
Yvonne Choong, California Medical Association (CMA)  
Paul Costa, Department of Consumer Affairs  
Merv Dymally, Member of the Public  
Karen Ehrlich, L.M., Midwifery Advisory Council  
Julie D'Angelo Fellmeth, Center for Public Interest Law  
Gisela Escalera, UC Davis  
Teresa Farley, UC Davis  
Stan Furmanski, M.D., Member of the Public  
Virginia Herold, Pharmacy Board of California  
Alice Huffman, National Association for the Advancement of Colored People (NAACP)  
Bridget Levich, UC Davis  
Angela Minniefield, OSHPD  
Margaret Montgomery, Kasier Permanente  
Jagbir Nagra, M.D., AUACOM

Catherine Nation, M.D., University of California, Office of the President  
James Nuovo, M.D., UC Davis Medical School  
Rosielyn Pulmano, Senate Business and Professions  
Carlos Ramirez, Office of the Attorney General  
Mauricio Rodriguez, UC Davis  
Amara Sheikh, Member of the Public  
Rehan Sheikh, Member of the Public  
Neil Simon, AUACOM  
Shannon Smith-Crowley, American Congress of Obstetricians and Gynecologists  
Glee Van Loon, UC Davis

**Agenda Item 15 Public Comment on Items Not on the Agenda**

Dr. Stan Furmanski suggested the Board create a "how to" video explaining the licensing and renewal process to post on its website. He reiterated his concern over testing orders issued by the Board due to a lack of validated testing materials. He indicated that out of state assessment programs, which may be considered as an alternative for the PACE program at UC San Diego, also lack appropriate testing materials in radiology, MRI, anesthesiology, or oncology. Further, he stated that these programs are not accredited as training programs, do not have grading standards, do not have qualified faculty, and have other issues making them unacceptable alternatives.

**Agenda Item 19 Adoption of Revised Emergency Contraception (EC) Protocol**

Virginia Herold, Executive Officer, California Board of Pharmacy, Shannon Smith-Crowley, American Congress of Obstetricians and Gynecologists (ACOG), and Katherine Besinque, PharmDn, USC School of Pharmacy, presented the revised protocol for pharmacists furnishing emergency contraception for the Board's consideration and approval. Ms. Smith-Crowley reported the FDA has approved most emergency contraception to be dispensed behind the counter for those 17 years of age and over; however the state-wide protocol is still valid and in effect for those under 17 years and needs to be updated. In addition, a new emergency contraception drug that requires a prescription, ella™ (Ulipristal), needs to be added to the protocol. Dr. Besinque noted the protocol was originally developed in 2003; the revisions reflect changes in emergency contraception practice.

*Dr. Moran made a motion to adopt the revised emergency contraception protocol; s/Schipske; motion carried.*

**Agenda Item 7 Enforcement Chief's Report**

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

Ms. Threadgill requested approval of eight orders restoring licenses to clear status following satisfactory completion of probation and three orders for license surrender during period of probation or administrative action.

*Dr. Low made a motion to approve the orders; s/Moran; motion carried.*

**B. Expert Utilization Report**

Ms. Threadgill directed members to page 63 of the meeting packet for the Expert Utilization Report. She noted the Board currently has 1,223 active experts on its list. Since January 1, 2011, the Board has utilized 283 experts, three of whom were "off list" experts, to review 444 cases.

**C. Enforcement Program Update**

**1. Staffing**

Ms. Threadgill announced the promotion of Andrew Hegelein to the Supervising Investigator II position that is responsible for the Office of Standards and Training, internet investigations, and Operation Safe Medicine.

The vacancy rate for investigators is currently hovering around 13%; however, the vacancy rate for supervising investigators has reached a staggering 29%, bringing the Enforcement Program's investigative staff to an overall vacancy rate of 16%. Freeze exemptions for the Supervising Investigator positions were approved and management has begun to process and fill these vacancies. Freeze exemptions have also been approved for the Medical Consultant positions throughout the state and staff is engaged in the selection process. It is anticipated that exemptions will also be received for investigator vacancies.

The Complaint Unit has experienced staffing challenges due to retirements and promotions, while the number of physician and surgeon complaints has increased from 6,539 in FY 2009/2010 to 7,117 in FY 2010/2011. Ms. Threadgill stated it is becoming increasingly difficult to perform required duties in light of the staffing shortages.

**2. Program Statistics**

Ms. Threadgill directed members to page 68 of the meeting packet for a chart reflecting the average days for each Enforcement Data Marker for all case types closed during the last three fiscal years. Flow diagrams are also included that display the entire enforcement process for each year.

The acquisition of medical records continues to be an area where there is room for improvement. Improvement opportunities also exist in the timelines for the completion of subject interviews. Ms. Threadgill referenced a case where the Board is seeking the subject interview that has been tied up in subpoena enforcement for almost two years and is now in the court of appeal. The Governor signed into law Board sponsored AB 1127 which makes it unprofessional conduct if a subject repeatedly fails to attend and participate in an interview requested by the Board. This will help improve timelines for subject interviews. Despite the challenges presented by the staffing shortages, investigators reduced the time it takes to resolve a case by 11 days in FY 2010/2011 in comparison to FY 2009/2010.

**3. Probation Program Enhancements**

At the May 2011 Enforcement Committee meeting, Probation Unit staff presented their proposal for enhancing and improving the existing practice monitor condition. Staff presented a number of forms that had been developed to provide better direction to the practice monitors. The feedback received from the Enforcement Committee was very positive and the Probation Unit has started moving forward to implement these improvements. All of the proposed forms which

were shared with the Committee in May have received final approval from Legal Counsel. The Probation Manager is in the process of updating the Procedure Manual to incorporate these changes and to provide direction and training to Probation Unit staff on developing an appropriate Monitoring Plan. It is anticipated that the new forms and protocols will be rolled out to any new probationer within the next three months. All existing practice monitors will then be transitioned to the new reporting format and chart audit tool; existing monitoring plans will be reviewed and modified, if necessary.

A chart displaying the components the Board considers when determining if other programs are equivalent to the UCSD PACE Program has been implemented (see page 67 of the packet). There is flexibility in determining equivalency if a program is missing a requirement that can be satisfied in another way.

During public comment, Mr. Furmanski provided members with a handout asserting why the various programs listed on page 67 will not work for 12 specialties.

**Agenda Item 8 Vertical Enforcement Program Report**

**A. Status Report on VE Manual**

Ms. Threadgill commended Deputy Chief Laura Sweet and Deputy Attorney General Thomas Lazar for their collaboration in making revisions to improve the Vertical Enforcement (VE) Manual. Statewide implementation of the newly revised manual is planned for September 2011.

**B. Statistics**

Carlos Ramirez, Senior Assistant Attorney General, directed members to the matrix of unfiled cases in the AG's Office as of July 14, 2011 (see page 70). He reported these numbers have now changed; currently, there are 2 unfiled cases that are 30 days old or less in the AG's office, 3 cases 31-60 days old, 2 cases 61-90 days old, and 2 cases 90 days or older.

The AG's Office has recently developed a statistical report which has been submitted for the Executive Director's approval. The scope of data will be expanded from the first quarter of the year going back to 2009 and will be provided to Ms. Whitney in the next few weeks.

**C. HQE Organization and Staffing**

Mr. Ramirez directed members to page 70.2 of the meeting packet for a roster of the Health Quality Enforcement Section showing the distribution of HQE staff throughout the state.

**Agenda Item 20 Status of the UC Medical School System**

Dr. Cathryn Nation, Associate Vice President for Health Sciences in the University of California's Office of the President delivered a presentation on the UC Medical School system.

Dr. Nation reported there has been no real expansion of the UC medical education system in almost 40 years, despite staggering growth in California's population, rapid aging, and increasing diversity. California is projected to face a shortfall of up to 17,000 physicians by 2015. Geographic areas with large medically underserved communities are a particular concern.

In 2010-2011, 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 Davis has 436 enrolled students; UC Irvine - 483; UC Los Angeles - 837; UC San Diego - 592; UC San Francisco - 791. The total UC medical school enrollment is 3,139. These numbers include students enrolled in two long standing programs operated by the UCLA School of Medicine: one with UC Riverside, which has a 35 year history and is the foundation of the UC's efforts to open a new medical school, and the other with Charles Drew University of Medicine and Science in South Central LA. There are three private allopathic medical schools in California: Loma Linda - 713 enrolled students; USC - 721; and Stanford - 461 (total enrollment 1,895). In addition, there are two osteopathic medical schools: Touro - 551, and Western 875 (total enrollment 1,426).

The number of students from ethnic groups that are underrepresented in medicine (URMs) make up a much greater percentage of the student population in UC medical schools versus those in private schools (23% of UC medical school students, 16% of private M.D. school students, 3.3% of private D.O. school students). Underrepresented ethnic groups among *all* California medical students make up approximately 16.2% of the medical student population. This compares to 14.6% nationally.

Eight or nine years ago, the UC system launched a system-wide initiative entitled "PRograms in Medical Education" (PRIME) to align public medical education with the social needs of Californians and the medically underserved, with a dual goal of realizing some of the benefits of diversity that were lost following the passage of Proposition 209 and the Regent's action that preceded that. Total enrollment of PRIME students across all five campuses in 2010/2011 was 253; 55% of these students were from ethnic groups underrepresented in medicine.

Each of the programs within the UC system has a different focus and seeks to recruit students with an interest in the particular area of focus, include an emphasis on particular needs during the teaching years, and place students during their third and fourth years in clerkships that will prepare them for future practice and GME.

- UC Davis - rural health / telemedicine
- UC San Francisco - urban underserved / homeless
- UC Los Angeles - diverse/disadvantaged / multicultural populations
- UC Irvine - Spanish speaking
- UC San Diego - health disparities / border health

UC System-wide PRIME enrollment will total approximately 300 students in the fall of 2011. This should result in 60-70 medical school graduates from the PRIME program each year. Virtually no state support has been provided for these programs. Core support is an on-going challenge for these programs.

Planning continues for a new School of Medicine at UC Riverside with a goal of admitting a first class in the fall of 2013. A submission to the LCME for preliminary accreditation was denied, with the reason for the denial being inadequate evidence of core state support. The UC Office of the President is working with the Chancellor and Founding Dean in hopes of being able to resubmit in one year. The goal will be to enroll a class of 40-50 students, contingent upon the budget.

The new UC Davis PRIME – UC Merced San Joaquin Valley PRIME program will admit its first class in the fall of 2011 (5 students), with goals for growth over time. In this partnership, UC Davis will be the LCME degree-granting program; clinical clerkships will be done in conjunction with UCSF at the Community Regional Medical Center in Fresno, as well as partnership from UC Merced with interest in taking on an increasing role as budget and resources allow.

With regard to residency training, the UC system trains more than 4,400 medical residents and fellows, nearly half of the state's total. Of these, 1,614 are in primary care, 919 in hospital-based specialties, 782 in surgery, and 1,104 in other specialties. Including trainees who are doing an additional year of training related to research or a clinical emphasis brings the total number of trainees up to almost 5,000.

Medical education in California faces unprecedented economic challenges. State support to the UC system for FY 2011/2012 was reduced by an additional \$650 million, this following multiple years of cuts and erosion to core support. Proposed cuts to Medicare funding for graduate medical education could result in cuts to UC medical centers of up to \$900 million over ten years (if passed by Congress). Further, 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.

The average four-year cost of attendance at UC medical schools is \$200,000; this represents a 35% - 56% increase in the past five years (depending upon the particular school). The cost for the most recently admitted class will likely climb to \$250,000. The debt load for graduating students is significant, with most students graduating with \$150,000 or more in debt (not including undergraduate debt).

Enrollment at for-profit medical schools is growing rapidly. The cost of these programs is high and graduation rates are much lower than for non-profits. 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.

### **Special Presentation**

Ms. Yaroslavsky presented Dr. John Chin with a plaque in recognition of his years of service to the Board and expressed the Board's appreciation for his work. Dr. Chin served on the Board from September 2006 through June 2011. He participated as an active member of Panel A, the Wellness Committee, Enforcement Committee and as Chair of the Special Programs Committee.

Dr. Chin thanked the Board, stating that it has been a privilege to serve alongside the other members.

### **Agenda Item 21      Consideration of Request for Recognition of American University of Antigua**

Mr. Worden directed members to page 97 of the meeting packet. He reported that the American University of Antigua College of Medicine (AUACOM) applied to the Board for recognition.

An evaluation of the school was conducted to determine if it met the requirements of Business and Professions Code Sections 2089 and 2089.5 and California Code of Regulations, Title 16, Section 1314.1(a)(2). AUACOM was determined to have met these requirements. Staff recommends that the Board recognize AUACOM and deem it to be in substantial compliance with the required statutes and regulations and to extend that recognition only to those students who matriculate at AUACOM on or after January 1, 2007.

The evaluation involved a review by staff and Dr. James Nuovo, Licensing Medical Consultant, of materials presented to the Board by AUACOM. A site visit to the school and two of the teaching hospitals was part of the Board's review. The site visit team consisted of Linda Whitney, Executive Director, Shelton Duruisseau, Ph.D., Board member, Anita Scuri, DCA Supervising Legal Counsel, and James Nuovo, M.D.

Dr. Nuovo provided a slide show presentation of the site visits and a summary of his written report and findings.

Dr. Duruisseau thanked the staff from AUACOM for their hospitality during the site visit and commented favorably on the diversity of the student body and the student's commitment to mastery of the material and service to medically underserved populations.

*Dr. Duruisseau made a motion to recognize the American University of Antigua College of Medicine and deem it to be in substantial compliance with the requirements of the Business and Professions Code Sections 2089 and 2089.5 and California Code of Regulations, Title 16, Division 13, Section 1314.1(a)(2) and to extend that recognition only to those students who matriculate at AUACOM on or after January 1, 2007; s/Levine.*

Neal Simon, President, AUACOM, thanked the site visit team for their work and also for their help in identifying areas for improvement.

Dr. Jabir Nagra, Executive Dean, Antigua Campus, noted the program networks with both non-government and government agencies in its efforts to engage with the local community.

Ms. Scuri clarified that the recognition does not extend to students who completed their basic sciences at Kasturba Medical College International Center in India.

*Ms. Yaroslavsky called for the vote; the motion as stated by Dr. Duruisseau carried.*

**Agenda Item 22 Annual Report on the MBC /UCD Telemedicine Pilot Program**

Mr. Schunke reported in 2007 the Board was authorized via Assembly Bill 329 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 bill required the Board to report to the Legislature with finding and recommendations at the end of the first year; however, the Board realized that a one-year pilot was not feasible and expanded the contract to a three-year program. The first report was delivered at the July 2010 meeting and is posted on the Board's website. The second annual report, presented to the Legislature earlier this month, is located in the meeting packet (beginning on page 181). The

report presents a summary of the milestones and achievements recognized in the second year of the pilot. A full summary and evaluation will be submitted in the final report to be prepared in the fall of 2012 at the conclusion of the pilot.

Dr. Nuovo reported the pilot focuses on the development of a diabetes self-management education program via telemedicine for patients with Type II diabetes living in a 33-county area of rural, underserved communities in northern and central California.

Glee Van Loon, UC Davis, pilot project manager, discussed some of the challenges faced in recruiting sites to participate in the program. She presented a map showing the geographic distribution of participating sites, as well as sites that were contacted but chose not to participate. To date, there are 12 clinics involved in the pilot.

Maricio Rodriguez and Gisela Escalera, UC Davis health coaches for the pilot, provide the teaching, coaching, and chart audits at the various site locations. They reported the educational materials and forms used in coaching have been translated into Spanish. Travel to the rural sites was often challenging and they discovered first-hand the difficulty program participants face in making healthy food choices due to limited or no access to fresh produce. The coaches work closely with clinic staff at each site, specifically with the site coordinators. They've received positive feedback from program participants.

Tom Balsbaugh, M.D., presented on the continuing medical education (CME) component of the pilot and on educating the health care providers at the various sites on the most current knowledge and care management strategies to support the provision of evidence-based diabetes care. Physician participation has been the greatest challenge as physicians in these clinics are extremely busy. Clinic support staff have participated in the training, highlighting the effectiveness of a team approach in diabetes management.

Teresa Farley, UC Davis, Administration Officer at the Center for Health Care Policy and Research, reported the majority of participants who have engaged with the pilot have had a positive experience. Individual clinics often serve large geographic areas, with participants sometimes driving 60 miles to the closest clinic in order to receive care.

Dr. Low asked about the funding for the pilot project and the metrics being used to evaluate the program.

Ms. Whitney reported the contract between UC Davis and the Medical Board is for \$400,000 over a three-year period.

Dr. Nuovo indicated the overall goal of AB 329 was to determine if telemedicine is an effective tool for reaching patients who don't normally have access to these types of educational resources. Qualitative reports of the obstacles faced in implementing such a program are one element of the evaluation. Other qualitative measurements include the impact of health coaching and education classes on the participants' perceptions of their ability to take care of themselves, control their disease, and overall sense of well-being. Objective measurements of factors such as hemoglobin A1C, blood pressure, etc. are also available. Both objective and qualitative measurements must

be included in the final report to determine if the project can be generalized to help the greater population with a disease that is an epidemic.

Given the economic times, Dr. Low stated that the project must show that telemedicine is a cost-effective way to improve the outcomes for diabetes and generates health care cost savings as individuals learn better diabetes self-management skills leading to fewer complications. These types of metrics are needed to show a good return for the investment in telemedicine. He was concerned that the project did not have this sort of focus.

Dr. Nuovo indicated that the final report would include a financial evaluation and return on investment assessment. Although the project's three-year span makes it difficult to track long-term outcomes, there are short term outcomes such as weight reduction and hemoglobin A1C that are accurate predictors of long term results. These will be included in the final report, as well.

Ms. Yaroslavsky asked if recommendations would be made for the population at large as a result of the study, particularly with regard to diet, portion control, etc.

Dr. Nuovo indicated this would be possible, as the study addresses larger public health issues.

**Agenda Item 23      Consideration of Petition to Repeal Section 1349 of Title 16 of the California Code of Regulations Pertaining to Physician-Podiatrist Partnerships**

Ms. Yaroslavsky reported that the author of the petition has requested that this item be deferred until the October 2011 meeting.

**Agenda Item 25      Report on Health Care Reform in California**

Angela Minniefield, Deputy Director, Office of Statewide Health Planning and Development (OSHPD), reported that OSHPD is one of 13 departments within the California Health and Human Services Agency. The department's vision is equitable healthcare accessibility for California; they have administered health workforce development programs and provided grant funding to address health workforce diversity, supply and distribution issues since the late 1970's.

California faces significant health workforce challenges. These include: a shortage of health professionals, an unequal distribution of health professionals, lack of racial and ethnic diversity, insufficient number of bilingual professions, constraints on capacity of educational programs, scope of practice laws, reimbursement policies limiting the ability to attract providers to underserved areas, the lagging economy and an increased demand for healthcare services.

Ms. Minniefield provided an overview of the elements of Title V of the Patient Protection and Affordable Care Act (PPACA). The Act supports innovations in healthcare workforce preparation and focuses on increasing the supply of the healthcare workforce via scholarships, loan repayment programs, internships, fellowships, etc. Further, the Act focuses on enhancing health workforce education and training opportunities via grants targeting primary care residency programs, physician assistant programs, nurse-managed healthcare clinics, etc. Additional

elements include supporting the existing healthcare workforce, strengthening primary care and other workforce improvements through pilot projects, and improving access to healthcare services.

At the state level, Ms. Minniefield reported OSHPD has partnered with the California Workforce Investment Board (CWIB) to develop a comprehensive strategy for workforce development. A planning grant was received to begin work that is focused on health professions education, training, and workforce development provisions in Title V of the PPACA. The Health Workforce Development Council was established in August 2010 as a special committee of the CWIB. It is tasked with understanding the current and future workforce needs of California's health delivery system and developing a comprehensive strategy to meet those needs. Currently, the Council is focused on activities related to the HRSA funded Health Workforce Planning Grant received in September 2010.

The Health Workforce Development Council established a Career Pathways Subcommittee, charged with developing recommendations on how existing health career pathways and infrastructure can increase access to primary care and facilitate the progress of students pursuing health professions. Pathways were reviewed for the following professions: primary care physicians, primary care nurses, clinical lab scientists, medical assistants, community health workers, public health professionals, social workers, and alcohol and other drug abuse counselors. The Subcommittee made recommendations to address education, data collection, and policy issues, as well as barriers to increasing the supply of primary care physicians.

Dr. Duruisseau expressed interest in having a discussion on which entities would be responsible for implementing the recommendations that have been made by the various speakers today.

Ms. Yaroslavsky suggested that this concern might be captured in the discussion of the Board's strategic plan.

#### **Agenda Item 11 Physician Assistant Committee Update**

Dr. Low reported the Physician Assistant Committee (PAC) met on May 19, 2011. At the meeting, the Committee moved to support SB541. The PA Education and Training Subcommittee brought forth a proposal to amend the regulations; the PAC moved to set the matter for hearing. A regulation requiring PAs to post a notice to consumers, similar to the Board's requirement for physician, is at the Office of Administrative Law for review and approval. Legal counsel will be sending a notification to the Department of Public Health as there have been some problems with agencies recognizing a PA's order for physical therapy. The Committee is also compliant with the travel restrictions; hence, all meetings have been moved to Sacramento to reduce travel. The location of future meetings will be determined in 2012. Due to the small size of the PAC, any vacancy creates a hardship. A half-time vacancy in the licensing area has created a backlog for the first time. A request for a hiring exemption was denied; this request is being resubmitted.

#### **Agenda Item 12 Federation of State Medical Boards Update**

Ms. Chang reported that Ms. Whitney has been appointed to the Federation's Minimal Data Set Work Group.

Ms. Chang noted there are 12 states that will participate in a pilot program on the maintenance of licensure; the Osteopathic Medical Board of California is a participant. She suggested inviting the Federation to give a presentation to the Board on the maintenance of licensure issue.

A new concept has been developed by the National Board of Medical Examiners and FSMB that will involve the combining and sharing of data from medical schools, USMLE exam results, license status, etc. Ms. Chang indicated that more information will be forthcoming on this concept.

New officers were selected at the recent meeting of the FSMB Foundation. Ms. Chang was elected to the position of Treasurer.

**Agenda Item 13 Health Professions Education Foundation Update**

Ms. Yaroslavsky directed members to page 73 of the meeting packet for the 2010 Steven M. Thompson Physician Corps Loan Repayment Program Annual Report to the Legislature. A list of the 2010 award recipients is located on page 80 of the packet. She reported HPEF was able to collaborate with the state to offer an additional \$1.7 million in loan repayment funds. The applications are currently being evaluated; it is anticipated that an additional 20-30 awards will be made.

**Agenda Item 10 Access to Care Update**

Ms. Schipske reported the Access to Care Committee met on July 28, 2011. Debra Ortiz, Vice President of Policy and Government Affairs for the California Primary Care Association, addressed the Committee, providing an overview of how the Association is attempting to grapple with the Affordable Care Act and the 4-5 million new healthcare consumers that will require services. The Committee asked Ms. Ortiz to keep them informed on the Associations efforts with regard to collaborative care. At the October 2011 meeting, the Committee will hear a presentation from Tom Sullivan, author of *Collaboration: A Health Care Imperative*.

**Agenda Item 16 Board Member Communications with Interested Parties**

Ms. Yaroslavsky reported she has had several phone calls with representatives from the Governor's Office and Senate Rules Committee with regard to appointees to the Board.

No other members had communications to report.

Ms. Yaroslavsky announced that Dr. Moran has completed her term on the Board. Dr. Moran was appointed to the Board in 2004. She has participated as an active member of Panel B, the Education Committee, Physician Humanitarian Award Committee, and Chair of the Physician Responsibility in Supervision Advisory Committee. The Board was proud to nominate Dr. Moran as a candidate for FSMB's Nominating Committee, and she was elected to serve in that capacity. Ms. Yaroslavsky presented Dr. Moran with a plaque in recognition of her service to the consumers of California.

Dr. Moran thanked the Board, stating it has been an honor and privilege to serve the citizens of the state and work with such a dedicated staff.

**Agenda Item 17 President's Report**

**A. Committee Appointment**

Ms. Yaroslavsky reported there are currently no members on the Physician Recognition Committee. Continuation of this committee is a subject of discussion in the strategic planning process; thus, any appointments to this committee will be deferred until the full Board has made a decision on the continuation of this function.

Ms. Yaroslavsky appointed Dr. Carreon to serve on the Special Programs Committee.

During the last quarter, Ms. Yaroslavsky has participated in three monthly conference calls with DCA director, Brian Stiger, and other healing arts board presidents. The minutes from these calls are now provided to the members as they become available. Ms. Yaroslavsky asked members to contact her if they have items they would like to have addressed in the calls. The major topics have been the hiring freeze, BreEZe, travel restrictions and the budget.

On June 15, 2011, Ms. Chang, Ms. Whitney, Ms. Kirchmeyer and Ms. Yaroslavsky met with Agency Secretary Anna Caballero, and Undersecretary Willie Armstrong. Ms. Yaroslavsky reported they seemed very supportive of the Board and understood its need to be removed from the hiring freeze and various restrictions. The Secretary stated that she was hopeful that executive orders would be issued soon to provide some relief. The Operation Safe Medicine (OSM) Program and the Board's lack of a Public Information Officer were also discussed.

**Agenda Item 18 Executive Director's Report**

**A. Introduction of Deputy Director**

Ms. Whitney introduced Kim Kirchmeyer as the Board's new Deputy Director. Ms. Kirchmeyer previously served as the Board's Deputy Director before leaving to work at the Department of Consumer Affairs for 18 months. She will be responsible for the administrative functions of the Board.

Ms. Whitney recognized Ross Locke, Business Services Assistant, who is retiring from state service. Mr. Locke has served as sound engineer at Board and committee meetings and provided operational support in the Business Services Office. Ms. Yaroslavsky presented Mr. Locke with a framed declaration in honor of his dedication and service.

**B. Staffing and Administrative Update**

Ms. Kirchmeyer indicated that at the May 2011 meeting, Ms. Whitney reported there were 61 vacancies at the Board; this number included the Consumer Protection Enforcement Initiative (CPEI) positions that were obtained through the Budget Change Proposal process. As of July 1, 2011, the Board has 58 vacancies (including the CPEI vacancies). However, this number does not take into account moving 6 positions from the OSM Unit into existing vacant positions due to the loss of the authority for OSM that occurred on July 1, 2011. Hence, the true number of vacancies (as compared to the numbers reported by Ms. Whitney in May) would be 64. This number does not include 7 future vacancies that will be occurring in the next couple of months due to retirements and staff transferring out of the Board. The 58 vacancies equates to a 20% vacancy rate at the Board.

Individuals may still be hired from within the Board and the Department; however, freeze waiver exemptions must still be requested to fill any positions with individuals from outside the Board or Department. Eight freeze exemption requests have been submitted to the Department:

- Three of the exemptions were approved by the Governor's Office; these included medical consultants for both the Licensing and Enforcement Units and four Supervising Investigators.
- Two of the freeze exemptions for 6 Office Technicians in our Licensing Program and 5 Investigators have been approved by DCA and SCSA and are currently pending at the Department of Finance.
- Three of the freeze exemptions are pending review by DCA; these are for a Public Information Officer, 3 Associate Governmental Program Analysts in the Licensing Program, and an Executive and Administrative Assistant in the Executive Office. Of the 3 support positions in the Executive Office, 2 of them are vacant; this requires individuals to perform two jobs in order to keep the Executive Office running.
- Staff is currently working on 3 additional freeze exemption requests; these are for Advisory Medical Consultants, Inspectors, and an Associate Governmental Program Analyst in the Enforcement Program.

### **C. Budget Overview**

Ms. Kirchmeyer introduced the Board's new Budget Analyst, Tamiko Heim. Ms. Kirchmeyer directed members to pages 86-94 of the meeting packet for the budget reports. Page 86 shows the most recent fund condition for the Board. It is projected that the Board will revert approximately \$2.5 million in FY 2010/11. This is due mainly to the restrictions on hiring as a result of the hiring freeze. The final FY 2010/11 reports are not yet available, so this number is still a projection.

The fund condition shows the \$9.0 million loan to the General Fund in the current fiscal year and also shows the Board obtaining the funding in FY 2012/13 for the Office of Safe Medicine. The fund condition shows the Board going to 1.5 months reserve in FY 2013/14. However, this is based upon figures that are currently available without any adjustments that will be made throughout this fiscal year and with assumptions that will change, including any reversions due to hiring, travel restrictions, or any other executive orders that may be issued.

As was discussed by Secretary Caballero, on July 21, 2011, Ms. Whitney received an email from the Department stating that the State and Consumer Services Agency has asked the boards to look for ongoing savings in their budgets. This savings is in addition to the current reductions due to the workforce cap and the normal budgeted salary savings. The direction provided was that the boards would identify a 5% saving plan. For the Medical Board this equates to approximately \$2.5 million. With the direction provided by Secretary Caballero, Board staff will work to review the budget and identify the savings. This reduction plan must be submitted to the Department by August 8, 2011. This 5% reduction plan will have an impact on the Board's fund condition and the Board will have to critically watch its spending in this fiscal year.

Recent direction was provided by the Department and the SCSA with regard to any Budget Change Proposals in which the board is seeking additional position authority. In such proposals, Agency will look at three main elements: 1) Is there a structural imbalance at the board (i.e., is

the board receiving less revenue than it is spending each year?) 2) Will an increase in spending authority require a refund of any general fund loan? 3) Will the increase require a fee increase for the licensees? Staff believes that this should not impact the Board at this time (particularly with regard to the augmentation request to staff the Operation Safe Medicine Unit).

Ms. Kirchmeyer reported she was notified by the Department that the travel for the Licensing Program Outreach by Mr. Schunke has been approved for the month of August.

#### **D. BreEZe Update**

Ms. Kirchmeyer stated the Department has been working for the last year and a half to enter into a contract to replace the existing and outdated licensing and enforcement databases. The project, called BreEZe, has reached several major milestones. The vendor's proposals were evaluated and based upon the fact that only one vendor had a compliant bid, only one cost proposal was opened. The costs were higher than anticipated, so the Department entered into negotiations with the vendor. After the negotiations, the Department was able to reduce the original proposal by \$11 million without changing the scope of the project. Although the proposal is still higher than anticipated, this was a number that the Department believed was justified and still affordable.

The Department had to prepare a Special Project Report that required approval by both the SCSA and the California Technology Agency (the State's information technology oversight agency). That Special Project Report was approved last week supporting the continuation of the project. Due to the fact that there was a change in the funding amount for the project, the Department also had to prepare a Section 11 Application that requires approval by the Department of Finance and then a 30-day notification to the Legislature. At this point the Department does not foresee any issues with approval of the Section 11 Application and is anticipating entering into a contract with the vendor by the end of August 2011.

The Department and Board staff have had calls with the vendor to discuss some of the requirements and to ensure readiness when the contract is signed. The Medical Board is scheduled in Release 1 that is anticipated for July 2012. Ms. Kirchmeyer indicated there are many staff members working on this project and thanked them for the time they have put into this project. Staff will become even more involved once the vendor is onboard and will continue to stay involved to ensure that the system meets the Board's needs. At this time, the most significant risk is data conversion – both DCA and Board staff will be working with the vendor to analyze and document the current systems in order to mitigate this risk.

Ms. Whitney stated there is also a risk if there is not enough staff available to dedicate to the conversion. The conversion will require more staff than is currently assigned to the project; staff will be pulled from other areas to assist. This will challenge the Board's ability to conduct its normal work.

#### **E. Board Meeting Dates and Locations**

##### **1) Location of October 27-28, 2011 Meeting**

Ms. Whitney stated that at the May 2011 meeting, members clearly stated their preference to hold the quarterly meetings at various locations throughout the state for consumer access. Some boards and committees have made the decision to hold all their meetings in Sacramento. Ms.

Whitney is confident that staff will be able to travel to the October 27-28, 2011 meeting in San Diego, although probably not the number of staff that normally attends. Committee meetings will be analyzed to determine if staff will be available to participate. It is possible that some committees may have to meet off-cycle in Sacramento, separate from the regularly scheduled Board meeting. Ms. Whitney stated it is possible that the 5% reduction drill might result in a lifting of the travel freeze, allowing staff to travel as necessary.

## **2) 2012 Board Meeting Dates and Locations**

Ms. Whitney directed members to page 95 in the packet for the proposed Board meeting dates and locations for 2012:

- February 2-3, 2012 in San Francisco
- May 3-4, 2012 in Los Angeles
- July 26-27 in Sacramento
- October 25-26 in San Diego

*Dr. Duruisseau made a motion to approve the proposed Board meeting dates and locations for 2012; s/Chang; motion carried.*

### **Agenda Item 26 Election of Officers**

Ms. Yaroslavsky reported at the July 2009 meeting, the Board voted to change the date it holds its election of officers from the last meeting of the calendar year to its July meeting. The Board also voted that the newly elected officers officially enter into those positions at the conclusion of that Board meeting.

Ms. Yaroslavsky opened the nominations for President of the Board.

*Dr. Salomonson nominated Ms. Yaroslavsky to continue as President; Dr. Carreon seconded the nomination; by a show of hands, Ms. Yaroslavsky was re-elected as President of the Board.*

Ms. Yaroslavsky opened the nominations for Vice President of the Board.

*Ms. Chang nominated Dr. Salomonson for Vice President; Ms. Schipske seconded the nomination; by a show of hands, Dr. Salomonson was elected as the Vice President of the Board.*

Ms. Yaroslavsky opened the nominations for Secretary of the Board.

*Dr. Levine nominated Ms. Schipske for Secretary; Dr. Salomonson seconded the nomination; by a show of hands, Ms. Schipske was elected as Secretary of the Board.*

### **Agenda Item 27 Agenda Items for October 27-28, 2011 Meeting**

Dr. Salomonson requested that an addiction medicine specialist address the Board on the diagnosis of substance abuse disorders and the criteria for determining when a physician is fit to practice with these various diagnoses.

Dr. Carreon concurred, stating he recently attended a lecture on chemical dependency at the Betty Ford Center and found the information very useful. He suggested that these experts might provide a lecture to the Board.

Ms. Schipske requested an update on the Governor's pending order to release inmates from prison and the impact this will have due to their need for medical care, particularly in light of cuts to county funding.

Ms. Schipske also asked for an update or clarification on medical marijuana issues, including the Board's assigning of fictitious name permits to medical marijuana clinics and physicians who fail to conduct a good faith exam before issuing a recommendation. She requested an overview of the Attorney General's new guidelines regarding medical marijuana collectives in order to ensure the Board's work is in sync with what the AG's Office is trying to enforce.

Dr. Levine would like to continue discussion on the maintenance of licensure and certification, particularly with regard to the work the Federation of State Medical Board's is doing. She suggested a regular update on the Federation's progress and a presentation from the American Board of Internal Medicine on the maintenance of certification for ABMS specialties.

**Agenda Item 28      Discussion and Possible Action on Draft Strategic Plan Presented by the Executive Committee and Strategic Plan Subcommittee**

Ms. Cordray reported the Executive Committee met on July 27, 2011 to discuss an outline prepared by staff and the Strategic Planning Subcommittee. The outline was a compilation of ideas and suggestions of Board members and staff obtained from interviews and surveys conducted in June 2011. The Committee reviewed the mission statement, goals and ideas for objectives proposed to be included in the 2012 Strategic Plan. Ms. Cordray indicated the Executive Committee reached consensus on the Board's mission, goals, and ideas to be refined into measurable objectives and have asked the full Board to weigh-in with their opinions. A memo summarizing these items was distributed to those present [Note: This document is available on the Board's website under the materials for the July 2011 meeting – see Agenda Item 28 Addendum]. Staff will take the Board's input and will work with the Strategic Plan Subcommittee and the Executive Committee to further refine the ideas. If there is concurrence by the committees, a first draft of the 2012 Strategic Plan will be presented at the October 2011 Board meeting. It is hoped that a final plan will be drafted and presented for adoption at the February 2012 Board meeting.

***Dr. Salomonson made a motion to adopt the following mission statement for the 2012 Strategic Plan:***

***“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 license and regulatory functions.”***

***Dr. Duruisseau seconded the motion; motion carried.***

The Executive Committee proposed six goals for the 2012 Plan. After discussion and input from members, the following goals were agreed upon by the full Board:

1. **Professional Qualifications:** Promote the professional qualification 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 Licensee Education:** Increase public and licensee 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 the changing healthcare environment and evaluate 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.

*Dr. Salomonson made a motion to approve the goals as stated above; s/Duruiseau; motion carried.*

Ms. Cordray reported the Executive Committee reviewed the ideas from Board members and staff and selected those with the potential to be developed into objectives for the Strategic Plan. Appropriateness to the Board's mission or mandate and ability to transform the concept into a measurable objective were the criteria used in determining which ideas to pursue. Board members provided input on the ideas presented and directed staff to further develop these into objectives for discussion at the October 2011 meeting.

During public comment, Rehan Sheikh noted the review of the Medical Practice Act and how the Board makes decisions was eliminated from the Strategic Plan at the Executive Committee meeting on July 27, 2011. He stated it was important to review decisions to determine if any errors have been made. He questioned the purpose of the Strategic Plan without these two elements and called for greater accountability for the Board.

**Agenda Item 29      Adjournment**

*There being no further business, Dr. Salomonson made a motion to adjourn; s/Levine.*  
The meeting was adjourned at 2:37 p.m.

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Barbara Yaroslavsky, President

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Gerrie Schipske, R.N.P., J.D., Secretary

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Linda K. Whitney, Executive Director

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: October 10, 2011  
ATTENTION: Medical Board of California  
SUBJECT: Special Faculty Permit Review Committee  
Recommendation  
STAFF CONTACT: Curtis J. Worden, Chief of Licensing

RECOMMENDED ACTION:

Board approves the recommendations of the Special Faculty Permit Review Committee (SFPRC) for appointments pursuant to Section 2168.1 of the California Business and Professions Code.

BACKGROUND AND ANALYSIS:

The Medical Board of California is authorized to issue a Special Faculty Permit (SFP) to a person who is academically eminent and meets all of the other requirements pursuant to Section 2168.1 of the California Business and Professions Code (B&P).

An individual who holds a valid SFP is authorized to practice medicine only within the medical school itself and any affiliated institutions in which the SFP holder is providing instruction as part of the medical school's educational program and for which the medical school has assumed direct responsibility.

The SFPRC is comprised of two Board members, one who is a physician and surgeon and one who is a public member, and of one representative from each of the medical schools in California. The SFPRC reviews and makes recommendations to the Board regarding the applicants applying pursuant to Section 2161.1 of the B&P.

At its September 15, 2011 meeting, the SFPRC reviewed the qualifications of two applicants: One from the University of California Los Angeles, David Geffen School of Medicine (UCLA-DGSOM) and one from the University of California San Francisco, School of Medicine (UCSF-SOM).

DANIEL HOMMES, M.D., UCLA- DGSOM - SFP APPLICANT:

On behalf of Neil Parker, M.D., UCLA-DGSOM, Senior Associate Dean Student Affairs and Graduate Medical Education, Gary Gitnick, M.D., UCLA-DGSOM, Chief of Digestive Diseases/Gastroenterology, Professor of Medicine, presented UCLA-DGSOM's request for Daniel Hommes, M.D. to receive a special faculty permit and the qualifications of Dr. Hommes. Dr. Gitnick indicated that Dr. Hommes is an internationally recognized physician in the specialized area of gastroenterology, specifically in the area of Inflammatory Bowel Diseases. Dr. Hommes has conducted pioneering work into the pathogenesis of the disease as well as the mechanism of action of new medications and has made innovative and significant authentic contributions to clinical research,

specifically regarding stem cell research and education in the gastroenterology field. In addition, Dr. Gitnick stated Dr. Homme's presence at UCLA-DGSOM will be a unique and remarkable addition to the Division of Digestive Diseases and would benefit patients at UCLA-DGSOM.

Dr. Hommes graduated from the University of Amsterdam in August 1993. He has completed several residencies and fellowships between 1990-2002. Dr. Hommes completed three years of residency training in internal medicine at the Academic Medical Center in Amsterdam from 1991-1994 and continued his training completing a research fellowship at the Center for Experimental Internal Medicine from 1994-1995. Dr. Hommes' training completed from 1995-2000 allowed him to become board certified in internal medicine in May 2000 and board certified in gastroenterology in May 2002.

Dr. Hommes has held academic positions in Amsterdam and the Netherlands: Head Center for Inflammatory Bowel Disease 2002; Department of Gastroenterology and Hepatology at Leiden University Medical Center 2006; Professor gastroenterology and hepatology 2007, Leiden University Medical Center (LUMC); Project leader for CuraRata "Integrating HealthCare and Research" 2007; Steering Committee LUMC 2008, along with several other academic positions. Dr. Hommes' highly innovative discoveries have been published in numerous top medical journals and his publications are referenced, discussed, and cited within peer-reviewed publications authored by international and national leaders in the field.

Dr. Hommes is a nationally recognized chairperson for several committees: Centraal Begeleidings Orgaan (CBO) Committee in 2007; founder and vice-chair Dutch Crohn Colitis Foundation (DCCF) 2006; Chair of Dutch Inflammatory Bowel Diseases (IBD) Guidelines Committee CBO 2004. His international recognition consists of being the President of the European Crohn and Colitis Organization 2010-2012; Editor Journal Crohn's and Colitis 2007; Chair of European Crohn's Colitis Organization (ECCO) Scientific Committee 2004, along with several other committees. Dr. Hommes is currently the Chairman of the Department of Gastroenterology and Hepatology at the Leiden University Medical Center in the Netherlands.

Dr. Gitnick stated that there is a great need for in California and in our nation for the type of stem cell therapy and research to treat Crohn's disease. Currently, this type of cutting edge research and treatment is not available in the U.S. After an extension search both nationally and internationally, UCLA-DGSOM has determined that Dr. Hommes is the most qualified individual to bring this advance treat and research to California.

Dr. Hommes will be performing clinical activities approximately 80% of the time and at least 10% teaching is included in the clinical activities and fellows round with faculty when they see patients. Under the University guidelines, this is considered teaching while performing clinical activities. The remaining 20% will be devoted to clinical administration and clinical trials.

GEORG WIESELTHALER, M.D., UCSF-SOM - SFP APPLICANT:

Neal Cohen, M.D., M.P.H., M.S., UCSF, Vice Dean Academic Affairs, presented UCSF-SOM's request for Georg Wieselthaler, M.D., to receive a special faculty permit and the qualifications of Dr. Wieselthaler. Dr. Cohen indicated that Dr. Wieselthaler is an extraordinarily accomplished surgeon who is a preeminent cardiothoracic and vascular surgeon and is regarded internationally as a leader in the field of Cardiac Transplantation and Mechanical Circulatory Support. UCSF-SOM believes Dr. Wieselthaler has the credentials to guide the UCSF-SOM program in advanced heart failure and provide patient care in this specialty of medicine.

Dr. Wieselthaler graduated from the University of Vienna, Austria in November 1987. He has completed several residency programs and fellowships between 1988-2007. Dr. Wieselthaler completed one year of military service in the department of surgery at the Military Hospital in Vienna 1988-1989 and continued his residency training in surgery for six years at the University of Vienna 1989-1995. Dr. Wieselthaler was staff surgeon at the University of Vienna from 1995-1999 and senior staff surgeon from 1999-2003. His clinical expertise is highly regarded in the United States. He was a visiting fellow at the following universities: Baylor College of Medicine, Texas 1999; Milton Hershey Medical Center, Pennsylvania 2003; Columbia Medical Center, New York 2005; Cleveland Clinic, Ohio 2007; along with the Ottawa Heart Center in Ottawa, Canada 2007.

Dr. Wieselthaler completed two advance fellowships in Austria working as a staff surgeon at St. Pollen Hospital 1996-1997 and at Lainz Hospital 1997-1998; he also completed two years of training with the Vienna Lung Transplant Program and Vienna Heart Transplant Program in Austria. He has been the principal investigator of the European trials for the Arrow Lion Heart implantable ventricular assist pump in which he performed numerous heart transplants, and is internationally recognized for his surgical experience in artificial heart and ventricular assist device implants. Dr. Wieselthaler has been recognized by the leading international transplant organization, which is the International Society for Heart and Lung Transplantation, where he now serves on the Board of Directors

Dr. Wieselthaler holds two academic appointments at the University of Vienna, Assistant Professor of Surgery in 2000, and Associate Professor of Surgery 2003-present. He holds several institutional appointments as the Medical Director of Mechanical Circulatory Support 1999-present, Vice Director Clinical Heart Transplant Program 2000-present, and Director of Interdisciplinary Surgical Heart Failure 2005-present. Dr. Wieselthaler has been the attending surgeon in the Department of Cardiothoracic Surgery at the Medical University of Vienna since 2003.

Dr. Cohen advised the SFPRC that UCSF-SOM is currently not in a position to meet the needs of the patients with heart failure who require circulatory assist devices or heart transplantations. While UCSF-SOM has a large heart failure patient population, it currently does not have a surgical program to support the needs of this patient population. UCSF-SOM is also required to appoint a surgeon who can qualify as a certified heart transplant surgeon no later than April 2012 or risk losing UCSF-SOM's national certification to perform heart transplant surgery. Upon his appointment at UCSF-SOM Dr. Wieselthaler will be the only surgeon in Northern California with the expertise and experience to perform the most advanced ventricular assist devices

implantations and techniques. UCSF-SOM was in competition with the Cleveland Clinic to recruit Dr. Wieselthaler.

Dr. Wieselthaler will devote approximately 70% of his time to patient care activity, 20% to teaching activities and 10% to administrative time.

SPECIAL FACULTY PERMIT REVIEW COMMITTEE FINDINGS:

The SFPRC recommended approval of Dr. Hommes for a SFP at UCLA, contingent upon receipt of follow-up documentation from UCLA regarding why a great need exists to fill the appointment as a SFP holder and follow-up documentation of the breakdown of time to be spent in various activities.

The SFPRC recommended approval of Dr. Wieselthaler for a SFP at UCSF, contingent upon receipt of follow-up documentation from UCSF regarding why a great need exists to fill the appointment as a SFP holder and follow-up documentation of the breakdown of time to be spent in various activities.

Board staff received and reviewed the requested follow-up documentation regarding the great need to fill the appointment and the breakdown of time to be spent in activities from UCLA and UCSF. Staff has determined it is in order as described above. Therefore, SFPRC recommends approval for both Dr. Hommes and Dr. Wieselthaler.

FISCAL CONSIDERATIONS:

None

If you have any questions concerning this memorandum, please telephone me at (916) 263-2382.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: October 13, 2011  
ATTENTION: Medical Board of California  
SUBJECT: Special Faculty Permit Review Committee  
Stanford University School of Medicine's  
Committee Member Change Request  
STAFF CONTACT: Curtis J. Worden, Chief of Licensing

RECOMMENDED ACTION:

Board approve Stanford University School of Medicine's (Stanford) request to change its Special Faculty Permit Committee (SFPRC) member from Lawrence Shuer, M.D., Associate Dean for Graduate Medical Education to Clarence Braddock, M.D., M.P.H., Associate Dean for Graduate Medical Affairs.

BACKGROUND AND ANALYSIS:

Pursuant to Section 2168.1(c)(1) "The division (now the Board) shall establish a review committee comprised of two members of the division, one of whom shall be a physician and surgeon and one whom shall be a public member, and one representative from each of the medical schools in California..." The Special Faculty Permit Review Committee is comprised of two Board members and one representative from each of the eight California medical schools for a total of ten members.

The Board has received a written request from Stanford requesting to change Stanford's SFPRC member from Lawrence Shuer, M.D., Associate Dean for Graduate Medical Education to Clarence Braddock, M.D., M.P.H., Associate Dean for Graduate Medical Affairs.

FISCAL CONSIDERATIONS:

None

If you have any questions concerning this memorandum, please telephone me at (916) 263-2382.

**0758 - Medical Board  
Analysis of Fund Condition**

(Dollars in Thousands)

FY 2011-12 Governor's Budget

	ACTUAL 2010-11	CURRENT YEAR 2011-12	BY 2012-13	BY+1 2013-14	BY+2 2014-15
<b>BEGINNING BALANCE</b>	\$ 27,903	\$ 30,802	\$ 18,963	\$ 13,500	\$ 7,457
Prior Year Adjustment	\$ -	\$ -	\$ -	\$ -	\$ -
Adjusted Beginning Balance	\$ 27,903	\$ 30,802	\$ 18,963	\$ 13,500	\$ 7,457
<b>REVENUES AND TRANSFERS</b>					
Revenues:					
125600 Other regulatory fees	\$ 289	\$ 285	\$ 285	\$ 285	\$ 285
125700 Other regulatory licenses and permits	\$ 5,502	\$ 5,616	\$ 5,616	\$ 5,616	\$ 5,616
125800 Renewal fees	\$ 43,781	\$ 45,057	\$ 45,039	\$ 45,621	\$ 46,009
125900 Delinquent fees	\$ 102	\$ 96	\$ 98	\$ 98	\$ 98
142500 Miscellaneous services to the public	\$ 48	\$ 48	\$ 48	\$ 48	\$ 48
150300 Income from surplus money investments	\$ 164	\$ 202	\$ 85	\$ 44	\$ -
160400 Sale of fixed assets	\$ 3	\$ 3	\$ 3	\$ 3	\$ 3
161000 Escheat of unclaimed checks and warrants	\$ 22	\$ 22	\$ 22	\$ 22	\$ 22
161400 Miscellaneous revenues	\$ 1	\$ 1	\$ 1	\$ 1	\$ 1
164300 Penalty assessments - Probation Monitoring	\$ -	\$ 900	\$ 900	\$ 900	\$ 900
Totals, Revenues	\$ 49,912	\$ 52,230	\$ 52,097	\$ 52,638	\$ 52,982
Transfers:					
GENERAL FUND LOAN		\$ (9,000)			
<b>TOTALS, REVENUES AND TRANSFERS</b>	\$ 49,912	\$ 43,230	\$ 52,097	\$ 52,638	\$ 52,982
<b>TOTAL RESOURCES</b>	\$ 77,815	\$ 74,032	\$ 71,060	\$ 66,138	\$ 60,439
<b>EXPENDITURES</b>					
Disbursements:					
0840 State Controller (State Operations)	\$ 80	\$ 58	\$ -	\$ -	\$ -
8880 FSCU (State Operations)	\$ 31	\$ 232			
1110 Program Expenditures (State Operations)	\$ 46,902	\$ 54,928	\$ 56,027	\$ 57,147	\$ 58,290
Executive Order B-3-11 CS 3.91		\$ (311)	\$ (311)	\$ (311)	\$ (311)
BL 11-08 Cellular Phone Reduction		\$ (38)	\$ (38)	\$ (38)	\$ (38)
<u>Anticipated Future Costs</u>					
Proposed Operation Safe Medicine			\$ 583	\$ 583	\$ 583
Anticipated BreEZe Cost		\$ 200	\$ 500	\$ 500	\$ 500
Anticipated Credit Card Cost			\$ 800	\$ 800	\$ 800
Totals, Disbursements	\$ 47,013	\$ 55,069	\$ 57,561	\$ 58,681	\$ 59,824
<b>FUND BALANCE</b>					
Reserve for economic uncertainties	\$ 30,802	\$ 18,963	\$ 13,500	\$ 7,457	\$ 615

<b>Months in Reserve</b>	6.7	4.0	2.8	1.5	0.1
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NOTES:

- A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED FOR 2011-12 AND BEYOND.
- B. INTEREST ON FUND ESTIMATED AT .68% in FY 10/11 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)

10/6/2011

**Medical Board of California**  
 FY 11/12  
 Budget Expenditure Report  
 (As of August 31, 2011)  
 (16.7% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENSES/ ENCUMB	PERCENT OF BUDGET EXP/ENCUMB	UNENCUMB BALANCE
<b>PERSONAL SERVICES</b>				
Salary & Wages (Staff & Exec Director)	16,575,643	2,166,841	13.1	14,408,802
Board Members	31,500	2,400	7.6	29,100
Phy Fitness Incentive Pay	29,623	2,665	9.0	26,958
Temp Help	1,144,410	149,735	13.1	994,675
Overtime	12,143	3,212	26.5	8,931
Staff Benefits	7,508,921	938,765	12.5	6,570,156
Salary Savings	(1,021,151)			(1,021,151)
<b>TOTALS, PERS SERVICES</b>	<b>24,281,089</b>	<b>3,263,618</b>	<b>13.4</b>	<b>21,017,471</b>
<b>OPERATING EXP &amp; EQUIP</b>				
General Expense	555,617	79,441	14.3	476,176
Fingerprint Reports	333,448	20,904	6.3	312,544
Minor Equipment	187,500	1,808	1.0	185,692
Printing	685,755	226,222	33.0	459,533
Communications	400,354	3,076	0.8	397,278
Postage	282,511	24,695	8.7	257,816
Insurance	41,053	0	0.0	41,053
Travel In-State	482,298	3,314	0.7	478,984
Travel Out-of-State	1,000	0	0.0	1,000
Training	78,895	3,354	4.3	75,541
Facilities Operation (Rent)	2,702,140	2,220,673	82.2	481,467
Consult/Prof Services	982,594	800,493	81.5	182,101
Departmental Prorata	4,170,547	0	0.0	4,170,547
Interagency Services	5,142	0	0.0	5,142
Consolidated Data Center	646,809	42,586	6.6	604,223
Data Processing	129,492	5,591	4.3	123,901
Central Admin Svcs (Statewide Prorata)	2,140,440	535,110	25.0	1,605,330
Attorney General Services	13,347,280	2,284,432	17.1	11,062,848
Office of Administrative Hearings	1,862,591	69,154	3.7	1,793,437
Evidence/Witness	1,893,439	146,575	7.7	1,746,864
Court Reporter Services	175,000	12,868	7.4	162,132
Major Equipment	633,000	0	0.0	633,000
Other Items of Expense	81	15,918	19,651.9	(15,837)
Vehicle Operations	261,925	23,090	8.8	238,835
Court-ordered Payments	0	0		0
Board of Control Claim	0	1,350		(1,350)
<b>TOTALS, OE&amp;E</b>	<b>31,998,911</b>	<b>6,520,654</b>	<b>20.4</b>	<b>25,478,257</b>
<b>TOTALS, EXPENDITURES</b>	<b>56,280,000</b>	<b>9,784,272</b>	<b>17.4</b>	<b>46,495,728</b>
Scheduled Reimbursements	(384,000)	(62,613)	16.3	(321,387)
Distributed Costs	(780,000)	(133,819)	17.2	(646,181)
<b>NET TOTAL, EXPENDITURES</b>	<b>55,116,000</b>	<b>9,587,840</b>	<b>17.4</b>	<b>45,528,160</b>
Unscheduled Reimbursements		(61,665)		
		<u>9,526,175</u>		

Budget Expenditure Report.xls  
 Date: October 10, 2011

MEDICAL BOARD OF CALIFORNIA  
LICENSING PROGRAM  
BUDGET REPORT  
JULY 1, 2011 - AUGUST 31, 2011

	FY 11/12 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
<b>PERSONAL SERVICES</b>			
Salaries & Wages	2,320,572	347,639	current
Staff Benefits	<u>1,088,719</u>	<u>156,345</u>	current
<b>TOTAL PERSONAL SERVICES</b>	<b>3,409,291</b>	<b>503,984</b>	
<b>OPERATING EXPENSES &amp; EQUIPMENT</b>			
General Expense	59,451	89	1-2
Fingerprint Reports*	333,448	20,808	1-2
Printing	61,000	6,222	1-2
Communications	55,000	117	1-2
Postage	125,000	10,713	1-2
Travel In-State	25,000	391	1-2
Training	8,500	1,643	1-2
Facilities Operation	226,000	222,177	current
Consult/Professional Services	601,873	334,220	1-2
Departmental Services	407,866	0	current
Interagency Services	503	0	current
Data Processing	4,000	1,476	1-2
Statewide Pro Rata	209,335	52,334	current
Attorney General	190,000	13,750	current
Evidence/Witness Fees	7,500	0	1-2
Court Reporter Services	250	0	1-2
Major Equipment	26,000	0	1-2
Minor Equipment	<u>66,000</u>	<u>47</u>	1-2
<b>TOTAL OPERATING EXPENSES &amp; EQUIPMENT</b>	<b>2,406,726</b>	<b>663,987</b>	
<b>SCHEDULED REIMBURSEMENTS</b>	<b>(384,000)</b>	<b>(62,613)</b>	
<b>DISTRIBUTED COSTS</b>	<b>(42,257)</b>	<b>0</b>	
<b>TOTAL BUDGET/EXPENDITURES</b>	<b>5,389,760</b>	<b>1,105,358</b>	

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

MEDICAL BOARD OF CALIFORNIA  
 ENFORCEMENT PROGRAM  
 BUDGET REPORT  
 JULY 1, 2011 - AUGUST 31, 2011

	FY 11/12 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
<b>PERSONAL SERVICES</b>			
Salaries & Wages	10,948,135	1,369,888	current
Staff Benefits	<u>4,773,947</u>	<u>540,866</u>	current
<b>TOTAL PERSONAL SERVICES</b>	<b>15,722,082</b>	<b>1,910,754</b>	
<b>OPERATING EXPENSE &amp; EQUIPMENT</b>			
General Expense/Fingerprint Reports	276,458	63,055	1-2
Printing	305,755	204,887	1-2
Communications	245,354	2,411	1-2
Postage	70,000	13,754	1-2
Insurance	38,770	0	current
Travel In-State	290,298	1,990	1-2
Training	34,000	835	1-2
Facilities Operations	2,071,140	1,583,547	current
Consultant/Professional Services	300,000	41,534	1-2
Departmental Services	3,109,177	0	current
Interagency Services	3,833	0	1-2
Data Processing	19,000	0	1-2
Statewide Pro Rata	1,595,698	398,925	current
Attorney General 1/ OAH	13,157,280	2,270,682	current
	1,862,591	69,154	1
Evidence/Witness Fees	1,820,939	142,625	1-2
Court Reporter Services	174,750	12,868	1-2
Major Equipment	511,000	0	1-2
Other Items of Expense (Law Enf. Materials/Lab, etc.)	81	15,918	1-2
Vehicle Operations	215,925	19,676	1-2
Minor Equipment	2,500	0	1-2
Court-Ordered Payments	<u>0</u>	<u>820</u>	current
<b>TOTAL OPERATING EXPENSES &amp; EQUIPMENT</b>	<b>26,104,549</b>	<b>4,842,681</b>	
<b>DISTRIBUTED COSTS</b>	<b>(735,630)</b>	<b>(133,819)</b>	
<b>TOTAL BUDGET/EXPENDITURES</b>	<b>41,091,002</b>	<b>6,619,616</b>	
Unscheduled Reimbursements		<u>(4,927)</u>	
		<u>6,614,689</u>	

1/See next page for monthly billing detail

MEDICAL BOARD OF CALIFORNIA  
 ATTORNEY GENERAL EXPENDITURES - FY 11/12  
 DOJ AGENCY CODE 003573 - ENFORCEMENT (6303)  
 page 1

		<u>Number of Hours</u>	<u>Rate</u>	<u>Amount</u>
July	Attorney Services	6,412.00	170.00	1,090,040.00
	Paralegal Services	246.75	120.00	29,610.00
	Auditor/Analyst Services	101.00	99.00	9,999.00
	Cost of Suit			<u>1,129,649.00</u>
August	Attorney Services	6,455.25	170.00	1,097,392.50
	Paralegal Services	230.00	120.00	27,600.00
	Auditor/Analyst Services	159.25	99.00	15,765.75
	Cost of Suit			<u>275.00</u>
				<u>1,141,033.25</u>
September	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst Services	0.00	99.00	0.00
	Cost of Suit			<u>0.00</u>
October	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst Services	0.00	99.00	0.00
	Cost of Suit			<u>0.00</u>
				<u>0.00</u>
November	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst	0.00	99.00	0.00
	Cost of Suit			<u>0.00</u>
				<u>0.00</u>
December	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst	0.00	99.00	0.00
	Cost of Suit			<u>0.00</u>
				<u>0.00</u>

**Total July-Dec = 2,270,682.25**  
**FY 11/12 Budget = 13,157,280.00**

Revised 10/07/2011

**ENFORCEMENT/PROBATION RECEIPTS**  
**MONTHLY PROFILE: JULY 2009 - JUNE 2012**

	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	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	
													FYTD Total
	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	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	
	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Total
Invest Cost Recovery	300	350											650
Criminal Cost Recovery	0	0											0
Probation Monitoring	42,542	41,848											84,390
Exam	1,639	777											2,416
Cite/Fine	200	4,350											4,550
MONTHLY TOTAL	44,681	47,325	0	0	0	0	0	0	0	0	0	0	92,005
FYTD TOTAL	44,681	92,005	92,005	92,005	92,005	92,005	92,005	92,005	92,005	92,005	92,005	92,005	

excel:enfreceiptsmonthlyprofile.xls.revised 8/31/2011

**Medical Board of California**  
**Board Members' Expense Report**  
**July 1, 2011 -Sept 30, 2011**

	<i>Per Diem*</i>			<i>TOTAL</i>	<i>Travel Expenses*</i>	<i>Total July-Sept</i>	<i>Total FYTD</i>
	July	Aug	Sept				
Dr. Carreon	1,300	0		1,300		1300	1300
Ms. Chang	0	0		0		0	0
Dr. Diego	0	0		0		0	0
Dr. Duruisseau	1,000	700	600	2,300	71.04	2371.04	2371.04
Dr. Levine	400	0		400	413.86	813.86	813.86
Dr. Low	0	0		0		0	0
Dr. Moran	1,000	0		1,000		1000	1000
Dr. Salomonson	0	0		0		0	0
Ms. Schipske	1,000	0		1,000	618.06	1618.06	1618.06
Ms. Yaroslavsky	0	0		0		0	0
<b>BOARD TOTAL</b>	<b>4,700</b>	<b>700</b>	<b>600</b>	<b>6000</b>	<b>1102.96</b>	<b>7102.96</b>	<b>7102.96</b>

\*includes claims paid/submitted through Sept, 2011

Board Members Expense Report.xls

Date: October 10, 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
<b>FY 08/09</b>									
\$ 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
<b>FY 09/10</b>									
\$ 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
<b>FY 10/11</b>									
\$ 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*	1,771,000	34,420,000	651,000	5,061,000	1,564,000		2,948,000	487,000	46,902,000 *
Positions Authorized	8.8	165.0	6.0	52.3	15.0		17.0	25.0	289.1
<b>FY 11/12</b>									
\$ Budgeted	1,901,000	41,091,000		5,390,000	1,604,000		3,092,000	2,038,000	55,116,000
\$ Spent thru 8/31*	723,000	6,615,000	82,000	1,105,000	288,000		415,000	298,000	9,526,000
Positions Authorized	8.8	166.6		53.3	15.0		17.0	25.0	285.7

\* net expenditures (includes unscheduled reimbursements)



State of California  
Medical Board of California  
2005 Evergreen Street, Suite 1200  
Sacramento, Ca 95815  
[www.mbc.ca.gov](http://www.mbc.ca.gov)

# Memorandum

Date: October 12, 2011  
To: Board Members  
From: Kurt Hepler, Senior Staff Counsel  
Subject: Polysomnography Regulations

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Members, the polysomnographic registration regulations are back before you for your review and consideration. As you may recall, when the Board first considered the regulations, there was an issue regarding the "grandfathering" of certain registration requirements. Specifically, the issue was whether the grandfathering applied to the examination requirement only or all the registration requirements. Consistent with the enabling legislation, the Board's proposed regulations permitted potential registrants to be released or grandfathered from the examination requirement if they had been practicing polysomnography safely for a period of five years.

The proponents of the original bill had suggested that the grandfathering needed to be applied globally to persons who had been practicing polysomnography safely for five or more years. However, this suggestion was not consistent with the enabling legislation.

The matter has now been resolved, as the applicable statute, section 3575 of the Business and Professions Code, has been amended to clarify that the grandfathering is applicable to the overall qualifications for a polysomnographic technologist, meaning that a person is eligible for registration if he or she meets the specified requirements or has been practicing polysomnography safely for five years.

These regulations, as proposed to be amended, establish eligibility requirements that are consistent with statute. If you agree, the proper action would then be to approve the revised text, circulate the regulations for a fifteen-day comment period, and in the absence of any adverse comments, authorize the Executive Director to complete the rulemaking file. If adverse comments are received, the regulations will have to be brought back before the Board.

Please contact me if you have any questions.

**MEDICAL BOARD OF CALIFORNIA**  
**Polysomnography Program**

**Third Modified Text**

(To save paper, only the sections being amended are included in this Notice.)

Changes to the originally proposed language are shown in  
double underline in bold with shading for new text and  
double strikethrough in bold with shading for deleted text.

Add Chapter 3.5 to Division 13 of Title 16, California Code of Regulations, to read as follows:

Chapter 3.5. Polysomnography

\* \* \*

1378.9. Examination.

~~(a)~~ The certification examination offered by the Board of Registered

Polysomnographic Technologists is approved by the board for purposes of qualifying for registration pursuant to Chapter 7.8 of Division 2 of the code:

~~(b) An applicant who applies for registration as a polysomnographic technologist on or before October 22, 2012, may, in lieu of successful completion of the examination approved by the board, submit any of the following as proof that the applicant has been practicing polysomnography safely for at least five years:~~

~~(1) One or more declarations under penalty of perjury by a supervising physician attesting to the period of time the physician supervised the applicant, the tasks performed by the applicant, and the applicant's ability to practice polysomnography safely.~~

~~(2) A letter of good standing from each state in which the applicant is registered or licensed.~~

NOTE: Authority cited: Sections 2018 and 3575, Business and Professions Code.  
Reference: Sections 3575-3577, Business and Professions Code.

1378.11. Registration Requirements.

(a) Polysomnographic Trainee. In addition to the requirements set forth in Section 3575(c) of the code, an applicant for registration as a polysomnographic trainee shall meet the following requirements:

(1) Not be subject to denial under Section 3576 of the code; and

(2) Have either (A) a high school diploma or GED and six months of supervised direct polysomnographic patient care experience; or (B) be currently enrolled in an approved polysomnographic education program; and

(3) Possess at the time of application a current certificate in Basic Life Support issued by the American Heart Association.

(b) Polysomnographic Technician. In addition to the requirements set forth in Section 3575(c) of the code, an applicant for registration as a polysomnographic technician shall meet the following requirements:

(1) Not be subject to denial under Section 3576 of the code; and

(2) Have successfully completed an approved polysomnographic education program; and

(3) Possess a minimum of six months experience as a registered polysomnographic trainee; and

(4) Possess at the time of application a current certificate in Basic Life Support issued by the American Heart Association.

(c) (1) Polysomnographic Technologist. An applicant for registration as a polysomnographic technologist shall meet the requirements set forth in Sections 3575 and 3576 of the code and shall possess at the time of application a current certificate in Basic Life Support issued by the American Heart Association.

**(2) With respect to applications received on or before October 22, 2012, an applicant for registration as polysomnographic technologist may satisfy the requirements of subdivision (b)(1) of section 3575 of the Code by submitting any of the following as proof that the applicant has been practicing polysomnography safely for at least five years:**

**(A) One or more declarations under penalty of perjury by a supervising physician attesting to the period of time the physician supervised the applicant, the tasks performed by the applicant, and the applicant's ability to practice polysomnography safely.**

**(B) A letter of good standing from each state in which the applicant is registered or licensed.**

NOTE: Authority cited: Sections 2018 and 3575, Business and Professions Code.  
Reference: Section 3575-3577, Business and Professions Code.

\* \* \*

<b>CONSUMER INFORMATION UNIT FY 11/12</b>					
	<b>FY 11/12</b>	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>
Total Calls Answered	<b>15,725</b>	15,725			
Calls Requesting Call Back	<b>4,647</b>	4,647			
Calls Abandoned	<b>4,356</b>	4,356			
Address Changes Completed	<b>3,451</b>	3,451			

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

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

<b>PHYSICIAN &amp; SURGEON DATA FY 11/12</b>					
	<b>FY 11/12</b>	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>
Applications Received	<b>1,711</b>	1,711			
Initial Reviews Completed	<b>1,491</b>	1,491			
Total Pending	<b>4,012</b>	4,012			
Reviewed	<b>3,273</b>	3,273			
Not Reviewed	<b>739</b>	739			
(SR2s Pending)	<b>108</b>	108			
Licenses Issued	<b>1,359</b>	1,359			
Renewals Issued	<b>16,092</b>	16,092			

<b>PHYSICIAN &amp; SURGEON DATA FY 10/11</b>					
	<b>FY 10/11</b>	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>
Applications Received*	<b>6,047</b>	1,503	1,505	1,543	1,496
Initial Reviews Completed	<b>5,984</b>	1,208	1,892	1,464	1,420
Total Pending	<b>N/A</b>	5,291	5,038	4,295	3,992
Reviewed	<b>N/A</b>	4,460	4,532	3,933	3,461
Not Reviewed	<b>N/A</b>	831	506	362	531
(SR2s Pending)	<b>N/A</b>	98	83	82	98
Licenses Issued	<b>5,272</b>	1,447	1,248	1,277	1,300
Renewals Issued	<b>62,656</b>	16,168	15,377	15,087	16,024

\* Applications Received Total and Q4 numbers have been corrected to match the FY 10/11 Annual Report. Previous Reported as: Total 5,914 and Q4 as 1,363 in July 2011 Board Meeting Packet.

SPECIAL PROGRAMS FY 11/12																				
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	8				5				5				8				3			
2112	0				0				0				0				0			
2113	5				2				2				10				2			
2168	3				2				0				2				3			
2072	0				0				0				1				0			
1327	0				0				0				0				0			

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

- 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 Permit - Correctional Facility
- 1327 - Medical Student Rotations - Non-ACGME Hospital Rotation

INTERNATIONAL MEDICAL SCHOOL APPLICATIONS FY 11/12					
	FY 11/12	Q1	Q2	Q3	Q4
New Self-Assessment Report Received	2	2			
Pending Self-Assessment Report	5	3			
New Applications Received w/o Recognized Schools	22	22			
Pending Application Received w/o Recognized Schools	57	35			
School Recognized Pursuant to CCR 1314(a)(1)	4	4			
School Recognized Pursuant to CCR 1314(a)(2)	1	1			
TOTAL Pending Applications w/o Recognized Schools	62	62			

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
School Recognized Pursuant to CCR 1314(a)(1)	16		3	3	10
School Recognized Pursuant to CCR 1314(a)(2)	2			2	

LICENSED MIDWIVES FY 11/12					
	FY 11/12	Q1	Q2	Q3	Q4
Applications Received	9	9			
Applications Pending	6	6			
Licenses Issued	4	4			
Licenses Renewed	24	24			

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

RESEARCH PSYCHOANALYST FY 11/12					
	FY 11/12	Q1	Q2	Q3	Q4
RP Applications Received	1	1			
RP Licenses Issued	3	3			

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

FICTITIOUS NAME PERMITS FY 11/12					
	FY 11/12	Q1	Q2	Q3	Q4
P&S - FNP Issued	384	384			
P&S - FNP Pending	59	59			
Podiatric FNP Issued	3	3			
Podiatric FNP Pending	N/A	0			

FICTITIOUS NAME PERMITS FY 10/11					
	FY 10/11	Q1	Q2	Q3	Q4
P&S - FNP Issued**1,288	1,288	310	317	291	370
P&S - FNP Pending	N/A	66	62	129	89
Podiatric FNP Issued	22	7	2	5	8
Podiatric FNP Pending	N/A	1	0	1	0

\*\* P&S - FNP Issued Total and Q4 have been corrected to match the FY10/11 Annual Report. Reported as: Total 1,266 and Q4 248 in July 2011 Board Meeting Packet

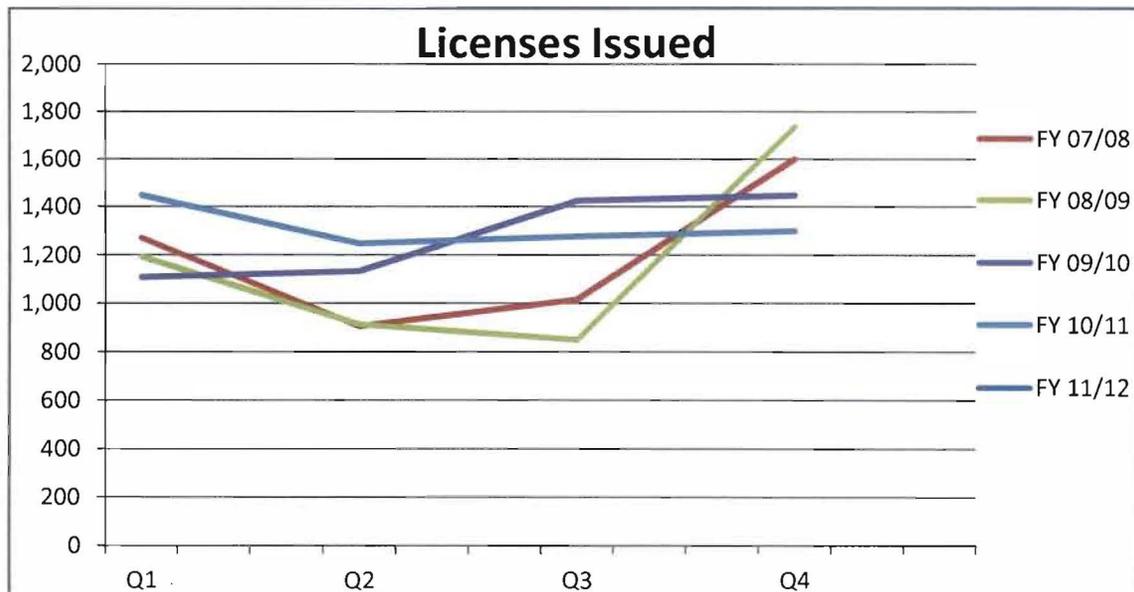
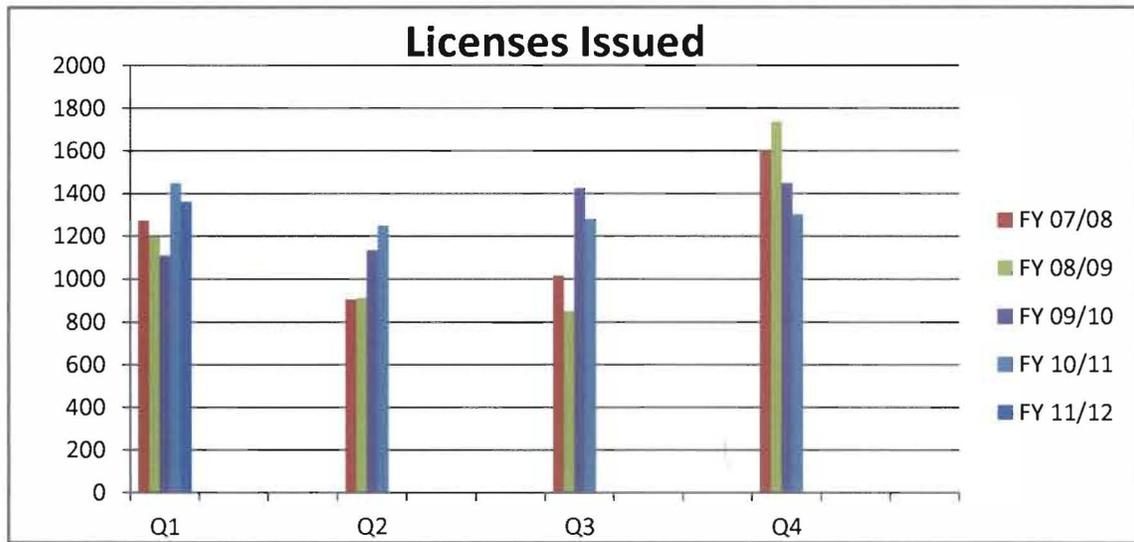
SPECIALTY BOARD APPLICATIONS FY 11/12					
	FY 11/12	Q1	Q2	Q3	Q4
Applications Received	0	0			
Applications Pending	1	1			

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

OPTICAL REGISTRATIONS FY 11/12					
	FY 11/12	Q1	Q2	Q3	Q4
Business Registrations Issued	10	10			
Pending Applications Business	30	30			
Out-of-State Business Registrations Issued	0	0			
Pending Applications Out of State Bus.	0	0			
Spectacle Lens Registrations Issued	47	47			
Pending Applications-Spectacle Lens	78	78			
Contact Lens Registrations Issued	13	13			
Pending Applications-Contact Lens	22	22			
Spectacle Lens Registrations Renewed	216	216			
Contact Lens Registrations Renewed	95	95			

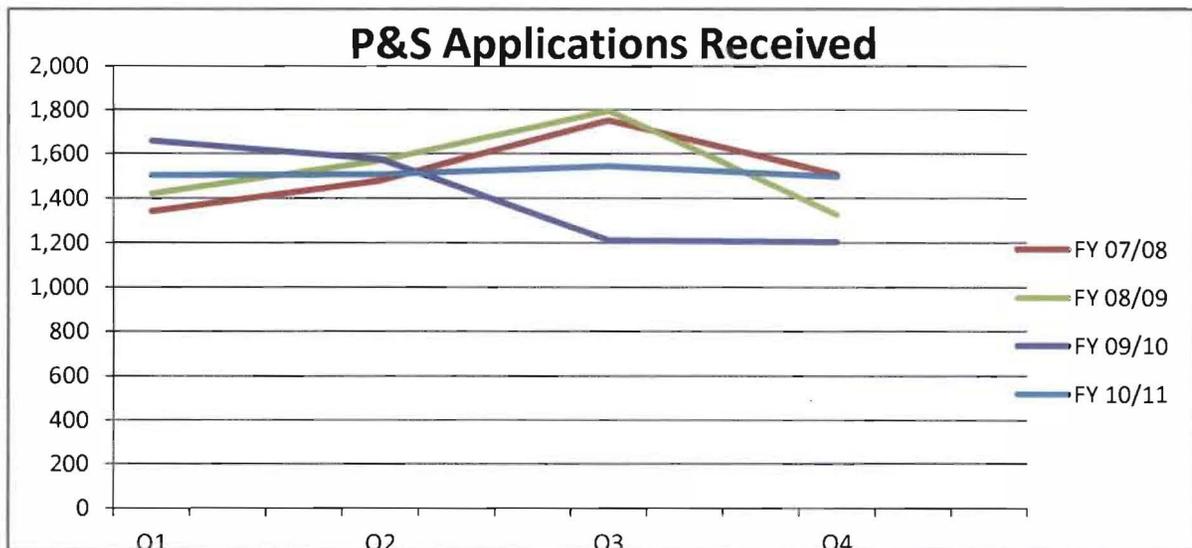
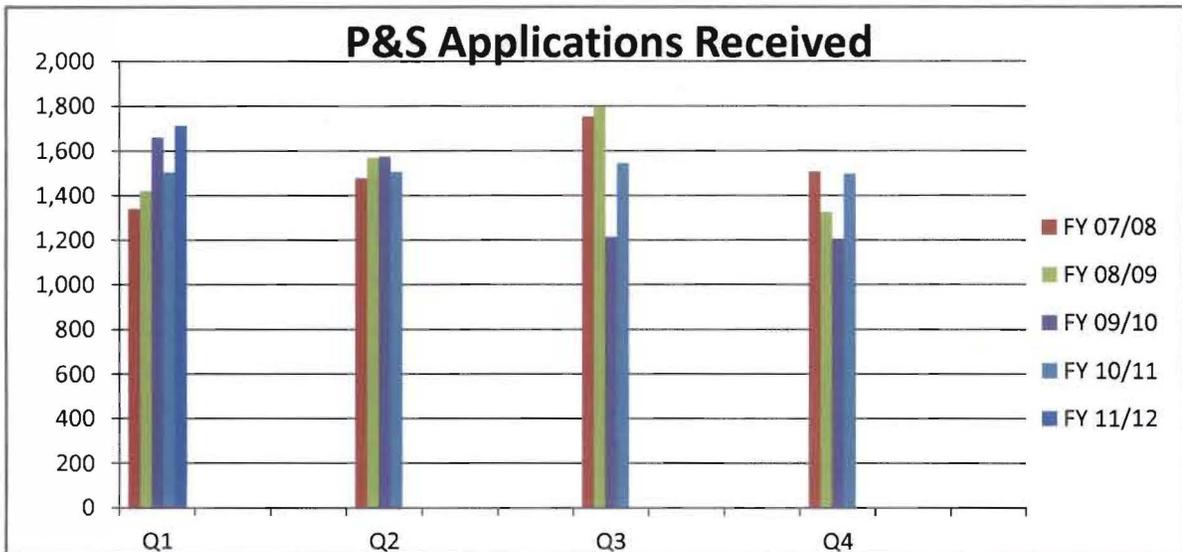
OPTICAL REGISTRATIONS FY 10/11					
	FY 010/11	Q1	Q2	Q3	Q4
Business Registrations Issued	69	16	21	17	15
Pending Applications Business	N/A	25	21	22	17
Out-of-State Business Registrations Issued	0	0	0	0	0
Pending Applications Out of State Bus.	0	0	0	0	0
Spectacle Lens Registrations Issued	196	42	55	53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

PHYSICIAN'S AND SURGEON'S LICENSES ISSUED					
Five Fiscal Year History					
Fiscal Year	QTR 1	QTR 2	QTR 3	QTR 4	TOTAL
FY 11/12	1,359				
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



<b>*PHYSICIAN'S AND SURGEON'S LICENSE AND PTAL APPLICATIONS RECEIVED</b>					
<b>Five Fiscal Year History</b>					
<b>Fiscal Year</b>	<b>QTR 1</b>	<b>QTR 2</b>	<b>QTR 3</b>	<b>QTR 4</b>	<b>TOTAL</b>
FY 11/12	1711				
FY 10/11*	1,503	1,505	1,543	1496	6,047
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

\* Applications Received Total and Q4 numbers have been corrected to match the FY 10/11 Annual Report. Previous Reported as: Total 5,914 and Q4 as 1,363 in July 2011 Board Meeting Packet.



## Licensing Program Weekly Application Production

Week Ending -->	16-Jul	23-Jul	30-Jul	6-Aug	13-Aug	20-Aug	27-Aug	3-Sep	10-Sep	17-Sep	24-Sep	1-Oct	8-Oct
Number of Workdays -->	5	5	5	5	5	5	5	5	4	5	5	5	5
<b>Applications Received</b>													
US/CAN	65	55	63	77	68	135	79	37	110	91	72	73	92
IMG - License	34	18	22	28	18	25	13	10	26	14	18	20	20
IMG - PTAL	39	30	40	43	33	54	44	22	35	28	24	30	30
<b>Total</b>	<b>138</b>	<b>103</b>	<b>125</b>	<b>148</b>	<b>119</b>	<b>214</b>	<b>136</b>	<b>69</b>	<b>171</b>	<b>133</b>	<b>114</b>	<b>123</b>	<b>142</b>
<b>Applications Completed (License or PTAL Issued)</b>													
US/CAN - Licensed	56	49	82	165	98	86	70	87	45	71	51	47	104
IMG - Licensed	32	38	25	36	35	33	21	56	12	25	23	14	32
<b>Total - Licensed</b>	<b>88</b>	<b>87</b>	<b>107</b>	<b>201</b>	<b>133</b>	<b>119</b>	<b>91</b>	<b>143</b>	<b>57</b>	<b>96</b>	<b>74</b>	<b>61</b>	<b>136</b>
<b>Total - PTAL's Issued</b>	<b>20</b>	<b>22</b>	<b>44</b>	<b>29</b>	<b>24</b>	<b>33</b>	<b>34</b>	<b>39</b>	<b>23</b>	<b>19</b>	<b>36</b>	<b>35</b>	<b>28</b>
<b>Applications Processed (Initial Review Completed)</b>													
<b>Application Complete Upon Initial Review (TBL)</b>													
US/CAN	4	8	7	7	9	6	10	11	3	17	8	21	17
IMG - License	0	0	0	0	0	0	0	0	0	1	0	1	0
IMG - PTAL	0	0	0	0	1	0	2	1	0	0	1	0	0
<b>Subtotal</b>	<b>4</b>	<b>8</b>	<b>7</b>	<b>7</b>	<b>10</b>	<b>6</b>	<b>12</b>	<b>12</b>	<b>3</b>	<b>18</b>	<b>9</b>	<b>22</b>	<b>17</b>
<b>Application Deficient Upon Initial Review</b>													
US/CAN	62	56	56	47	65	19	43	40	40	46	65	66	63
IMG - License	17	14	16	9	16	32	17	25	25	19	25	11	22
IMG - PTAL	29	27	32	23	26	24	36	38	43	29	61	45	36
<b>Subtotal</b>	<b>108</b>	<b>97</b>	<b>104</b>	<b>79</b>	<b>107</b>	<b>75</b>	<b>96</b>	<b>103</b>	<b>108</b>	<b>94</b>	<b>151</b>	<b>122</b>	<b>121</b>
<b>Total</b>	<b>112</b>	<b>105</b>	<b>111</b>	<b>86</b>	<b>117</b>	<b>81</b>	<b>108</b>	<b>115</b>	<b>111</b>	<b>112</b>	<b>160</b>	<b>144</b>	<b>138</b>
<b>Applications Awaiting Initial Review - Current as of: --&gt;</b>													
NEW: 0-30 days	415	419	450	419	512	606	620	543	611	523	506	556	525
AGING: 31-60 days	104	76	65	76	90	111	135	187	147	267	232	165	191
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
<b>Total</b>	<b>519</b>	<b>495</b>	<b>515</b>	<b>495</b>	<b>602</b>	<b>717</b>	<b>755</b>	<b>730</b>	<b>758</b>	<b>790</b>	<b>738</b>	<b>721</b>	<b>716</b>
<b>Date of Oldest US Appl Awaiting Initial Review--&gt;</b>													
06/08/11	06/16/11	06/27/11	07/06/11	07/13/11	07/14/11	07/18/11	07/26/11	08/01/11	08/09/11	08/15/11	08/19/11	08/26/11	
<b>Number of calendar days for US Initial Reviews</b>													
42	41	37	35	35	41	44	44	44	43	45	47	47	
<b>Days out of Compliance</b>													
0	0	0	0	0	0	0	0	0	0	0	2	2	
<b>Date of Oldest IMG Appl Awaiting Initial Review--&gt;</b>													
06/16/11	06/22/11	06/28/11	06/30/11	07/11/11	07/18/11	07/25/11	08/01/11	08/08/11	08/15/11	08/22/11	08/30/11	09/07/11	
<b>Number of calendar days for IMG Initial Reviews</b>													
34	34	36	41	37	37	37	38	37	37	38	36	35	
<b>Days out of Compliance</b>													
0	0	0	0	0	0	0	0	0	0	0	0	0	
<b>Date of Oldest US Pending Mail Awaiting Review--&gt;</b>													
07/06/11	07/15/11	07/19/11	08/03/11	08/10/11	08/17/11	08/23/11	08/29/11	09/06/11	09/14/11	09/21/11	09/27/11	10/05/11	
<b>Number of calendar days for US Pending Mail</b>													
14	11	14	7	7	7	8	8	8	7	7	8	7	
<b>Date of Oldest IMG Pending Mail Awaiting Review--&gt;</b>													
07/13/11	07/19/11	07/22/11	08/03/11	08/10/11	08/17/11	08/24/11	08/30/11	09/07/11	09/14/11	09/21/11	09/28/11	10/05/11	
<b>Number of calendar days for IMG Pending Mail</b>													
7	7	11	7	7	7	7	7	7	7	7	7	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 *Applications Awaiting Initial Review* section. The data in the *Applications Awaiting Initial Review* section reflects current data when the report is ran on the following Tuesday.

**INTERNATIONAL MEDICAL SCHOOL REVIEW**  
Per CCR Section 1314.1

COUNTRY	Medical School Name	Date Request Received	Status of Application	CCR 1314.1(a)(1)	CCR 1314.1(a)(2)	Comments/Decision
Antigua and Barbuda	American University of Antigua College of Medicine	3/28/2008	Recognized 7/29/2011		X	On July 29, 2011 the Board approved AUACOM (Antigua Campus Only) for students who matriculate on or after January 1, 2007. This recognition does not extend to course work obtained at Kasturba Medical College (KMCIC).
Australia	Australian National University Medical School (ANU)	3/24/2011	Recognized 10/07/2011	X		ANU provided all of the necessary documents to verify eligibility for recognition pursuant to CCR 1314.1(a)(1).
Australia	Queenlands University (QU) - Australia U.S. Branch Campus	10/29/2010	Pending	?	?	Staff needs to send correspondence to QU identifying information that MBC needs for evaluation of QU's US Branch Campus.
Austria	Medical University of Innsbruck	6/2/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Bangladesh	Chittagong University, Comilla Medical College	6/17/2010	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Bangladesh	University of Dhaka, Zainul Haque Sikder Women's Medical College & Hospital	7/13/2010	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Brazil	Faculdade de Medicina de Itajuba (FMIT)	7/1/2011	Pending	?	?	Staff requested additional information from FMIT to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Brazil	Universidade Federal Do rio Grande Do Norte (UFRN)	3/24/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Brazil	Universidade Luterana Do Brasil (ULBRA)	5/4/2011	Recognized 7/7/2011	X		ULBRA provided all of the necessary documents to verify eligibility for recognition pursuant to CCR 1314.1(a)(1).

**INTERNATIONAL MEDICAL SCHOOL REVIEW**  
Per CCR Section 1314.1

<b>COUNTRY</b>	<b>Medical School Name</b>	<b>Date Request Received</b>	<b>Status of Application</b>	<b>CCR 1314.1(a)(1)</b>	<b>CCR 1314.1(a)(2)</b>	<b>Comments/Decision</b>
Bulgaria	Medical University Prof. Dr. Paraskev Stoyanov Varna	6/10/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
China	Peking University Health Science Center	6/15/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
China	Shanghai Railway Medical University	7/6/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
China	Tianjin Second Medical College	7/19/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
China	Tongji Medical College of Huazhong University of Science and Technology	08/31/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
China	Xi'an Jiaotong University College of Medicine	6/21/2010	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Dominican Republic	Universidad Iberoamericans (UNIBE)	08/22/2008	Pending		X	Staff is reviewing Medical Consultant's request for additional information.
Egypt	Benha School of Medicine, Benha University	9/2/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Egypt	October 6 University Faculty of Medicine	9/27/2011	Pending	?	?	Staff needs to review Self-Assessment Report
Georgia	Tbilisi Medical Institute 'Vita'	6/22/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).

**INTERNATIONAL MEDICAL SCHOOL REVIEW**  
Per CCR Section 1314.1

<b>COUNTRY</b>	<b>Medical School Name</b>	<b>Date Request Received</b>	<b>Status of Application</b>	<b>CCR 1314.1(a)(1)</b>	<b>CCR 1314.1(a)(2)</b>	<b>Comments/Decision</b>
India	Dr. Bhim Rao Ambedkar University, Agra, Subharati Medical College	7/25/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Kannur University, Academy of Medical Sciences, Pariyaram	5/2/2011	Recognized 9/21/2011	X		AMSP KU (AMSP UC, KUHS) provided all of the necessary documents to verify eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Karnatak University, Karnataka Institute of Medical Sciences	10/7/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Maharashtra University of Health Sciences, Lokmanya Tilak Municipal Medical College	8/26/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Maharashtra University of Health Sciences, Nasik District Maratha Vidya Prasarak Samaj's Medical College	9/21/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Maharashtra University of Health Sciences, Terna Medical College and Hospital (TMCH)	6/23/2011	Pending	?	?	Staff needs to review letter and request additional information.
India	Mahatma Gandhi University, Malankara Orthodox Syrian Church Medical College	2/24/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	NTR University of Health Sciences, Kamineni Institute of Medical Sciences	9/13/2011	Pending	?	?	9/10/2011 - Applicant advised to request medical school to complete the Self-Assessment Report
India	NTR University of Health Sciences, P E S Institute of Medical Sciences and Research	6/21/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Pondicherry University, Vinayaka Mission's Medical College	8/31/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).

**INTERNATIONAL MEDICAL SCHOOL REVIEW**  
Per CCR Section 1314.1

<b>COUNTRY</b>	<b>Medical School Name</b>	<b>Date Request Received</b>	<b>Status of Application</b>	<b>CCR 1314.1(a)(1)</b>	<b>CCR 1314.1(a)(2)</b>	<b>Comments/Decision</b>
India	Rajiv Gandhi University of Health sciences, Father Muller's Institute of Medical Education and Research, Mangalore	6/17/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Shivaji University, Dr. D. Y. Patil Education Society's Medical College	9/8/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Tamil Nadu Dr. M.G.R. Medical University, K.A.P. Vishwanathan Government Medical College	6/2/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Tilaka Manjhi Bhagalpur University, Jawaharlal Nehru Medical College	8/29/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	University of Kashmie, Sheri-Kashmir Institute of Medical Sciences	8/10/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	West Bengal University of Health Sciences, Nilratan Sircar Medical College	7/19/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Iran	Ahvaz Jondishapour University of Medical Sciences	9/13/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Iran	Golestan University of Medical Education & Health Services	6/9/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Iran	Iran University of Medical Sciences & Health Services	9/13/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).

**INTERNATIONAL MEDICAL SCHOOL REVIEW**  
Per CCR Section 1314.1

<b>COUNTRY</b>	<b>Medical School Name</b>	<b>Date Request Received</b>	<b>Status of Application</b>	<b>CCR 1314.1(a)(1)</b>	<b>CCR 1314.1(a)(2)</b>	<b>Comments/Decision</b>
Iran	Shiraz University of Medical Sciences	9/12/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Iraq	University of Sulaimani College of Medicine	8/3/2010	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Italy	Universita degli Studi di Milano Bicocca Faculty of Medicine and Surgery	9/9/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Japan	Faculty of Medicine, University of Miyazaki	10/6/2010	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Japan	Kansai Medical University	6/23/2010	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Japan	University of Toyama	1/18/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Kazakhstan	Karaganda State Medical Academy	8/25/2010	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Malaysia	Manipal University, Melaka-Manipal Medical College	6/10/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Nepal	Kathmandu University, Manipal College of Medical Sciences	12/6/2010	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).

**INTERNATIONAL MEDICAL SCHOOL REVIEW**  
Per CCR Section 1314.1

<b>COUNTRY</b>	<b>Medical School Name</b>	<b>Date Request Received</b>	<b>Status of Application</b>	<b>CCR 1314.1(a)(1)</b>	<b>CCR 1314.1(a)(2)</b>	<b>Comments/Decision</b>
Nigeria	Ladoke Akintola University of Technology College of Health Sciences	11/13/2010	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Nigeria	Olabisi Onabanjo University, Obafemi Awolowo College of Health Sciences	7/7/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Nepal	Universal College of Medical Sciences, Pakihawa Campus	7/15/2011	Pending	?	?	Staff needs to review Self-Assessment Report
Norway	Norwegian University of Science and Technology (NUST), Faculty of Medicine	10/25/2010	Recognized 8/25/2011	X		NUST provided all of the necessary documents to verify eligibility for recognition pursuant to CCR 1314.1(a)(1).
Pakistan	Baqai Medical University, Baqai Medical College	6/15/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Pakistan	King Edward Medical University	5/11/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Pakistan	University of Health Sciences, Nishtar Medical College and Hospital (NMCH)	5/2011	Pending	?	?	Staff needs to request additional information from NMCH.
Poland	Medical University of Warsaw English Language Program	4/15/2010	Pending		X	Staff is reviewing Medical Consultant's request for additional information.
Russia	Yaroslavl State Medical Academy	5/10/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Sierra Leone	University of Sierra Leone College of Medicine & Allied Health Sciences	10/6/2010	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Singapore	Duke-National University of Singapore School of Medicine (DNUS)	4/1/2011	Pending	?	?	Staff has requested information from DNUS.

**INTERNATIONAL MEDICAL SCHOOL REVIEW**  
Per CCR Section 1314.1

<b>COUNTRY</b>	<b>Medical School Name</b>	<b>Date Request Received</b>	<b>Status of Application</b>	<b>CCR 1314.1(a)(1)</b>	<b>CCR 1314.1(a)(2)</b>	<b>Comments/Decision</b>
South Korea	Catholic University of Korea College of Medicine	6/30/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
South Korea	Dankook University College of Medicine	12/6/2010	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Syria	Al-Baath University Faculty of Medicine	3/10/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Taiwan	Fu Jen Catholic University School of Medicine	3/23/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Ukraine	Odessa State Medical University	11/23/2010	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Venezuela	Universidad Central de Venezuela Escuela de Medicina Jose Marie Vargas	6/7/2010	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Venezuela	Universidad Central de Venezuela Escuela de Medicina Luis Razetti	6/7/2010	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Vietnam	Can Tho University School of Medicine and Pharmacy	7/30/2010	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Vietnam	Hue University of Medicine	5/11/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).

**Reevaluations of Previously  
Reviewed International Medical Schools  
Mandated pursuant to CCR Section 1314.1 (f)(2)**

<b>Name of School</b>	<b>Recognition Date*</b>	<b>7-Year Reevaluation Date</b>	<b>Proposed Reevaluation Timeline</b>
Ross University (Dominica)	6/30/1990**	December 2010**	Pending Proper Staffing Levels
American Univ. of Caribbean (St. Maarten, N.A.)	9/15/1989**	December 2010**	Pending Proper Staffing Levels
St. George's University (Grenada)	9/15/1989**	December 2010**	Pending Proper Staffing Levels
Semmelweis University (Hungary)	5/30/2002	December 2010**	Pending Proper Staffing Levels
Szeged University (Hungary)	9/22/2003	December 2010**	Pending Proper Staffing Levels
Charles University (Czech. Republic)	12/29/2003	December 2010	Pending Proper Staffing Levels
Saba University (Saba, N.A.)	11/5/2004 Only To Those Students Who Matriculated On Or After January 1, 2002	November 2011	Pending Proper Staffing Levels
Debrecen University (Hungary)	4/28/2005	April 2012	Pending Proper Staffing Levels
Pecs Univ. (Hungary)	5/3/2005	May 2012	Pending Proper Staffing Levels
Jagiellonian Univ. (Hungary)	7/27/2007	July 2014	Pending Proper Staffing Levels
Med. Univ. of Poznan (Poland)	7/27/2007	July 2014	Pending Proper Staffing Levels
ELAM (Cuba)	7/27/2007	July 2014	Pending Proper Staffing Levels
Med. Univ. of Lublin (Poland)	7/25/2008	July 2015	Pending Proper Staffing Levels



# CALIFORNIA LICENSED MIDWIFE ANNUAL REPORT Summary

as of 7/14/2011 8:32:51 AM

**SECTION A - Submission Summary**

Number of Midwives Expected to Report	<b>258</b>
Number Reported	<b>216</b>
Number Unreported	<b>42</b>
Note: Report Field Numbers 1 through 10 are specific to each midwife report submitted and are not included in this aggregation.	

**SECTION B - REPORTING PERIOD**

Line No.	Report Year
<b>11</b>	<b>2010</b>

**SECTION C - SERVICES PROVIDED IN CALIFORNIA - This report should reflect services provided in California only.**

Line No.		Total # Yes	Total # No
<b>12</b>	Did you or a student midwife supervised by you perform midwife services in the <b>State of California</b> during the year when the intended place of birth at the onset of your care was an out-of-hospital setting?	<b>151</b>	<b>65</b>

**SECTION D - CLIENT SERVICES**

Line No.		Total #
<b>13</b>	Total number of clients served as primary caregiver during this calendar year.	<b>3115</b>
<b>14</b>	Number of clients who left care for a non-medical reason. (DO NOT include these clients in any further categories on this report)	<b>120</b>
<b>15</b>	Total number of clients served whose births were still pending on the last day of this reporting year.	<b>809</b>
<b>16</b>	Enter the number of clients served who also received collaborative care. <b>IMPORTANT: SEE DEFINITION OF COLLABORATIVE CARE!</b>	<b>1802</b>
<b>17</b>	Enter the number of clients served under the supervision of a licensed physician and surgeon. <b>IMPORTANT: SEE DEFINITION OF SUPERVISION!</b>	<b>203</b>

## SECTION E - OUTCOMES PER COUNTY IN WHICH BIRTH, FETAL DEMISE, OR INFANT OR MATERNAL DEATH OCCURRED

(A1) County Code	(A2) County Name	(B) # of Live Births	(C) # of Cases Fetal Demise	(D) # of Infant Deaths	(E) # of Maternal Deaths	(A1) County Code	(A2) County Name	(B) # of Live Births	(C) # of Cases Fetal Demise	(D) # of Infant Deaths	(E) # of Maternal Deaths
01	ALAMEDA	162	0	0	0	30	ORANGE	69	0	0	0
02	ALPINE	0	0	0	0	31	PLACER	40	1	0	0
03	AMADOR	0	0	0	0	32	PLUMAS	1	0	0	0
04	BUTTE	4	0	0	0	33	RIVERSIDE	79	2	0	0
05	CALAVERAS	4	0	0	0	34	SACRAMENTO	53	1	0	0
06	COLUSA	1	0	0	0	35	SAN BENITO	1	0	0	0
07	CONTRA COSTA	45	0	0	0	36	SAN BERNARDINO	60	3	0	0
08	DEL NORTE	1	0	0	0	37	SAN DIEGO	167	1	0	0
09	EL DORADO	19	0	0	0	38	SAN FRANCISCO	163	1	0	0
10	FRESNO	20	0	0	0	39	SAN JOAQUIN	4	0	0	0
11	GLENN	0	0	0	0	40	SAN LUIS OBISPO	36	1	0	0
12	HUMBOLDT	50	0	0	0	41	SAN MATEO	29	0	0	0
13	IMPERIAL	0	0	0	0	42	SANTA BARBARA	21	0	0	0
14	INYO	0	0	0	0	43	SANTA CLARA	44	2	0	0
15	KERN	37	0	0	0	44	SANTA CRUZ	30	0	0	0
16	KINGS	1	0	0	0	45	SHASTA	51	2	0	0
17	LAKE	7	0	0	0	46	SIERRA	0	0	0	0
18	LASSEN	4	0	0	0	47	SISKIYOU	1	0	0	0
19	LOS ANGELES	380	0	0	0	48	SOLANO	7	0	0	0
20	MADERA	2	0	0	0	49	SONOMA	47	0	0	0
21	MARIN	45	0	0	0	50	STANISLAUS	7	0	0	0
22	MARIPOSA	0	0	0	0	51	SUTTER	2	0	0	0
23	MENDOCINO	15	0	0	0	52	TEHAMA	2	0	0	0
24	MERCED	4	0	0	0	53	TRINITY	5	0	0	0
25	MODOC	0	0	0	0	54	TULARE	6	0	0	0
26	MONO	0	0	0	0	55	TUOLUMNE	21	0	0	0
27	MONTEREY	2	0	0	0	56	VENTURA	97	0	0	0
28	NAPA	24	0	0	0	57	YOLO	14	0	0	0
29	NEVADA	50	1	0	0	58	YUBA	5	0	0	0

**SECTION F - OUTCOMES OF OUT-OF-HOSPITAL BIRTHS**

Line No.		Total #
19	Number of planned out-of-hospital births at the onset of labor	2245
20	Number of completed births in an out-of-hospital setting	1840
21	Breech deliveries	13
22	Successful VBAC's	109
23	Twins both delivered out-of-hospital	5
24	Higher Order Multiples - all delivered out-of-hospital	0

**SECTION G - ANTEPARTUM TRANSFER OF CARE, ELECTIVE/NON-EMERGENCY**

Line No.	Code	Reason	Total #
25	G1	Medical or mental health conditions <i>unrelated</i> to pregnancy	10
26	G2	Hypertension developed in pregnancy	22
27	G3	Blood coagulation disorders, including phlebitis	2
28	G4	Anemia	3
29	G5	Persistent vomiting with dehydration	2
30	G6	Nutritional & weight loss issues, failure to gain weight	1
31	G7	Gestational diabetes	7
32	G8	Vaginal bleeding	3
33	G9	Suspected or known placental anomalies or implantation abnormalities	7
34	G10	Loss of pregnancy (includes spontaneous and elective abortion)	27
35	G11	HIV test positive	0
36	G12	Suspected intrauterine growth restriction, suspected macrosomia	8
37	G12.1	Fetal anomalies	2
38	G13	Abnormal amniotic fluid volumes; oligohydramnios or polyhydramnios	28
39	G14	Fetal heart irregularities	4
40	G15	Non vertex lie at term	31
41	G16	Multiple gestation	11
42	G17	Clinical judgment of the midwife (where a single other condition above does not apply)	12
43	G18	Client request	37
44	G19	Other	23

**SECTION H – ANTEPARTUM TRANSFER OF CARE, URGENT/EMERGENCY**

Line No.	Code	Reason	Total #
45	H1	Non pregnancy-related medical condition	0
46	H2	Severe or persistent headache, pregnancy-induced hypertension (PIH), or preeclampsia	8
47	H3	Isoimmunization, severe anemia, or other blood related issues	1
48	H4	Significant infection	0
49	H5	Significant vaginal bleeding	1
50	H6	Preterm labor or preterm rupture of membranes	26
51	H7	Marked decrease in fetal movement, abnormal fetal heart tones, non-reassuring non-stress test (NST)	8
52	H8	Fetal demise	5
53	H9	Clinical judgment of the midwife (where a single other condition above does not apply)	0
54	H10	Other	0

**SECTION I – INTRAPARTUM TRANSFER OF CARE, ELECTIVE/NON-EMERGENCY**

Line No.	Code	Reason	Total #
55	I1	Persistent hypertension; severe or persistent headache	6
56	I2	Active herpes lesion	1
57	I3	Abnormal bleeding	4
58	I4	Signs of infection	4
59	I5	Prolonged rupture of membranes	31
60	I6	Lack of progress; maternal exhaustion; dehydration	179
61	I7	Thick meconium in the absence of fetal distress	16
62	I8	Non-vertex presentation	18
63	I9	Unstable lie or mal-position of the vertex	7
64	I10	Multiple gestation ( <b>NO BABIES DELIVERED PRIOR TO TRANSFER</b> )	1
65	I11	Clinical judgment of the midwife (where a single other condition above does not apply)	14
66	I12	Client request; request for medical methods of pain relief	50
67	I13	Other	2

**SECTION J – INTRAPARTUM TRANSFER OF CARE, URGENT/EMERGENCY**

Line No.	Code	Reason	Total #
68	J1	Suspected preeclampsia, eclampsia, seizures	1
69	J2	Significant vaginal bleeding; suspected placental abruption; severe abdominal pain inconsistent with normal labor	4
70	J3	Suspected uterine rupture	0
71	J4	Maternal shock, loss of consciousness	0
72	J5	Prolapsed umbilical cord	1
73	J6	Non-reassuring fetal heart tones and/or signs or symptoms of fetal distress	32
74	J7	Clinical judgment of the midwife (where a single other condition above does not apply)	13
75	J8	Other life threatening conditions or symptoms	2
76	J9	Multiple gestation ( <b>AT LEAST ONE BABY HAS BEEN DELIVERED OUT-OF-HOSPITAL</b> )	0

**SECTION K - POSTPARTUM TRANSFER OF CARE - MOTHER, ELECTIVE/NON-EMERGENCY**

Line No.	Code	Reason	Total #
77	K1	Adherent or retained placenta without significant bleeding	7
78	K2	Repair of laceration beyond level of midwife's expertise	10
79	K3	Postpartum depression	0
80	K4	Social, emotional or physical conditions outside of scope of practice	1
81	K5	Excessive or prolonged bleeding in later postpartum period	3
82	K6	Signs of infection	3
83	K7	Clinical judgment of the midwife (where a single other condition above does not apply)	0
84	K8	Client request	2
85	K9	Other	2

**SECTION L - POSTPARTUM TRANSFER OF CARE - MOTHER, URGENT/EMERGENCY**

Line No.	Code	Reason	Total #
86	L1	Abnormal or unstable vital signs	1
87	L2	Uterine inversion, rupture or prolapse	0
88	L3	Uncontrolled hemorrhage	4
89	L4	Seizures or unconsciousness, shock	1
90	L5	Adherent or retained placenta with significant bleeding	10
91	L6	Suspected postpartum psychosis	1
92	L7	Signs of significant infection	0
93	L8	Clinical judgment of the midwife (where a single other condition above does not apply)	1
94	L9	Other	3

**SECTION M - TRANSFER OF CARE - INFANT, ELECTIVE/NON-EMERGENCY**

Line No.	Code	Reason	Total #
95	M1	Low birth weight	1
96	M2	Congenital anomalies	9
97	M2.1	Birth injury	0
98	M3	Poor transition to extrauterine life	6
99	M4	Insufficient passage of urine or meconium	0
100	M5	Parental request	1
101	M6	Clinical judgment of the midwife (where a single other condition above does not apply)	4
102	M7	Other	1

**SECTION N – TRANSFER OF CARE - INFANT, URGENT/EMERGENCY**

Line No.	Code	Reason	Total #
103	N1	Abnormal vital signs or color, poor tone, lethargy, no interest in nursing	11
104	N2	Signs or symptoms of infection	6
105	N3	Abnormal cry, seizures or loss of consciousness	2
106	N4	Significant jaundice at birth or within 30 hours	1
107	N5	Evidence of clinically significant prematurity	0
108	N6	Congenital anomalies	2
109	N6.1	Birth injury	1
110	N7	Significant dehydration or depression of fontanelles	0
111	N8	Significant cardiac or respiratory issues	9
112	N9	Ten minute APGAR score of six (6) or less	3
113	N10	Abnormal bulging of fontanelles	0
114	N11	Clinical judgment of the midwife (where a single other condition above does not apply)	2
115	N12	Other	0

**SECTION O – BIRTH OUTCOMES AFTER TRANSFER OF CARE**

Line No.	Reason	(A) Total # of Vaginal Births		(B) Total # of Caesarean Deliveries	
		Code		Code	
<b>MOTHER</b>					
116	Without complication	O1	341	O8	190
117	With serious pregnancy/birth related medical complications resolved by 6 weeks	O2	10	O9	4
118	With serious pregnancy/birth related medical complications <b>not</b> resolved by 6 weeks	O3	0	O10	1
119	Death of mother	O4	0	O11	0
120	Unknown	O5	0	O12	0
121	Information not obtainable	O6	1	O13	0
122	Other	O7	0	O14	0
<b>INFANT</b>					
123	Healthy live born infant	O15	301	O24	149
124	With serious pregnancy/birth related medical complications resolved by 4 weeks	O16	19	O25	4
125	With serious pregnancy/birth related medical complications <b>not</b> resolved by 4 weeks	O17	2	O26	2
126	Fetal demise diagnosed prior to labor	O18	4	O27	0
127	Fetal demise diagnosed during labor or at delivery	O19	6	O28	0
128	Live born infant who subsequently died	O20	1	O29	1
129	Unknown	O21	1	O30	1
130	Information not obtainable	O22	0	O31	0
131	Other	O23	7	O32	2

**SECTION P – COMPLICATIONS LEADING TO MATERNAL AND/OR INFANT MORTALITY**

Line No.	Complication	Out-of-Hospital (A)		After Transfer (B)		Total # from (A) and (B) (C)	
		Code		Code		Code	
<b>MOTHER</b>							
132	Blood loss	P8	0	P15	0	P1	0
133	Sepsis	P9	0	P16	0	P2	0
134	Eclampsia/toxemia or HELLP syndrome	P10	0	P17	0	P3	0
135	Embolism (pulmonary or amniotic fluid)	P11	0	P18	0	P4	0
136	Unknown	P12	0	P19	0	P5	0
137	Information not obtainable	P13	0	P20	0	P6	0
138	Other	P14	0	P21	0	P7	0
<b>INFANT</b>							
139	Anomaly incompatible with life	P30	0	P38	0	P22	0
140	Infection	P31	0	P39	2	P23	2
141	Meconium aspiration, other respiratory	P32	0	P40	0	P24	0
142	Neurological issues/seizures	P33	0	P41	0	P25	0
143	Other medical issue	P34	0	P42	0	P26	0
144	Unknown	P35	0	P43	0	P27	0
145	Information not obtainable	P36	0	P44	0	P28	0
146	Other	P37	0	P45	0	P29	0

**Medical Board of California  
Expert Reviewer Program Report**

**CASES BY SPECIALTY SENT FOR REVIEW  
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ACTIVE LIST EXPERTS BY SPECIALTY**

October 1, 2011

<b>SPECIALTY</b>	<b>Number of cases reviewed/sent to Experts</b>	<b>Number of Experts used and how often utilized</b>	<b>Active List Experts Y-T-D: 1,200↓</b>
<i>ADDICTION</i>	11	<b>5 EXPERTS</b> 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES	16↑
ALLERGY & IMMUNOLOGY (A&I)			6
ANESTHESIOLOGY (Anes)	11	<b>10 EXPERTS</b> 6 LIST EXPERTS REVIEWED 1 CASE 4 LIST EXPERTS REVIEWED 2 CASES	95↓
COLON & RECTAL SURGERY (CRS)	2	<b>1 EXPERT</b> 1 LIST EXPERT REVIEWED 2 CASES	4
<i>COMPLEMENTARY/ALTERNATIVE MEDICINE</i>	4	<b>2 EXPERTS</b> 2 LIST EXPERTS REVIEWED 2 CASES	29↑
<i>CORRECTIONAL MEDICINE</i>	2	<b>2 EXPERTS</b> 2 LIST EXPERTS REVIEWED 1 CASE	44↓
DERMATOLOGY (D)	26	<b>5 EXPERTS</b> 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 5 CASES* 1 LIST EXPERT REVIEWED 8 CASES* 1 LIST EXPERT REVIEWED 10 CASES*  <i>[INVOLVED COMPANION CASES AND SHORT LIST OF EXPERTS IN THIS FIELD]</i>	17↑
EMERGENCY (EM)	17	<b>16 EXPERTS</b> 9 LIST EXPERTS REVIEWED 1 CASE 4 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERTS REVIEWED 3 CASES	61↑
<i>ETHICS</i>	1	<b>1 EXPERT</b> 1 LIST EXPERT REVIEWED 1 CASE	7↑
FAMILY (FM)	85	<b>48 EXPERTS</b> 30 LIST EXPERTS REVIEWED 1 CASE 6 LIST EXPERTS REVIEWED 2 CASES 6 LIST EXPERTS REVIEWED 3 CASES 2 LIST EXPERTS REVIEWED 4 CASES 3 LIST EXPERTS REVIEWED 5 CASES 1 LIST EXPERT REVIEWED 8 CASES*  *{3 CASE REVIEWS; 5 PHYSICAL EVALUATIONS}	104

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<b>SPECIALTY</b>	<b>Number of cases reviewed/sent to Experts</b>	<b>Number of Experts used and how often utilized</b>	<b>Active List Experts Y-T-D: 1,200↓</b>
HAND SURGERY			19↓
HOSPICE & PALLIATIVE MEDICINE	1	<b>1 EXPERT</b> 1 LIST EXPERT REVIEWED 1 CASE	12
INTERNAL (General Internal Med)	71	<b>46 EXPERTS</b> 32 LIST EXPERTS REVIEWED 1 CASE 9 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES 3 LIST EXPERTS REVIEWED 5 CASES	239↓
Cardiovascular Disease (Cv)	21	<b>16 EXPERTS</b> 13 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES	35
Gastroenterology (Ge)	1	<b>1 EXPERT</b> 1 LIST EXPERT REVIEWED 1 CASE	25↑
Medical Oncology (Onc)	7	<b>6 EXPERTS</b> 5 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	14↓
MIDWIFE REVIEWER	3	<b>2 EXPERTS</b> 1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	10↓
NEUROLOGICAL SURGERY (NS)	5	<b>3 EXPERTS</b> 1 LIST EXPERT REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES	11↓
NEUROLOGY (N)	9	<b>9 EXPERTS</b> 6 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES	30↓
NEUROLOGY with Special Qualifications in Child Neurology (N/ChiN)			5
NUCLEAR MEDICINE (NuM)			6
OCCUPATIONAL MEDICINE	1	<b>1 EXPERT</b> 1 LIST EXPERT REVIEWED 1 CASE	10

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<b>SPECIALTY</b>	<b>Number of cases reviewed/sent to Experts</b>	<b>Number of Experts used and how often utilized</b>	<b>Active List Experts Y-T-D: 1,200↓</b>
OBSTETRICS & GYNECOLOGY (ObG)	88	<p align="center"><b>38 EXPERTS</b></p> 19 LIST EXPERTS REVIEWED 1 CASE 8 LIST EXPERTS REVIEWED 2 CASES 3 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES 2 LIST EXPERTS REVIEWED 5 CASES 2 LIST EXPERTS REVIEWED 7 CASES* 3 LIST EXPERTS REVIEWED 9 CASES*  <i>*[INCLUDED SUPPLEMENTAL WORK OF CASES PREVIOUSLY REVIEWED AND SHORT LIST OF EXPERTS IN THIS FIELD]</i>	98↑
OPHTHALMOLOGY (Oph)	19	<p align="center"><b>15 EXPERTS</b></p> 3 OFF LIST EXPERTS REVIEWED 1 CASE 7 LIST EXPERTS REVIEWED 1 CASE 4 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	39↓
ORTHOPAEDIC SURGERY (OrS)	17	<p align="center"><b>11 EXPERTS</b></p> 6 LIST EXPERTS REVIEWED 1 CASE 4 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 4 CASES	36↓
OTOLARYNGOLOGY (Oto)	10	<p align="center"><b>8 EXPERTS</b></p> 7 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 5 CASES	29
PAIN MEDICINE (PM)	47	<p align="center"><b>18 EXPERTS</b></p> 8 LIST EXPERTS REVIEWED 1 CASE 4 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 5 CASES 3 LIST EXPERTS REVIEWED 6 CASES 1 LIST EXPERT REVIEWED 7 CASES	26↓
PATHOLOGY (Path)	4	<p align="center"><b>3 EXPERTS</b></p> 1 LIST EXPERT REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES	12↓
PEDIATRICS (Ped)	6	<p align="center"><b>5 EXPERTS</b></p> 3 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES	57↓
Neonatal-Perinatal Medicine (NP)	4	<p align="center"><b>2 EXPERTS</b></p> 1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES	6

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<b>SPECIALTY</b>	<b>Number of cases reviewed/sent to Experts</b>	<b>Number of Experts used and how often utilized</b>	<b>Active List Experts Y-T-D: 1,200↓</b>
Pediatric Cardiology (Cd)	1	<b>1 EXPERT</b> 1 LIST EXPERT REVIEWED 1 CASE	7
PHYSICAL MEDICINE & REHABILITATION (PMR)	1	<b>1 EXPERT</b> 1 LIST EXPERT REVIEWED 1 CASE	11
PLASTIC SURGERY (PIS)	35	<b>20 EXPERTS</b> 12 LIST EXPERTS REVIEWED 1 CASE 4 LIST EXPERTS REVIEWED 2 CASES 3 LIST EXPERTS REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES	57↓
PUBLIC HEALTH and GENERAL PREVENTIVE MED.	1	<b>1 EXPERT</b> 1 LIST EXPERT REVIEWED 1 CASE	5
PSYCHIATRY (Psyc)	101	<b>39 EXPERTS</b> 5 OFF LIST EXPERTS REVIEWED 1 CASE 10 LIST EXPERTS REVIEWED 1 CASE 7 LIST EXPERTS REVIEWED 2 CASES 6 LIST EXPERTS REVIEWED 3 CASES 6 LIST EXPERTS REVIEWED 4 CASES 3 LIST EXPERTS REVIEWED 5 CASES 1 LIST EXPERT REVIEWED 7 CASES* 1 LIST EXPERT REVIEWED 9 CASES**	113↓
*MOSTLY PSYCH EVALUATIONS ** COMBINATION CASE REVIEWS, PSYCH EVALUATIONS, PREPATION&TESTIMONY OF CASES PREVIOUSLY REVIEWED			
Addiction Psychiatry (AdP)	5	<b>3 EXPERTS</b> 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES	28↓
RADIOLOGY (Rad)/ Diagnostic Radiology (Rad DR)	10	<b>8 EXPERTS</b> 5 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES	40
Radiation Oncology (Rad RO)	1	<b>1 EXPERT</b> 1 OFF LIST EXPERT	5
SLEEP MEDICINE (S)			10
SURGERY (S)	17	<b>14 EXPERTS</b> 10 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 4 CASES	57↓
Pediatric Surgery (PdS)	1	<b>2 EXPERTS</b> 2 LIST EXPERTS REVIEWED 1 CASE	3
Vascular Surgery (VascS)	5	<b>4 EXPERTS</b> 2 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES	13↓
THORACIC SURGERY (TS)	2	<b>2 EXPERTS</b> 2 LIST EXPERTS REVIEWED 1 CASE	19

**Medical Board of California  
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ACTIVE LIST EXPERTS BY SPECIALTY  
October 1, 2011**

<b>SPECIALTY</b>	<b>Number of cases reviewed/sent to Experts</b>	<b>Number of Experts used and how often utilized</b>	<b>Active List Experts Y-T-D: 1,200↓</b>
<i>(MEDICAL) TOXICOLOGY</i>	1	<b>1 EXPERT</b> 1 LIST EXPERT REVIEWED 1 CASE	3
UROLOGY (U)	18	<b>10 EXPERTS</b> 3 LIST EXPERTS REVIEWED 1 CASE 4 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES	19
<i>WORKERS= COMP/QME/IME</i>			34

/susan (9.30.11)

Medical Board of California  
Investigation Prosecution Timeframes\*

	2005		2006		2007		2008		2009		2010		Q1 2011	Q2 2011	Q3 2011
	Prior to VE	All	VE	All	VE	All	VE	All	VE	All	VE	All	All	All	All
<b>Calendar Day Age from Case Assigned to Case Closed Not Resulting in Prosecution</b>															
Average	271	299	138	330	268	374	358	383	381	333	333	332	305	283	
Median	252	285	134	304	269	335	324	346	346	298	297	312	289	255	
Record Count	827	703	192	648	539	609	588	673	672	664	663	192	231	225	
<b>Calendar Day Age from Request to Suspension Order Granted</b>															
Average	51	44	4	34	38	19	19	52	39	40	40	13	20	29	
Median	17	3	2	22	23	10	10	23	23	1	1	5	10	24	
Record Count	24	21	11	17	13	21	17	17	16	27	27	4	7	14	
<b>Calendar Day Age from Request to Receipt of Medical Records</b>															
Average	58	53	37	59	57	63	58	73	73	64	64	90	46	65	
Median	32	31	26	31	31	28	28	32	32	29	29	27	21	37	
Record Count	475	376	228	264	259	256	252	243	243	257	257	38	34	42	
<b>Calendar Day Age from Request to Physician Interview Completed</b>															
Average	48	51	43	52	50	63	63	52	52	46	46	55	58	57	
Median	36	42	38	37	36	41	42	37	37	34	34	41	38	40	
Record Count	597	453	172	406	371	473	466	696	696	582	582	145	145	127	
<b>Calendar Day Age from Request to Receipt of Expert Opinion</b>															
Average	51	47	35	51	43	50	50	48	48	47	47	63	49	61	
Median	41	35	31	36	35	39	38	36	35	37	37	43	39	41	
Record Count	519	424	82	344	270	374	359	426	424	415	415	152	150	146	
<b>Calendar Day Age from Case Assigned to Completed Investigation and Accusation Filed</b>															
Average	556	554	140	543	340	565	493	584	578	589	588	535	614	522	
Median	525	504	120	523	339	541	486	575	569	616	616	530	628	522	
Record Count	187	149	17	198	95	157	131	189	186	200	199	59	60	57	
<b>Calendar Day Age from Accusation Filed to Disciplinary Outcome**</b>															
Average	608	602	85	576	188	561	243	473	339	426	340	456	450	403	
Median	526	466	99	426	182	384	238	351	309	326	304	361	432	387	
Record Count	212	195	3	226	29	203	80	198	145	171	156	35	43	54	

\*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	Q3 2011
<b>*Citations Issued</b>	80	81	76	109	124	100	13	5	28
Citations Issued for Failure to Produce Records	0	6	3	3	2	5	0	0	4
<b>Civil Actions Filed</b>	3	3	1	1	2	1	0	3	3
Civil Actions Filed for Failure to Produce Records	2	2	1	1	0	0	0	3	0

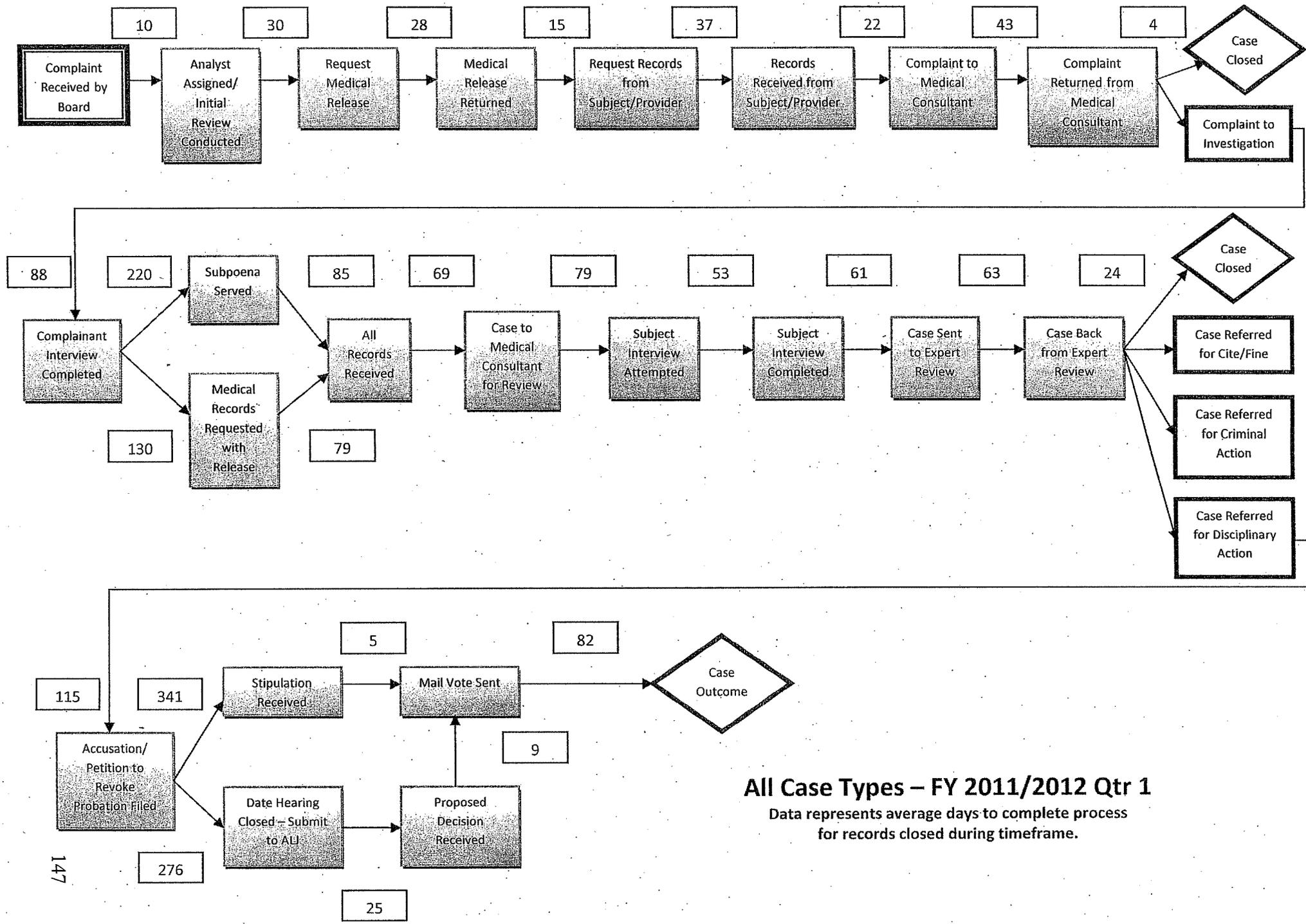
\*Excludes citations issued for failure to comply with CME audit and for failure to notify Board of change of address

**Enforcement Data Markers  
All Case Types**

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		FY 2011/2012 Qtr 1	
	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records
<b>Complaint Processes</b>								
Complaint Received by Board → Analyst Assigned/Initial Review Conducted	10	6761	11	6869	9	7513	10	1995
Analyst Assigned/Initial Review Conducted → Request Medical Release	25	1216	24	1360	28	1567	30	328
Request Medical Release → Medical Release Returned	29	1044	26	1166	25	1321	28	270
Medical Release Returned → Request Records from Subject/Provider	7	687	7	802	11	888	15	175
Request Records from Subject/Provider → Records Received from Subject/Provider	39	1759	38	1879	35	1906	37	428
Records Received from Subject/Provider → Complaint to Medical Consultant	15	1617	16	1865	17	1768	22	411
Complaint to Medical Consultant → Complaint Returned from Medical Consultant	54	1934	54	2120	52	2129	43	506
Complaint Returned from Medical Consultant → Case Closed/Complaint to Investigation	7	1932	4	2114	5	2126	4	503
<b>Investigative Processes</b>								
Complaint to Investigation → Complainant Interview Completed	103	349	102	424	110	490	88	70
Complainant Interview Completed → Subpoena Served	173	42	237	43	172	44	220	8
Complainant Interview Completed → Medical Records Requested with Release	76	141	88	170	59	194	130	48
Subpoena Served → All Records Received	124	120	100	178	88	166	85	34
Medical Records Requested with Release → All Records Received	95	372	92	406	85	420	79	98
All Records Received → Case to Medical Consultant for Review	78	227	84	318	70	369	69	78
Case to Medical Consultant for Review → Subject Interview Attempted	110	374	109	488	77	558	79	135
Subject Interview Attempted → Subject Interview Completed	66	712	53	880	53	961	53	256
Subject Interview Completed → Case Sent to Expert Review	97	412	81	511	72	580	61	157
Case Sent to Expert Review → Case Back from Expert Review	79	510	72	601	63	658	63	182
Case Back from Expert Review → Case Closed or Referred for Action	39	495	31	585	30	656	24	186

**Enforcement Data Markers  
All Case Types**

Data represents average days to complete Disciplinary processes for records closed during reported time frames.	FY 2008/2009		FY 2009/2010		FY 2010/2011		FY 2011/2012 Qtr 1	
	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records
Case Referred for Action → Accusation/Petition to Revoke Probation Filed	121	239	113	237	103	219	115	70
Accusation/Petition to Revoke Probation Filed → Stipulation Received	330	159	291	173	318	142	341	53
Stipulation Received → Mail Vote Sent	6	136	6	132	4	124	5	40
Accusation/Petition to Revoke Probation Filed → Date Hearing Closed - Submit to ALJ	416	25	370	30	393	44	276	12
Date Hearing Closed - Submit to ALJ → Proposed Decision Received	28	35	98	43	39	58	25	16
Proposed Decision Received → Mail Vote Sent	5	54	5	53	6	60	9	17
Mail Vote Sent → Case Outcome	131	206	87	208	111	205	82	69
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		FY 2011/2012 Qtr 1	
	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records
Complaint Received → Closure in Complaint Unit	84	5278	84	5247	80	5755	84	1466
Complaint Received → Closure at Field/Referred for Administrative or Criminal Action/Citation Issued	467	1585	464	1747	453	1861	416	553

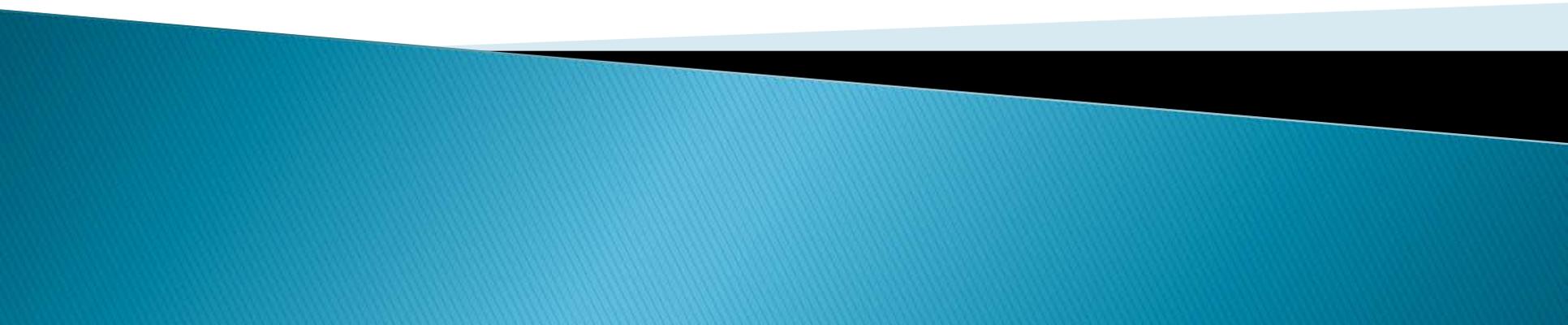


**All Case Types – FY 2011/2012 Qtr 1**

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

# Health Quality Enforcement Section

Program and Statistics



# Vertical Enforcement Program

- ▶ Upon referral to the district office, each complaint is jointly assigned to an investigator and DAG who is ultimately responsible for prosecuting the case if warranted by the evidence.
- ▶ Early identification of urgent cases requiring emergency action.
- ▶ Joint assignment of investigator and DAG shall exist for the duration of the disciplinary matter.
- ▶ During joint assignment, the DAG is responsible for directing, but not supervising, the investigator who, in turn, is responsible for gathering evidence necessary for the DAG to evaluate the case.
- ▶ DAG participation in physician interviews, and also in other witness interviews where appropriate.
- ▶ DAG review of expert packages and expert opinion reports.
- ▶ DAG review and approval of proposed closure of investigations.
- ▶ DAG review and approval of subpoenas and, where necessary, handling of subpoena enforcement actions in superior court.

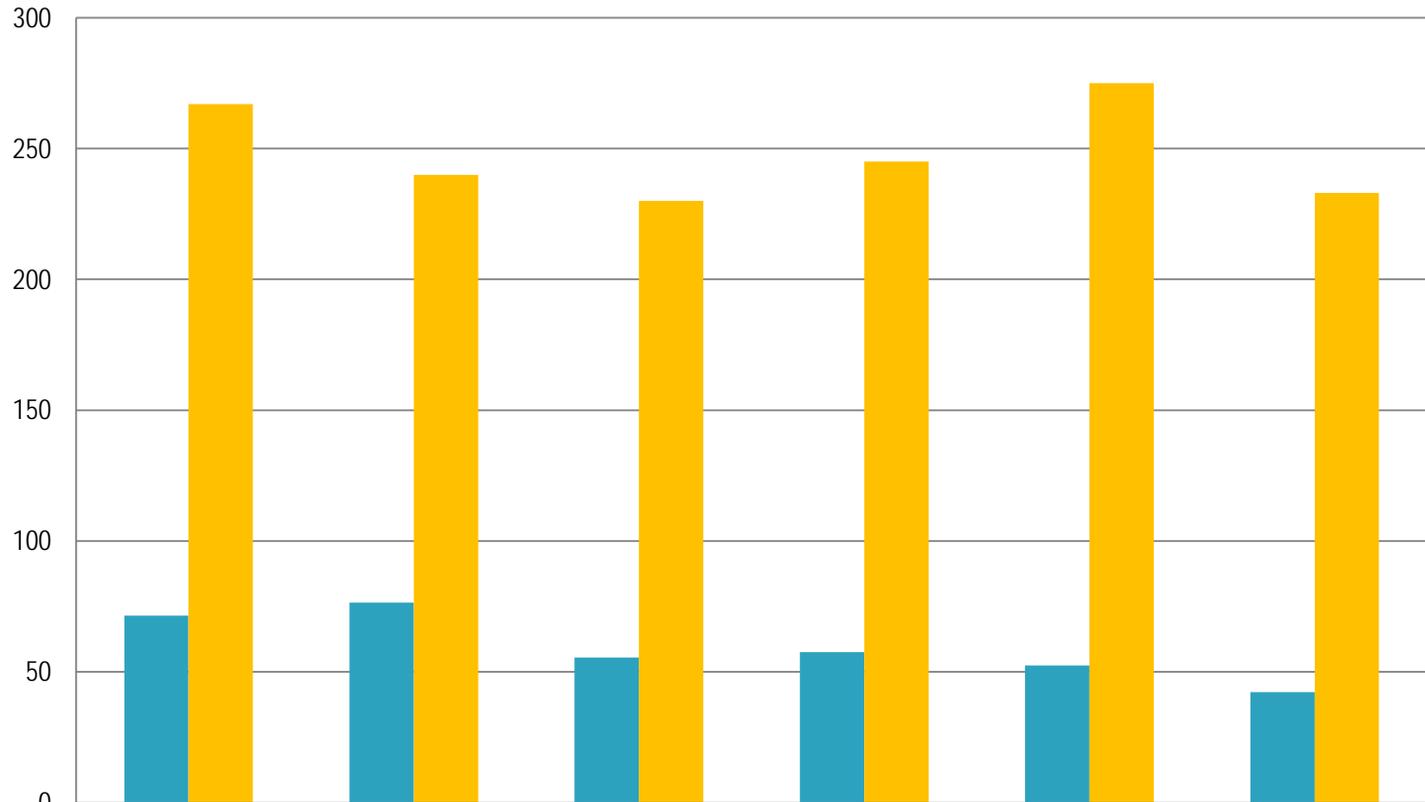
# Fiscal Challenges

- ▶ Hiring Freezes – thus freezing investigator vacancies.
- ▶ Executive Orders prohibiting contracting with experts to evaluate cases or court reporter services by OAH.
- ▶ Furloughs of investigators and administrative law judges which contribute to both investigation and prosecution completion delays.
- ▶ Transfer of pending investigations from one district office to another which cause delays in investigations.

# Impact of Fiscal Challenges

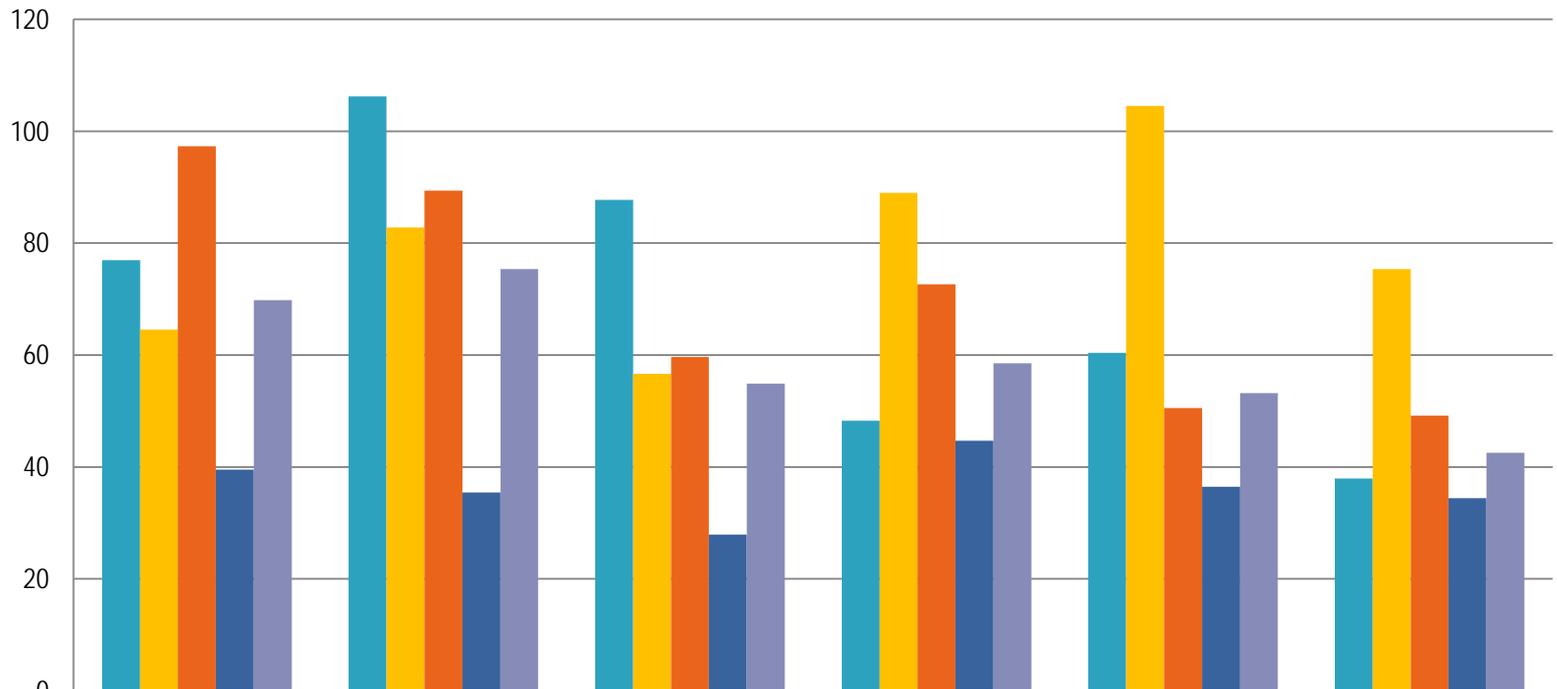
- ▶ Continuing high investigator vacancy rates throughout the state.
- ▶ “Revolving door” as experienced, trained investigators are recruited by other agencies and newly-hired replacement investigators begin their training.
- ▶ Some investigations stalled.
- ▶ Unavailability of medical consultants in the district offices which, in turn, contributes to investigation completion delays.

# Statewide Average Number of Days from Case “Accepted for Prosecution” to “Pleading Sent” to MBC for filing (Accusations and Accusations/Petitions to Revoke Probation Combined)<sup>1</sup>



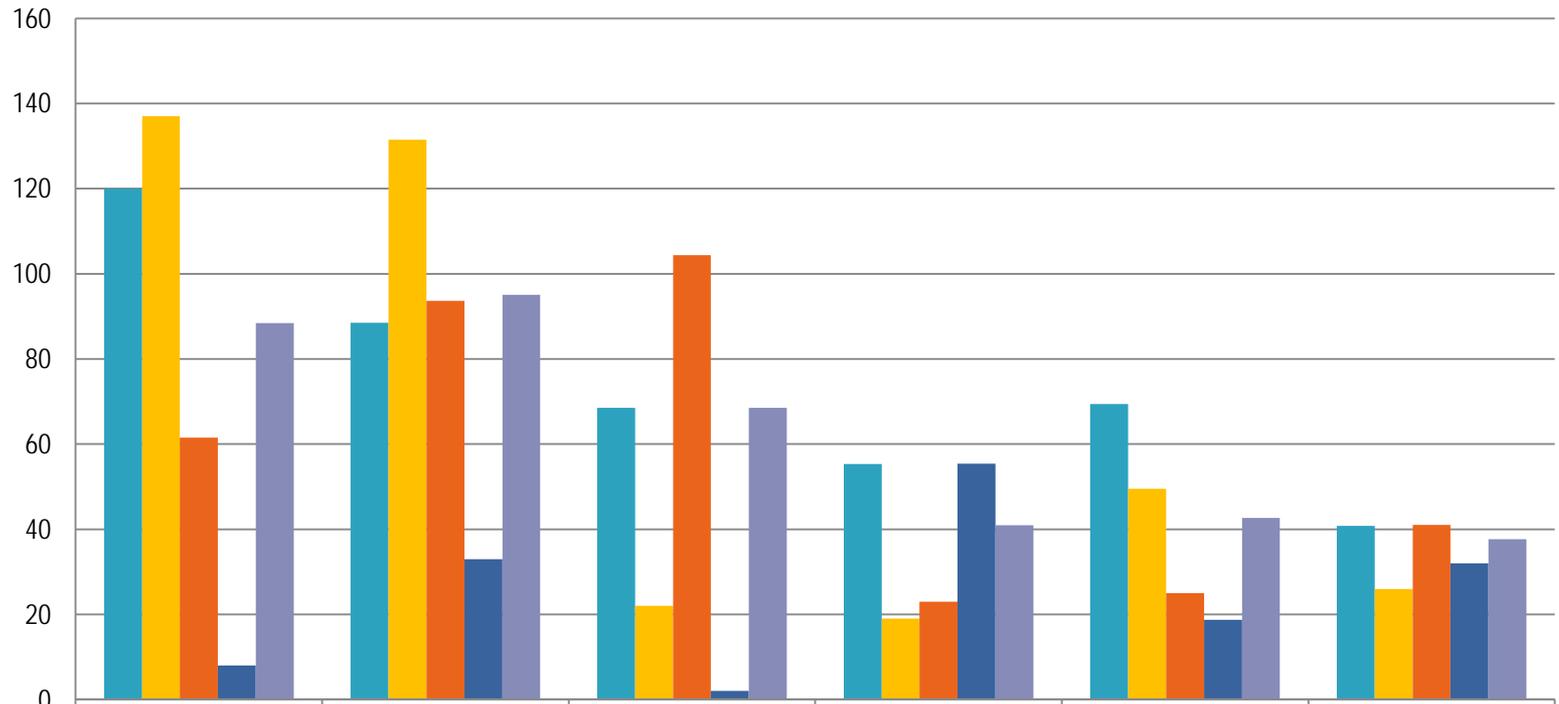
	2005	2006	2007	2008	2009	2010
Statewide Average	71.54	76.51	55.47	57.5	52.45	42.26
No. of Acc & Acc/PRP	267	240	230	245	275	233

## Average Number of Days from “Accepted for Prosecution” to “Pleading Sent” to MBC for Filing (Accusations Only)<sup>1</sup>



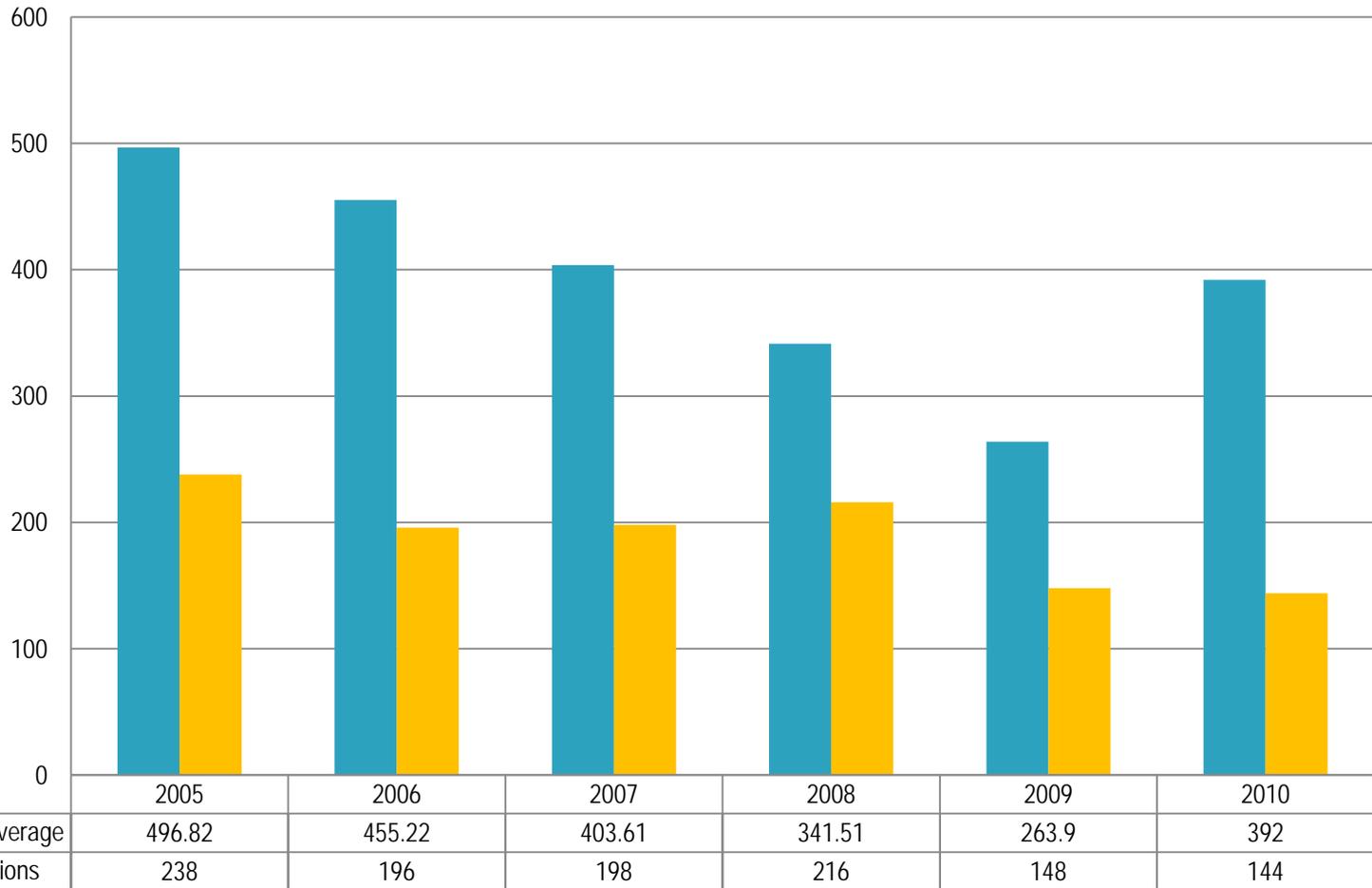
	2005	2006	2007	2008	2009	2010
■ Los Angeles	76.98	106.2	87.74	48.28	60.42	37.93
■ Sacramento	64.53	82.77	56.64	89	104.5	75.35
■ San Diego	97.3	89.4	59.67	72.63	50.55	49.15
■ San Francisco	39.53	35.44	27.91	44.71	36.48	34.4
■ Statewide	69.79	75.36	54.87	58.5	53.19	42.54
No. of Accusations	242	226	220	231	256	220

# Average Number of Days from “Accepted for Prosecution” to “Pleading Sent” to MBC for Filing (Accusations/Petitions to Revoke Probation Only)<sup>1</sup>

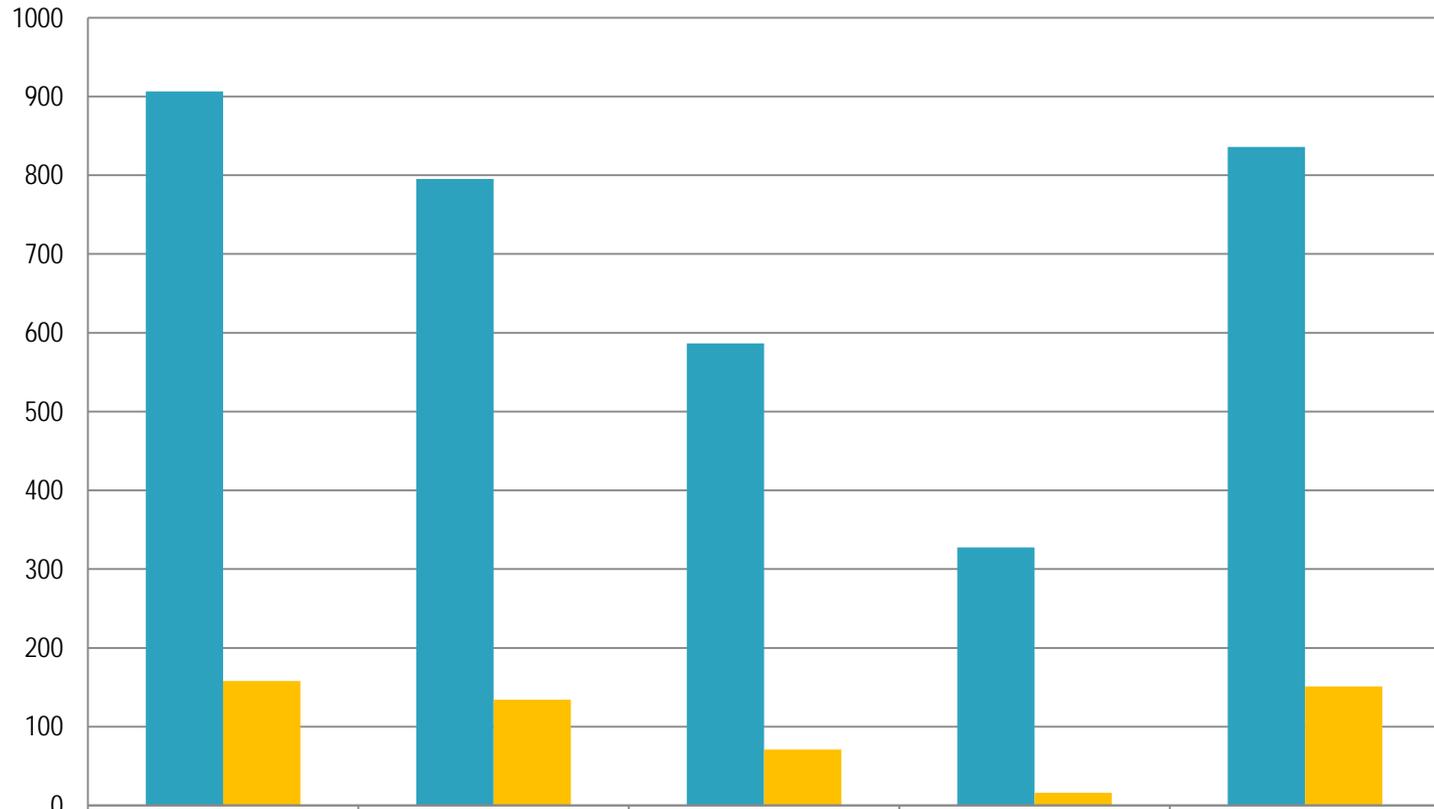


	2005	2006	2007	2008	2009	2010
Los Angeles	120	88.5	68.5	55.33	69.43	40.8
Sacramento	137	131.5	22	19	49.5	26
San Diego	61.54	93.67	104.4	23	25	41
San Francisco	8	33	2	55.4	18.75	32
Statewide	88.44	95.07	68.5	40.93	42.63	37.69
No. of Acc/PRP & PRP	25	14	10	14	19	13

## Statewide Average Number of Days from “Accepted for Prosecution” to “Decision Signed by MBC” (Accusations and Accusations/Petitions to Revoke Probation Combined)<sup>2</sup>

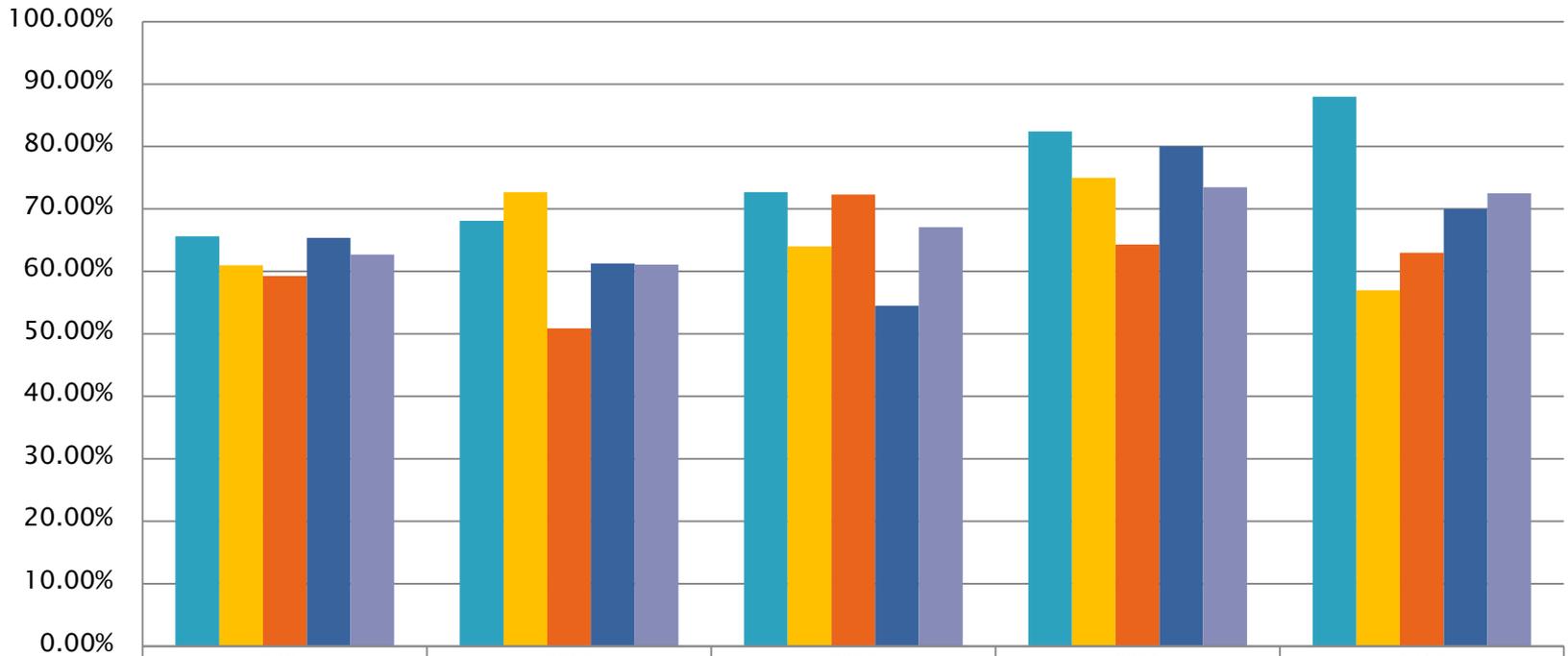


## Statewide Average Number of Days from “Received at District Office” to “Decision Signed by MBC” (Accusations and Accusations/Petitions to Revoke Probation Combined)<sup>3</sup>



■ Statewide Average	2006	2007	2008	2009	2010
	906.57	795.47	586.64	327.38	836
■ No. of Decisions	158	134	71	16	151

## Accusations Resulting in “Serious Discipline” 4



■ Los Angeles	65.60%	68.10%	72.70%	82.40%	88.00%
■ Sacramento	61.00%	72.70%	64.00%	75.00%	57.00%
■ San Diego	59.30%	50.90%	72.30%	64.30%	63.00%
■ San Francisco	65.40%	61.30%	54.50%	80.00%	70.00%
■ Statewide	62.70%	61.10%	67.10%	73.50%	72.50%

2006

2007

2008

2009

2010

65.60%

68.10%

72.70%

82.40%

88.00%

61.00%

72.70%

64.00%

75.00%

57.00%

59.30%

50.90%

72.30%

64.30%

63.00%

65.40%

61.30%

54.50%

80.00%

70.00%

62.70%

61.10%

67.10%

73.50%

72.50%

No. of Decisions

231

219

201

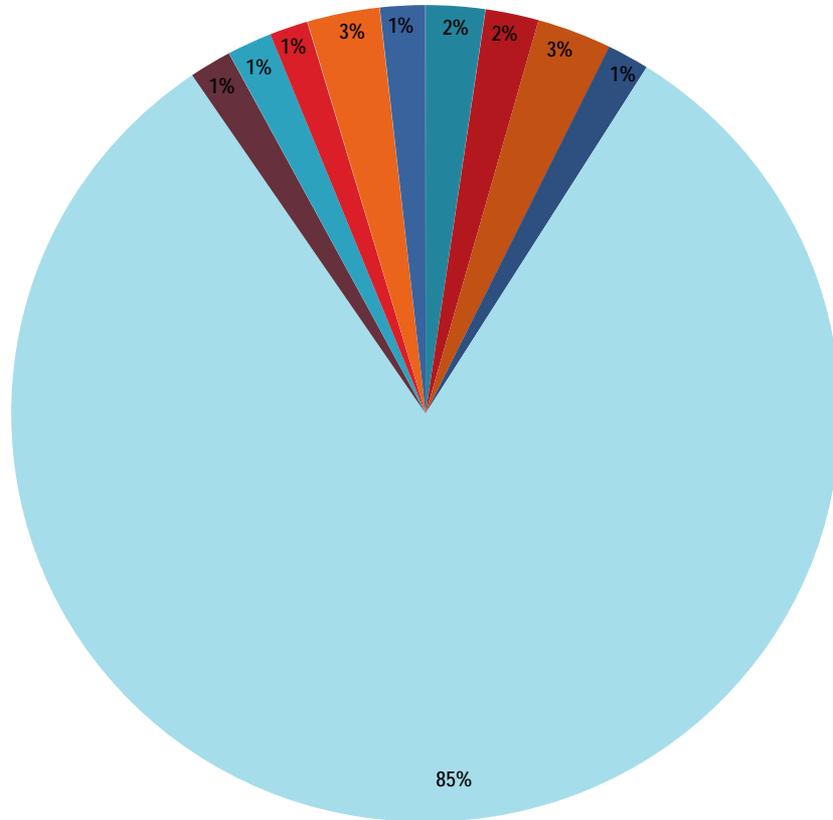
98

152

# HQE Clients

- ▶ Acupuncture Board
- ▶ Board of Podiatric Medicine
- ▶ Board of Psychology
- ▶ Board of Registered Dispensing Opticians
- ▶ Medical Board of California (Licensing and Enforcement)
- ▶ Osteopathic Medical Board
- ▶ Physician Assistant Committee
- ▶ Physical Therapy Board
- ▶ Respiratory Care Board
- ▶ Speech–Language Pathology & Audiology Board and Hearing Aid Dispensers Bureau

# HQE BUDGET



- Acupuncture Board
- Board of Podiatric Medicine
- Board of Psychology
- Board of Registered Dispensing Opticians
- Medical Board of California
- Osteopathic Medical Board
- Physical Therapy Board
- Physician Assistant Committee
- Respiratory Care Board
- Speech-Language Pathology & Audiology Board and Hearing Aid Dispensers Bureau

## Endnotes

<sup>1</sup> The methodology utilized for this first key statistical measure is as follows: The average number of days was calculated from the date the case was “Accepted for Prosecution” to the date “Pleading Sent” to the Medical Board for filing. Administrative cases that were initially “Accepted for Prosecution,” only to be reviewed and returned to the Medical Board District Office for additional investigation, have been calculated separately deleting the time period of investigation. The cases reflected in the chart include out-of-state discipline cases. Calculations were done using matters that had been resolved.

<sup>2</sup> The methodology utilized for this second key statistical measure is as follows: The average number of days was calculated from date the case was “Accepted for Prosecution” to the date “Decision Signed by Client.” Every effort was made to delete duplicate cases and multiple administrative matters that were consolidated into one Decision signed by the client. In addition, administrative cases that were initially “Accepted for Prosecution,” only to be reviewed and returned to the Medical Board District Office for additional investigation, have been calculated separately deleting the time period of investigation. The calculations for this statistical measure include out-of-state discipline cases. Calculations were done using matters that had been resolved.

<sup>3</sup> The methodology utilized for this third key statistical measure is as follows: The average number of days was calculated from date the consumer complaint was “Received at District Office” to the date “Decision Signed by Client.” For multiple investigation matters resulting in a single administrative matter (by amendment to the existing Accusation and/or Accusation/Petition to Revoke Probation), the earliest “Received at District Office” date was used. Calculations were done using matters that had been resolved.

<sup>4</sup> The methodology utilized to calculate serious discipline is as follows: “Serious discipline” is defined as: (1) outright revocation of licensure; (2) surrender of licensure; and (3) revocation of licensure, stayed, with a period of probation of at least one year. In calculating each outcome, cases that were “declined to prosecute” and cases that did not reach an administrative outcome (i.e., Accusations filed but waiting administrative hearing) were omitted from the calculations. Out-of-state discipline cases were also omitted from the calculations.

# LEGISLATIVE PACKET



## MEDICAL BOARD MEETING

OCTOBER 28, 2011  
SAN DIEGO, CA

**Medical Board of California  
Tracker - Legislative Bill File  
10/18/2011**

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 415	Logue	Healing Arts: Telehealth	Chaptered, #547	Support	9/2/2011
AB 507	Hayashi	Pain Management	Chaptered, #396	Support	8/16/2011
AB 536	Ma	Physicians and Surgeons: Expungement	Chaptered, #379	Support	6/14/2011
AB 584	Fong	Worker's Comp: Utilization Review	Vetoed	Support	4/6/2011
AB 1127	Brownley	Physicians & Surgeons: Physician Interview	Chaptered, #115	Sponsor/Support	4/4/2011
AB 1267	Halderman	Physicians & Surgeons: Misdemeanor Incarceration	Chaptered, #169	Sponsor/Support	6/30/2011
AB 1424	Perea	Delinquent Tax Debt: License Suspension	Chaptered, #455		9/2/2011
AJR 13	Lara	Graduate Medical Education Residency Positions	Chaptered, # 85	Support	6/2/2011
SB 100	Price	Healing Arts : Outpatient Settings	Chaptered, #645	Support	7/12/2011
SB 233	Pavley	Emergency Services and Care: Physician Assistants	Chaptered, #333	Support	8/25/2011
SB 380	Wright	Chronic Disease Prevention - Nutrition/Lifestyle Behavior	Chaptered, #236	Neutral	6/20/2011
SB 541	Price	Regulatory Boards: Expert Consultants	Chaptered, #339	Sponsor/Support	6/21/2011
SB 543	Steinberg/Price	Omnibus - PTs/Medical Corporations	Chaptered, #448		9/2/2011
SB 824	Negrete McLeod	Opticians: Change of Ownership	Chaptered, #389	Support	8/29/2011
SB 943	Sen. B&P	Healing Arts - Polysom Grandfathering	Chaptered, #350	Support	8/29/2011
<b>2-Year Status</b>					
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 589	Perea	Medical School Scholarships	2-year	Support	8/17/2011
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

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** AB 1127  
**Author:** Brownley  
**Chapter:** # 115  
**Bill Date:** April 4, 2011, amended  
**Subject:** Physicians and Surgeons: Unprofessional Conduct  
**Sponsor:** Medical Board of California  
**Position:** Sponsor/Support

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill makes 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:**

The Board is the sponsor of this important consumer protection legislation. 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.

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

**OPPOSITION:** None on file

**FISCAL:** None

**IMPLEMENTATION:**

- Newsletter Article
- Notify/Train Board Staff
- Notify Attorney General's Office
- Update Citation and Fine Regulations

September 28, 2011

Assembly Bill No. 1127

CHAPTER 115

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

[Approved by Governor July 25, 2011. Filed with  
Secretary of State July 25, 2011.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1127, 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 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.

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

SECTION 1. Section 2234 of the Business and Professions Code is amended to read:

2234. The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed

by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct which would have warranted the denial of a certificate.

(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

(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.

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** AB 1267  
**Author:** Halderman  
**Chapter:** # 169  
**Bill Date:** June 30, 2011, amended  
**Subject:** Physicians and Surgeons: Certificate  
**Sponsor:** Medical Board of California  
**Position:** Sponsor/Support

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill authorizes 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 requires the Board to change the physician's license status back to its prior or appropriate status within five business days of receiving notice that the physician is no longer incarcerated. This bill 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 9<sup>th</sup> 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 30<sup>th</sup> 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 bill now starts the five day time line when the Board receives notice that the physician is no longer incarcerated. This bill requires the Board 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

**IMPLEMENTATION:**

- Newsletter Article
- Notify/Train Board Staff
- Notify Attorney General's Office
- Adopt regulations to specify the type of notice that needs to be submitted to the Board to let the Board know the physician is no longer incarcerated. The regulations also need to specify what will be posted on the Board's Web site as the reason for inactive status for misdemeanor incarcerations.

September 29, 2011

**Assembly Bill No. 1267**

**CHAPTER 169**

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

[Approved by Governor August 3, 2011. Filed with  
Secretary of State August 3, 2011.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1267, 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 after receiving notice that the physician and surgeon is no longer incarcerated, as specified, and would require the board to adopt regulations in this regard.

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

SECTION 1. Section 2236.2 is added to the Business and Professions Code, to read:

2236.2. (a) Notwithstanding Article 9 (commencing with Section 700) of Chapter 1 of Division 2 or any other provision of law, a physician and surgeon's certificate shall be automatically placed on inactive status during any period of time that the holder of the certificate is incarcerated after conviction of a misdemeanor.

(b) A physician and surgeon's certificate placed on inactive status pursuant to subdivision (a) shall be returned by the board to its prior or appropriate status within five business days of receiving notice that the physician and surgeon is no longer incarcerated. The board shall adopt regulations that specify the type of notice required to be submitted to the board.

(c) The reason for the inactive status described in subdivision (a) shall be disclosed on the board's Internet Web site.

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MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** SB 541  
**Author:** Price  
**Chapter:** # 339  
**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

**DESCRIPTION OF CURRENT LEGISLATION:**

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

The June 21<sup>st</sup> 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.

**IMPLEMENTATION:**

- Newsletter Article
- Notify/Train Board Staff - DCA training for staff may be required.
- Notify/Train expert consultants
- Work closely with DCA on the new simplified contracting process for utilizing expert consultants.
- Develop tracking system to ensure no expert exceeds contract levels, and time for contract process.

October 3, 2011

**Senate Bill No. 541**

**CHAPTER 339**

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

[Approved by Governor September 26, 2011. Filed with Secretary of State September 26, 2011.]

**LEGISLATIVE COUNSEL'S DIGEST**

SB 541, Price. 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.

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

SECTION 1. Section 40 is added to the Business and Professions Code, to read:

40. (a) Subject to the standards described in Section 19130 of the Government Code, any board, as defined in Section 22, the State Board of Chiropractic Examiners, or the Osteopathic Medical Board of California may enter into an agreement with an expert consultant to do any of the following:

- (1) Provide an expert opinion on enforcement-related matters, including providing testimony at an administrative hearing.
- (2) Assist the board as a subject matter expert in examination development, examination validation, or occupational analyses.

(3) Evaluate the mental or physical health of a licensee or an applicant for a license as may be necessary to protect the public health and safety.

(b) An executed contract between a board and an expert consultant shall be exempt from the provisions of Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

(c) Each board shall establish policies and procedures for the selection and use of expert consultants.

(d) Nothing in this section shall be construed to expand the scope of practice of an expert consultant providing services pursuant to this section.

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

To ensure that licensees engaging in certain professions and vocations are adequately regulated at the earliest possible time in order to protect and safeguard consumers and the public in this state, it is necessary that this act take effect immediately.

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MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** AB 415  
**Author:** Logue  
**Chapter:** # 547  
**Subject:** Healing Arts: Telehealth  
**Sponsor:** California State Rural Health Association  
**Position:** Support

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill repeals existing law related to telemedicine and replaces this law with the Telehealth Advancement Act of 2011, which revises and updates existing law to facilitate the advancement of telehealth as a service delivery mode in managed care and the Medi-Cal Program.

**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 amendments, which were taken in May, 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 10<sup>th</sup> 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 27<sup>th</sup> amendments are technical and clarifying changes related to Medical reimbursement, they do not affect the Board or the Board's support position.

The July 7<sup>th</sup> 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.

**The August 15<sup>th</sup> amendments specify that this bill does not apply to patients under the jurisdiction of the Department of Corrections and Rehabilitation or any other correctional facility. They also make changes to address concerns raised by the health care service plans. The September 2<sup>nd</sup> amendments make changes to conform the bill to federal regulations, for the purposes of participation in the Medicare and Medicaid Programs. 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

**IMPLEMENTATION:**

- Newsletter Article
- Notify/Train Board Staff
- Monitor implementation by others

October 10, 2011

**Assembly Bill No. 415**

**CHAPTER 547**

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.

[Approved by Governor October 7, 2011. Filed with  
Secretary of State October 7, 2011.]

**LEGISLATIVE COUNSEL'S DIGEST**

AB 415, 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 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 federal regulations, for the purposes of participation in the Medicare and Medicaid programs, authorize the governing body of a hospital whose patients are receiving telemedicine services to grant privileges based on its medical staff recommendations that rely on information provided by the distant-site hospital. Existing state regulations require medical staff, appointed by the governing body of a hospital, to adopt procedures for the evaluation of staff applications for credentials and privileges. 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 of state law 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, prior to the delivery of health care via telehealth, to 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, subject to contract terms and conditions, also preclude health care service plans and health insurers from imposing prior to payment, certain requirements regarding the manner of service delivery. This bill would establish procedures for granting privileges to, and verifying and approving credentials for, providers of telehealth services. 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.

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

SECTION 1. This act shall be known, and may be cited, as the Telehealth Advancement Act of 2011.

SEC. 2. The Legislature finds and declares all of the following:

(a) Lack of primary care providers, specialty providers, and transportation continue to be significant barriers to access to health services in medically underserved rural and urban areas.

(b) Parts of California have difficulty attracting and retaining health professionals, as well as supporting local health facilities to provide a continuum of health care.

(c) Many health care providers in medically underserved areas are isolated from mentors, colleagues, and the information resources necessary to support them personally and professionally.

(d) It is the intent of the Legislature to create a parity of telehealth with other health care delivery modes, to actively promote telehealth as a tool to

advance stakeholders' goals regarding health status and health system improvement, and to create opportunities and flexibility for telehealth to be used in new models of care and system improvements.

(e) Telehealth is a mode of delivering health care services and public health utilizing information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, and self-management of patients at a distance from health care providers.

(f) Telehealth is part of a multifaceted approach to address the problem of inadequate provider distribution and the development of health systems in medically underserved areas by improving communication capabilities and providing convenient access to up-to-date information, consultations, and other forms of support.

(g) The use of information and telecommunication technologies 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 service originates.

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

(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.

(f) This section shall not apply to a patient under the jurisdiction of the Department of Corrections and Rehabilitation or any other correctional facility.

(g) (1) Notwithstanding any other provision of law and for purposes of this section, the governing body of the hospital whose patients are receiving the telehealth services may grant privileges to, and verify and approve credentials for, providers of telehealth services based on its medical staff recommendations that rely on information provided by the distant-site hospital or telehealth entity, as described in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

(2) By enacting this subdivision, it is the intent of the Legislature to authorize a hospital to grant privileges to, and verify and approve credentials for, providers of telehealth services as described in paragraph (1).

(3) For the purposes of this subdivision, "telehealth" shall include "telemedicine" as the term is referenced in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

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, 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) No health care service plan shall limit the type of setting where services are provided for the patient or by the health care provider before payment is made for the covered services appropriately provided 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.

(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 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) Notwithstanding any other provision, this section shall not 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, 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) No health insurer shall limit the type of setting where services are provided for the patient or by the health care provider before payment is made for the covered services appropriately provided by telehealth, subject to the terms and conditions of the contract between the policyholder or contract holder and the insurer, and between the insurer and its participating providers or provider groups.

(e) Notwithstanding any other provision, this section shall not 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.

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** AB 507  
**Author:** Hayashi  
**Chapter:** # 396  
**Bill Date:** August 16, 2011, Amended  
**Subject:** Control Substances: Pain Management  
**Sponsor:** American Cancer Society  
**Position:** Support

**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.

**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 continues 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 27<sup>th</sup> amendments make changes to existing law affecting the Pharmacy Board; these changes do not impact the Board's analysis or recommended position.

The June 20<sup>th</sup> amendments take out the take out the provisions impacting the Pharmacy Board. The June 20<sup>th</sup> and the July 1<sup>st</sup> 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.

The August 16<sup>th</sup> amendments make changes to the findings and declarations, and change the language in the bill from "pain or a condition causing pain", back to the original language, "severe chronic intractable pain".

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

**IMPLEMENTATION:**

- Newsletter Article
- Notify/Train Board Staff
- Notify the Attorney General's Office
- Update the Enforcement Operations Manual
- Possibly modify disciplinary guidelines or other regulations

October 3, 2011

**Assembly Bill No. 507**

**CHAPTER 396**

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

[Approved by Governor October 2, 2011. Filed with  
Secretary of State October 2, 2011.]

**LEGISLATIVE COUNSEL'S DIGEST**

AB 507, Hayashi. Controlled substances: 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. 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. Existing law sets forth the Pain Patient's Bill of Rights.

This bill would revise the Pain Patient's Bill of Rights.

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

SECTION 1. Section 11453 of the Health and Safety Code is repealed.

SEC. 2. Section 124960 of the Health and Safety Code is amended to read:

124960. The Legislature finds and declares all of the following:

- (a) The state has a right and duty to control the illegal use of opiate drugs.
- (b) Inadequate treatment of acute and chronic pain originating from cancer or noncancerous conditions is a significant health problem.
- (c) For some patients, pain management is the single most important treatment a physician can provide.
- (d) A patient suffering from severe chronic intractable pain should have access to proper treatment of his or her pain.
- (e) Due to the complexity of their problems, many patients suffering from severe chronic intractable pain may require referral to a physician with expertise in the treatment of severe chronic intractable pain. In some cases,

severe chronic intractable pain is best treated by a team of clinicians in order to address the associated physical, psychological, social, and vocational issues.

(f) In the hands of knowledgeable, ethical, and experienced pain management practitioners, opiates administered for severe acute pain and severe chronic intractable pain can be safe.

(g) Opiates can be an accepted treatment for patients in severe chronic intractable pain who have not obtained relief from any other means of treatment.

(h) A patient suffering from severe chronic 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 severe chronic 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 severe chronic 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 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 severe chronic intractable pain. However, that physician shall inform the patient that there are physicians who treat severe chronic 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 who suffers from severe chronic 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 severe chronic 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 device, as long as the prescribing physician acts in conformance with the California Intractable Pain Treatment Act, Section 2241.5 of the Business and Professions Code.

(c) The patient's physician may refuse to prescribe opiate medication for the patient who requests a treatment for severe chronic intractable pain. However, that physician shall inform the patient that there are physicians who treat pain and whose methods include the use of opiates.

(d) A physician who uses opiate therapy to relieve severe chronic intractable pain may prescribe a dosage deemed medically necessary to relieve the patient's pain, as long as that prescribing is in conformance with Section 2241.5 of the Business and Professions Code.

(e) A patient may voluntarily request that his or her physician provide an identifying notice of the prescription for purposes of emergency treatment or law enforcement identification.

(f) Nothing in this section shall do either of the following:

(1) Limit any reporting or disciplinary provisions applicable to licensed physicians and surgeons who violate prescribing practices or other provisions set forth in the Medical Practice Act, Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, or the regulations adopted thereunder.

(2) Limit the applicability of any federal statute or federal regulation or any of the other statutes or regulations of this state that regulate dangerous drugs or controlled substances.

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** AB 536  
**Author:** Ma  
**Chapter:** # 379  
**Bill Date:** June 14, 2011, amended  
**Subject:** Physicians and Surgeons  
**Sponsor:** Union of American Physician and Dentists  
**Position:** Support

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill requires the Medical Board of California (the Board) to post notification of expungement orders and the 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 have required 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 14<sup>th</sup> version of the bill incorporated the Board's suggested amendments and the bill now requires the Board to post notification of expungement orders and the date of expungement on its Internet Web site within six months of the receipt of the

certified expungement order. It is currently the Board's policy to post expungement information on the Board's Web site; this bill aligns statute with board policy and procedures.

**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

**IMPLEMENTATION:**

- Newsletter Article
- Notify/Train Board Staff
- Establish the process for notification and updating the Web site

October 3, 2011

**Assembly Bill No. 536**

**CHAPTER 379**

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

[Approved by Governor September 30, 2011. Filed with  
Secretary of State September 30, 2011.]

**LEGISLATIVE COUNSEL'S DIGEST**

AB 536, 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 post notification of an expungement order and the date of the order within 6 months of receiving a certified copy of the expungement order from the licensee.

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

SECTION 1. Section 2027 of the Business and Professions Code is amended to read:

2027. (a) The board shall post on the Internet the following information in its possession, custody, or control regarding licensed physicians and surgeons:

(1) With regard to the status of the license, whether or not the licensee is in good standing, subject to a temporary restraining order (TRO), subject to an interim suspension order (ISO), or subject to any of the enforcement actions set forth in Section 803.1.

(2) With regard to prior discipline, whether or not the licensee has been subject to discipline by the board or by the board of another state or jurisdiction, as described in Section 803.1.

(3) Any felony convictions reported to the board after January 3, 1991.

(4) All current accusations filed by the Attorney General, including those accusations that are on appeal. For purposes of this paragraph, "current accusation" shall mean an accusation that has not been dismissed, withdrawn, or settled, and has not been finally decided upon by an administrative law

judge and the Medical Board of California unless an appeal of that decision is pending.

(5) Any malpractice judgment or arbitration award reported to the board after January 1, 1993.

(6) Any hospital disciplinary actions that resulted in the termination or revocation of a licensee's hospital staff privileges for a medical disciplinary cause or reason. The posting shall also provide a link to any additional explanatory or exculpatory information submitted electronically by the licensee pursuant to subdivision (f) of Section 805.

(7) Any misdemeanor conviction that results in a disciplinary action or an accusation that is not subsequently withdrawn or dismissed.

(8) Appropriate disclaimers and explanatory statements to accompany the above information, including an explanation of what types of information are not disclosed. These disclaimers and statements shall be developed by the board and shall be adopted by regulation.

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

(b) 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.

(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.

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

(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.

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OFFICE OF THE GOVERNOR

OCT 07 2011

To the Members of the California State Assembly:

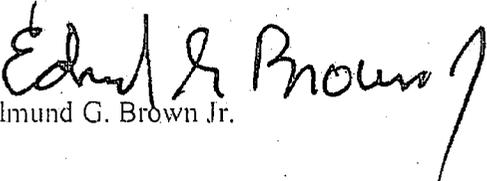
I am returning Assembly Bill 584 without my signature.

This bill would require that the physician conducting utilization review of requests for medical treatment in Workers Compensation claims be licensed in California.

This requirement of using only California-licensed physicians to conduct utilization review in Workers Compensation cases would be an abrupt change and inconsistent with the manner in which utilization review is conducted by health care service plans under the Knox-Keene Act and by those regulated by the California Department of Insurance.

I am not convinced that establishing a separate standard for Workers Compensation utilization review makes sense.

Sincerely,

  
Edmund G. Brown Jr.

**Assembly Bill No. 584**

\_\_\_\_\_  
Passed the Assembly April 28, 2011

\_\_\_\_\_  
*Chief Clerk of the Assembly*

\_\_\_\_\_  
Passed the Senate September 6, 2011

\_\_\_\_\_  
*Secretary of the Senate*

\_\_\_\_\_  
This bill was received by the Governor this \_\_\_\_ day  
of \_\_\_\_\_, 2011, at \_\_\_\_ o'clock \_\_\_\_M.

\_\_\_\_\_  
*Private Secretary of the Governor*

## CHAPTER \_\_\_\_\_

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, 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 2 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 a claim for disability benefits may also be supported by a health professional as defined, and as specified.

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

SECTION 1. Section 3209.3 of the Labor Code is amended to read:

3209.3. (a) "Physician" means physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law and within the scope of their practice as defined by California state law.

(b) "Psychologist" means a psychologist licensed by California state law with a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology pursuant to Section 2914 of the Business and Professions Code, 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.

(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.

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.

(2) "Physician" 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.

(3) (A) "Practitioner" means a 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) 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.

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** AB 1424  
**Author:** Perea  
**Chapter:** # 455  
**Subject:** Delinquent Tax Debtors: Suspension of Licenses  
**Sponsor:** Author

**DESCRIPTION OF CURRENT LEGISLATION:**

Beginning July 1, 2012, this bill requires a state governmental licensing entity (SGLE), including the Medical Board of California (the Board), to suspend a state occupational, professional, or drivers license of a tax debtor whose name appears on the Franchise Tax Board (FTB) or the State Board of Equalization's (BOE) list of the largest tax delinquencies.

**ANALYSIS:**

Existing law requires the Medical Board and other professional licensing agencies to deny and suspend licenses for applicants and licensees that fail to pay court-ordered child support debts. These suspensions are noted on the Board's system, but the processing of this paperwork and related inquiries are handled by a program in the Department of Consumer Affairs for all boards and bureaus. This bill would be similar to this law, but would affect those applicants and individuals that are on the FTB or BOE list of the largest tax delinquencies. Board staff assumes that the requirements in this bill would be handled in the same way that suspensions and denials are handled now for child support debts.

The purpose of this bill is strengthen the tax collection process and help increase funding for the budget, by providing an incentive for professionally licensed individuals to pay their delinquent taxes. FTB staff estimates that this will result in an annual gain of \$19 million in FY 11-12, \$24 million in FY 12-13, up to a projected \$31 million in FY 15-16.

The FTB and BOE publish annual lists of the largest tax delinquencies. This bill expands these lists from the top 250 tax delinquencies in excess of \$100,000, to the top 500 tax delinquencies in excess of \$100,00. This means that this bill will affect 1,000 individuals on an annual basis. If these individuals are licensees of the Medical Board of California, their license will be suspended or their application will be denied. This bill also prohibits state agencies from entering into a contract for goods and services with a tax debtor on the FTB or BOE list.

This bill requires SGLEs, including the Board, to include on every application for licensure or licensure renewal notification to the applicant, the following information: the law allows the BOE and FTB to share taxpayer information with the Board; the applicant

is required to pay his or her tax obligations; and, a license may be suspended if a state tax obligation is not paid.

This bill requires SGLEs, including the Board, to immediately provide a preliminary notice to an applicant whose name appears on either the BOE or FTB certified list notifying them that the license will be suspended or the issuance of a license or renewal will be withheld. This bill requires SGLEs, including the Board to issue a temporary license valid for a period of 90 days to any applicant whose name is on the FTB and BOE certified list if the applicant is otherwise eligible for a license. This bill allows FTB and/or BOE to suspend a license issued by the Board if the Board fails to suspend, revoke or deny renewal of a license within 90 days of the mailing of the preliminary notice of suspension required by this bill.

This bill requires SGLEs, including the Board, to list the reason the licensee is suspended on the Web site. This mirrors what the Board does currently when a licensee is suspended for the failure to comply with a child support order. This bill requires that once the individual is released from the FTB or BOE list, the suspension shall be purged from the Board's Web site within three business days. This bill also specifies that a suspension, denial, or non-renewal pursuant to this bill does not constitute discipline of a licensee for purposes of reporting to the National Practitioner Data Bank.

This bill states that unless otherwise provided in this bill, the policies, practices and procedures of a state governmental licensing entity with respect to license suspension shall be the same as those applicable with respect to suspension pursuant to Section 17520 of the Family Code, related to a licensee's non-compliance with a child support order. Board staff envisions that the requirements in this bill will be folded into the existing process; as such, this will result in minimal and absorbable workload to the Board.

**SUPPORT:** California Tax Reform Associates  
Service Employees International Union

**OPPOSITION:** CalCPA  
CalTax (Oppose Unless Amended)

**FISCAL:** Minimal and Absorbable

**IMPLEMENTATION:**

- Newsletter Article
- Notify/Train Board Staff
- The Board will need to work with DCA on the process and procedures to implement this bill. This will be similar to what is being done now for licensees that are out of compliance with their child support order.
- Computer system updates will be needed in order to implement this bill.
- Application and renewal forms will need to be revised as required by this bill.

October 7, 2011

**Assembly Bill No. 1424**

**CHAPTER 455**

An act to amend Sections 31 and 476 of, and to add Section 494.5 to, the Business and Professions Code, to add Section 12419.13 to the Government Code, to add Section 10295.4 to the Public Contract Code, to amend Sections 7063, 19195, and 19533 of, to add Sections 6835, 7057, 7057.5, 19377.5, 19571, and 19572 to, to add Article 9 (commencing with Section 6850) to Chapter 6 of Part 1 of Division 2 of, and to add Article 7 (commencing with Section 19291) to Chapter 5 of Part 10.2 of Division 2 of, the Revenue and Taxation Code, and to add Section 34623.1 to the Vehicle Code, relating to taxation.

[Approved by Governor October 4, 2011. Filed with  
Secretary of State October 4, 2011.]

**LEGISLATIVE COUNSEL'S DIGEST**

**AB 1424, Perea. Franchise Tax Board: delinquent tax debt.**

The Personal Income Tax Law and the Corporation Tax Law impose taxes on, or measured by, income. Existing law requires the Franchise Tax Board to make available as a matter of public record each calendar year a list of the 250 largest tax delinquencies in excess of \$100,000, and requires the list to include specified information with respect to each delinquency. Existing law requires every board, as defined, and the Department of Insurance, upon request of the Franchise Tax Board, to furnish to the Franchise Tax Board certain information with respect to every licensee.

This bill would require the State Board of Equalization, quarterly, and the Franchise Tax Board, at least twice each calendar year, to make available a list of the 500 largest tax delinquencies described above. This bill would require the Franchise Tax Board to include additional information on the list with respect to each delinquency, including the type, status, and license number of any occupational or professional license held by the person or persons liable for payment of the tax and the names and titles of the principal officers of the person liable for payment of the tax if that person is a limited liability company or corporation. This bill would require a person whose delinquency appeared on either list and whose name has been removed, as provided, to comply with the terms of the arranged resolution, and would authorize the State Board of Equalization and the Franchise Tax Board, if the person fails to comply with the terms of the arranged resolution, to add the person's name to the list without providing prior written notice, as provided.

This bill would require a state governmental licensing entity, other than the Department of Motor Vehicles, State Bar of California, and Alcoholic Beverage Control Board, as provided, that issues professional or occupational

licenses, certificates, registrations, or permits, to suspend, revoke, and refuse to issue a license if the licensee's name is included on either list of the 500 largest tax delinquencies described above. This bill would not include the Contractors' State License Board in the definition of "state governmental licensing entity." This bill would also require those licensing entities to collect the social security number or federal taxpayer identification number of each individual applicant of that entity for the purpose of matching those applicants to the names on the lists of the 500 largest tax delinquencies, and would require each application for a new license or renewal of a license to indicate on the application that the law allows the State Board of Equalization and the Franchise Tax Board to share taxpayer information with a board and requires the licensee to pay his or her state tax obligation and that his or her license may be suspended if the state tax obligation is not paid. This bill would also authorize the State Board of Equalization and the Franchise Tax Board to disclose to state governmental licensing entities identifying information, as defined, of persons on the list of the 500 largest tax delinquencies, as specified. This bill would authorize a motor carrier permit of a licensee whose name is on the certified list of tax delinquencies to be suspended, as provided. The bill would require the State Board of Equalization and the Franchise Tax Board to meet certain requirements and would make related changes.

The bill would provide that the release or other use of information received by a state governmental licensing entity pursuant to these provisions, except as authorized, is punishable as a misdemeanor. By creating a new crime, the bill would impose a state-mandated local program.

This bill would also prohibit a state agency from entering into any contract for the acquisition of goods or services with a contractor whose name appears on either list of the 500 largest tax delinquencies described above.

Existing law authorizes the Franchise Tax Board to collect specified amounts for the Department of Industrial Relations and specified amounts imposed by a court pursuant to specified procedures.

This bill would authorize the State Board of Equalization and the Franchise Tax Board to enter into an agreement to collect any delinquent tax debt due to the Internal Revenue Service or any other state imposing an income tax, or a tax measured by income, or a sales or use tax, or a similar tax, pursuant to specified procedures, provided that the Internal Revenue Service or that state has entered into an agreement to collect delinquent tax debts due to the State Board of Equalization or the Franchise Tax Board, and the agreements do not cause the net displacement of civil service employees, as specified. This bill would require the Controller, upon execution of a reciprocal agreement between the State Board of Equalization, the Franchise Tax Board, and any other state imposing a sales and use tax, a tax similar to a sales and use tax, an income tax, or tax measured by income, to offset any delinquent tax debt due to that other state from a person or entity, against any refund under the Sales and Use Tax Law, the Personal Income Tax Law, or the Corporation Tax Law owed to that person or entity, as provided.

Existing law requires, in the event that the debtor has more than one debt being collected by the Franchise Tax Board and the amount collected is insufficient to satisfy the total amount owed, the amount collected to be applied to specified priorities.

This bill would include specified tax delinquencies collected pursuant to this bill.

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

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

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

SECTION 1. Section 31 of the Business and Professions Code is amended to read:

31. (a) As used in this section, "board" means any entity listed in Section 101, the entities referred to in Sections 1000 and 3600, the State Bar, the Department of Real Estate, and any other state agency that issues a license, certificate, or registration authorizing a person to engage in a business or profession.

(b) Each applicant for the issuance or renewal of a license, certificate, registration, or other means to engage in a business or profession regulated by a board who is not in compliance with a judgment or order for support shall be subject to Section 17520 of the Family Code.

(c) "Compliance with a judgment or order for support" has the meaning given in paragraph (4) of subdivision (a) of Section 17520 of the Family Code.

(d) Each licensee or applicant whose name appears on a list of the 500 largest tax delinquencies pursuant to Section 7063 or 19195 of the Revenue and Taxation Code shall be subject to Section 494.5.

(e) Each application for a new license or renewal of a license shall indicate on the application that the law allows the State Board of Equalization and the Franchise Tax Board to share taxpayer information with a board and requires the licensee to pay his or her state tax obligation and that his or her license may be suspended if the state tax obligation is not paid.

(f) For purposes of this section, "tax obligation" means the tax imposed under, or in accordance with, Part 1 (commencing with Section 6001), Part 1.5 (commencing with Section 7200), Part 1.6 (commencing with Section 7251), Part 1.7 (commencing with Section 7280), Part 10 (commencing with Section 17001), or Part 11 (commencing with Section 23001) of Division 2 of the Revenue and Taxation Code.

SEC. 2. Section 476 of the Business and Professions Code is amended to read:

476. (a) Except as provided in subdivision (b), nothing in this division shall apply to the licensure or registration of persons pursuant to Chapter 4

(commencing with Section 6000) of Division 3, or pursuant to Division 9 (commencing with Section 23000) or pursuant to Chapter 5 (commencing with Section 19800) of Division 8.

(b) Section 494.5 shall apply to the licensure of persons authorized to practice law pursuant to Chapter 4 (commencing with Section 6000) of Division 3, and the licensure or registration of persons pursuant to Chapter 5 (commencing with Section 19800) of Division 8 or pursuant to Division 9 (commencing with Section 23000).

SEC. 3. Section 494.5 is added to the Business and Professions Code, to read:

494.5. (a) (1) Except as provided in paragraphs (2), (3), and (4), a state governmental licensing entity shall refuse to issue, reactivate, reinstate, or renew a license and shall suspend a license if a licensee's name is included on a certified list.

(2) The Department of Motor Vehicles shall suspend a license if a licensee's name is included on a certified list. Any reference in this section to the issuance, reactivation, reinstatement, renewal, or denial of a license shall not apply to the Department of Motor Vehicles.

(3) The State Bar of California may recommend to refuse to issue, reactivate, reinstate, or renew a license and may recommend to suspend a license if a licensee's name is included on a certified list. The word "may" shall be substituted for the word "shall" relating to the issuance of a temporary license, refusal to issue, reactivate, reinstate, renew, or suspend a license in this section for licenses under the jurisdiction of the California Supreme Court.

(4) The Alcoholic Beverage Control Board may refuse to issue, reactivate, reinstate, or renew a license, and may suspend a license, if a licensee's name is included on a certified list.

(b) For purposes of this section:

(1) "Certified list" means either the list provided by the State Board of Equalization or the list provided by the Franchise Tax Board of persons whose names appear on the lists of the 500 largest tax delinquencies pursuant to Section 7063 or 19195 of the Revenue and Taxation Code, as applicable.

(2) "License" includes a certificate, registration, or any other authorization to engage in a profession or occupation issued by a state governmental licensing entity. "License" includes a driver's license issued pursuant to Chapter 1 (commencing with Section 12500) of Division 6 of the Vehicle Code. "License" excludes a vehicle registration issued pursuant to Division 3 (commencing with Section 4000) of the Vehicle Code.

(3) "Licensee" means an individual authorized by a license to drive a motor vehicle or authorized by a license, certificate, registration, or other authorization to engage in a profession or occupation issued by a state governmental licensing entity.

(4) "State governmental licensing entity" means any entity listed in Section 101, 1000, or 19420, the office of the Attorney General, the Department of Insurance, the Department of Motor Vehicles, the State Bar of California, the Department of Real Estate, and any other state agency,

board, or commission that issues a license, certificate, or registration authorizing an individual to engage in a profession or occupation, including any certificate, business or occupational license, or permit or license issued by the Department of Motor Vehicles or the Department of the California Highway Patrol. "State governmental licensing entity" shall not include the Contractors' State License Board.

(c) The State Board of Equalization and the Franchise Tax Board shall each submit its respective certified list to every state governmental licensing entity. The certified lists shall include the name, social security number or taxpayer identification number, and the last known address of the persons identified on the certified lists.

(d) Notwithstanding any other law, each state governmental licensing entity shall collect the social security number or the federal taxpayer identification number from all applicants for the purposes of matching the names of the certified lists provided by the State Board of Equalization and the Franchise Tax Board to applicants and licensees.

(e) (1) Each state governmental licensing entity shall determine whether an applicant or licensee is on the most recent certified list provided by the State Board of Equalization and the Franchise Tax Board.

(2) If an applicant or licensee is on either of the certified lists, the state governmental licensing entity shall immediately provide a preliminary notice to the applicant or licensee of the entity's intent to suspend or withhold issuance or renewal of the license. The preliminary notice shall be delivered personally or by mail to the applicant's or licensee's last known mailing address on file with the state governmental licensing entity within 30 days of receipt of the certified list. Service by mail shall be completed in accordance with Section 1013 of the Code of Civil Procedure.

(A) The state governmental licensing entity shall issue a temporary license valid for a period of 90 days to any applicant whose name is on a certified list if the applicant is otherwise eligible for a license.

(B) The 90-day time period for a temporary license shall not be extended. Only one temporary license shall be issued during a regular license term and the term of the temporary license shall coincide with the first 90 days of the regular license term. A license for the full term or the remainder of the license term may be issued or renewed only upon compliance with this section.

(C) In the event that a license is suspended or an application for a license or the renewal of a license is denied pursuant to this section, any funds paid by the applicant or licensee shall not be refunded by the state governmental licensing entity.

(f) (1) A state governmental licensing entity shall refuse to issue or shall suspend a license pursuant to this section no sooner than 90 days and no later than 120 days of the mailing of the preliminary notice described in paragraph (2) of subdivision (e), unless the state governmental licensing entity has received a release pursuant to subdivision (h). The procedures in the administrative adjudication provisions of the Administrative Procedure Act (Chapter 4.5 (commencing with Section 11400) and Chapter 5

(commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code) shall not apply to the denial or suspension of, or refusal to renew, a license or the issuance of a temporary license pursuant to this section.

(2) Notwithstanding any other law, if a board, bureau, or commission listed in Section 101, other than the Contractors' State License Board, fails to take action in accordance with this section, the Department of Consumer Affairs shall issue a temporary license or suspend or refuse to issue, reactivate, reinstate, or renew a license, as appropriate.

(g) Notices shall be developed by each state governmental licensing entity. For an applicant or licensee on the State Board of Equalization's certified list, the notice shall include the address and telephone number of the State Board of Equalization, and shall emphasize the necessity of obtaining a release from the State Board of Equalization as a condition for the issuance, renewal, or continued valid status of a license or licenses. For an applicant or licensee on the Franchise Tax Board's certified list, the notice shall include the address and telephone number of the Franchise Tax Board, and shall emphasize the necessity of obtaining a release from the Franchise Tax Board as a condition for the issuance, renewal, or continued valid status of a license or licenses.

(1) The notice shall inform the applicant that the state governmental licensing entity shall issue a temporary license, as provided in subparagraph (A) of paragraph (2) of subdivision (e), for 90 calendar days if the applicant is otherwise eligible and that upon expiration of that time period, the license will be denied unless the state governmental licensing entity has received a release from the State Board of Equalization or the Franchise Tax Board, whichever is applicable.

(2) The notice shall inform the licensee that any license suspended under this section will remain suspended until the state governmental licensing entity receives a release along with applications and fees, if applicable, to reinstate the license.

(3) The notice shall also inform the applicant or licensee that if an application is denied or a license is suspended pursuant to this section, any moneys paid by the applicant or licensee shall not be refunded by the state governmental licensing entity. The state governmental licensing entity shall also develop a form that the applicant or licensee shall use to request a release by the State Board of Equalization or the Franchise Tax Board. A copy of this form shall be included with every notice sent pursuant to this subdivision.

(h) If the applicant or licensee wishes to challenge the submission of his or her name on a certified list, the applicant or licensee shall make a timely written request for release to the State Board of Equalization or the Franchise Tax Board, whichever is applicable. The State Board of Equalization or the Franchise Tax Board shall immediately send a release to the appropriate state governmental licensing entity and the applicant or licensee, if any of the following conditions are met:

(1) The applicant or licensee has complied with the tax obligation, either by payment of the unpaid taxes or entry into an installment payment agreement, as described in Section 6832 or 19008 of the Revenue and Taxation Code, to satisfy the unpaid taxes.

(2) The applicant or licensee has submitted a request for release not later than 45 days after the applicant's or licensee's receipt of a preliminary notice described in paragraph (2) of subdivision (e), but the State Board of Equalization or the Franchise Tax Board, whichever is applicable, will be unable to complete the release review and send notice of its findings to the applicant or licensee and state governmental licensing entity within 45 days after the State Board of Equalization's or the Franchise Tax Board's receipt of the applicant's or licensee's request for release. Whenever a release is granted under this paragraph, and, notwithstanding that release, the applicable license or licenses have been suspended erroneously, the state governmental licensing entity shall reinstate the applicable licenses with retroactive effect back to the date of the erroneous suspension and that suspension shall not be reflected on any license record.

(3) The applicant or licensee is unable to pay the outstanding tax obligation due to a current financial hardship. "Financial hardship" means financial hardship as determined by the State Board of Equalization or the Franchise Tax Board, whichever is applicable, where the applicant or licensee is unable to pay any part of the outstanding liability and the applicant or licensee is unable to qualify for an installment payment arrangement as provided for by Section 6832 or Section 19008 of the Revenue and Taxation Code. In order to establish the existence of a financial hardship, the applicant or licensee shall submit any information, including information related to reasonable business and personal expenses, requested by the State Board of Equalization or the Franchise Tax Board, whichever is applicable, for purposes of making that determination.

(i) An applicant or licensee is required to act with diligence in responding to notices from the state governmental licensing entity and the State Board of Equalization or the Franchise Tax Board with the recognition that the temporary license will lapse or the license suspension will go into effect after 90 days and that the State Board of Equalization or the Franchise Tax Board must have time to act within that period. An applicant's or licensee's delay in acting, without good cause, which directly results in the inability of the State Board of Equalization or the Franchise Tax Board, whichever is applicable, to complete a review of the applicant's or licensee's request for release shall not constitute the diligence required under this section which would justify the issuance of a release. An applicant or licensee shall have the burden of establishing that he or she diligently responded to notices from the state governmental licensing entity or the State Board of Equalization or the Franchise Tax Board and that any delay was not without good cause.

(j) The State Board of Equalization or the Franchise Tax Board shall create release forms for use pursuant to this section. When the applicant or licensee has complied with the tax obligation by payment of the unpaid

taxes, or entry into an installment payment agreement, or establishing the existence of a current financial hardship as defined in paragraph (3) of subdivision (h), the State Board of Equalization or the Franchise Tax Board, whichever is applicable, shall mail a release form to the applicant or licensee and provide a release to the appropriate state governmental licensing entity. Any state governmental licensing entity that has received a release from the State Board of Equalization and the Franchise Tax Board pursuant to this subdivision shall process the release within five business days of its receipt. If the State Board of Equalization or the Franchise Tax Board determines subsequent to the issuance of a release that the licensee has not complied with their installment payment agreement, the State Board of Equalization or the Franchise Tax Board, whichever is applicable, shall notify the state governmental licensing entity and the licensee in a format prescribed by the State Board of Equalization or the Franchise Tax Board, whichever is applicable, that the licensee is not in compliance and the release shall be rescinded. The State Board of Equalization and the Franchise Tax Board may, when it is economically feasible for the state governmental licensing entity to develop an automated process for complying with this subdivision, notify the state governmental licensing entity in a manner prescribed by the State Board of Equalization or the Franchise Tax Board, whichever is applicable, that the licensee has not complied with the installment payment agreement. Upon receipt of this notice, the state governmental licensing entity shall immediately notify the licensee on a form prescribed by the state governmental licensing entity that the licensee's license will be suspended on a specific date, and this date shall be no longer than 30 days from the date the form is mailed. The licensee shall be further notified that the license will remain suspended until a new release is issued in accordance with this subdivision.

(k) The State Board of Equalization and the Franchise Tax Board may enter into interagency agreements with the state governmental licensing entities necessary to implement this section.

(l) Notwithstanding any other law, a state governmental licensing entity, with the approval of the appropriate department director or governing body, may impose a fee on a licensee whose license has been suspended pursuant to this section. The fee shall not exceed the amount necessary for the state governmental licensing entity to cover its costs in carrying out the provisions of this section. Fees imposed pursuant to this section shall be deposited in the fund in which other fees imposed by the state governmental licensing entity are deposited and shall be available to that entity upon appropriation in the annual Budget Act.

(m) The process described in subdivision (h) shall constitute the sole administrative remedy for contesting the issuance of a temporary license or the denial or suspension of a license under this section.

(n) Any state governmental licensing entity receiving an inquiry as to the licensed status of an applicant or licensee who has had a license denied or suspended under this section or who has been granted a temporary license under this section shall respond that the license was denied or suspended

or the temporary license was issued only because the licensee appeared on a list of the 500 largest tax delinquencies pursuant to Section 7063 or 19195 of the Revenue and Taxation Code. Information collected pursuant to this section by any state agency, board, or department shall be subject to the Information Practices Act of 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code). Any state governmental licensing entity that discloses on its Internet Web site or other publication that the licensee has had a license denied or suspended under this section or has been granted a temporary license under this section shall prominently disclose, in bold and adjacent to the information regarding the status of the license, that the only reason the license was denied, suspended, or temporarily issued is because the licensee failed to pay taxes.

(o) Any rules and regulations issued pursuant to this section by any state agency, board, or department may be adopted as emergency regulations in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, and safety, or general welfare. The regulations shall become effective immediately upon filing with the Secretary of State.

(p) The State Board of Equalization, the Franchise Tax Board, and state governmental licensing entities, as appropriate, shall adopt regulations as necessary to implement this section.

(q) (1) Neither the state governmental licensing entity, nor any officer, employee, or agent, or former officer, employee, or agent of a state governmental licensing entity, may disclose or use any information obtained from the State Board of Equalization or the Franchise Tax Board, pursuant to this section, except to inform the public of the denial, refusal to renew, or suspension of a license or the issuance of a temporary license pursuant to this section. The release or other use of information received by a state governmental licensing entity pursuant to this section, except as authorized by this section, is punishable as a misdemeanor. This subdivision may not be interpreted to prevent the State Bar of California from filing a request with the Supreme Court of California to suspend a member of the bar pursuant to this section.

(2) A suspension of, or refusal to renew, a license or issuance of a temporary license pursuant to this section does not constitute denial or discipline of a licensee for purposes of any reporting requirements to the National Practitioner Data Bank and shall not be reported to the National Practitioner Data Bank or the Healthcare Integrity and Protection Data Bank.

(3) Upon release from the certified list, the suspension or revocation of the applicant's or licensee's license shall be purged from the state governmental licensing entity's Internet Web site or other publication within three business days. This paragraph shall not apply to the State Bar of California.

(r) If any provision of this section or the application thereof to any person or circumstance is held invalid, that invalidity shall not affect other

provisions or applications of this section that can be given effect without the invalid provision or application, and to this end the provisions of this section are severable.

(s) All rights to review afforded by this section to an applicant shall also be afforded to a licensee.

(t) Unless otherwise provided in this section, the policies, practices, and procedures of a state governmental licensing entity with respect to license suspensions under this section shall be the same as those applicable with respect to suspensions pursuant to Section 17520 of the Family Code.

(u) No provision of this section shall be interpreted to allow a court to review and prevent the collection of taxes prior to the payment of those taxes in violation of the California Constitution.

(v) This section shall apply to any licensee whose name appears on a list of the 500 largest tax delinquencies pursuant to Section 7063 or 19195 of the Revenue and Taxation Code on or after July 1, 2012.

SEC. 4. Section 12419.13 is added to the Government Code, to read:

12419.13. (a) (1) The Controller shall, upon execution of a reciprocal agreement between the State Board of Equalization or the Franchise Tax Board, and any other state imposing a sales and use tax, an income tax, or tax measured by income, offset any delinquent tax debt due to that other state from a person or entity, against any refund under the Sales and Use Tax Law, the Personal Income Tax Law, or the Corporation Tax Law owed to that person or entity.

(2) Standards and procedures for submission of requests for offsets shall be as prescribed by the Controller.

(3) Payment of the offset amount shall occur only after other offset requests for debts owed by a person or entity to this state or the federal government have been satisfied in accordance with the priority established under Section 12419.3.

(b) The reciprocal agreement identified in subdivision (a) shall prescribe the manner in which the administrative costs of the Controller, the State Board of Equalization, and the Franchise Tax Board shall be reimbursed.

SEC. 5. Section 10295.4 is added to the Public Contract Code, to read:

10295.4. (a) Notwithstanding any other law, a state agency shall not enter into any contract for the acquisition of goods or services with a contractor whose name appears on either list of the 500 largest tax delinquencies pursuant to Section 7063 or 19195 of the Revenue and Taxation Code. Any contract entered into in violation of this subdivision is void and unenforceable.

(b) This section shall apply to any contract executed on or after July 1, 2012.

SEC. 6. Section 6835 is added to the Revenue and Taxation Code, to read:

6835. (a) The board may enter into an agreement with the Internal Revenue Service or any other state imposing a sales and use tax, or a similar tax, for the purpose of collecting delinquent tax debts with respect to amounts assessed or imposed under this part, provided the agreements do not cause

the net displacement of civil service employees. The agreement may provide, at the discretion of the board, the rate of payment and the manner in which compensation for services shall be paid.

(b) At the discretion of the board, the Internal Revenue Service or the other state collecting the tax debt pursuant to subdivision (a) may, as part of the collection process, refer the tax debt for litigation by its legal representatives in the name of the board.

(c) For purposes of this section, "displacement" includes layoff, demotion, involuntary transfer to a new class, involuntary transfer to a new location requiring a change of residence, and time base reductions. "Displacement" does not include changes in shifts or days off, nor does it include reassignment to any other position within the same class and general location.

SEC. 7. Article 9 (commencing with Section 6850) is added to Chapter 6 of Part 1 of Division 2 of the Revenue and Taxation Code, to read:

Article 9. Collection of Tax Debts Due to the Internal Revenue Services or Other States

6850. (a) The board may enter into an agreement to collect any delinquent tax debt due to the Internal Revenue Service or any other state imposing a sales and use tax, or similar tax, if, pursuant to Section 6835, the Internal Revenue Service or such a state has entered into an agreement to collect delinquent tax debts due to the board.

(b) Upon written notice to the debtor from the board, any amount referred to the board under subdivision (a) shall be treated as final and due and payable to the State of California, and shall be collected from the debtor by the board in any manner authorized under the law for collection of a delinquent sales and use tax liability, including, but not limited to, the recording of a notice of state tax lien under Article 2 (commencing with Section 7170) of Chapter 14 of Division 7 of Title 1 of the Government Code, and the issuance of an order and levy under Article 4 (commencing with Section 706.070) of Chapter 5 of Division 2 of Title 9 of Part 2 of the Code of Civil Procedure in the manner provided for earnings withholding orders for taxes.

(c) This part shall apply to amounts referred under this section in the same manner and with the same force and effect and to the full extent as if the language of those laws had been incorporated in full into this section, except to the extent that any provision is either inconsistent with this section or is not relevant to this section.

(d) The activities required to implement and administer this section shall not interfere with the primary mission of the board to administer this part.

(e) In no event shall a collection under this section be construed as a payment of sales and use taxes imposed under this part, or in accordance with Part 1.5 (commencing with Section 7200), or Part 1.6 (commencing with Section 7251), of Division 2.

SEC. 8. Section 7057 is added to the Revenue and Taxation Code, to read:

7057. (a) The board may disclose to state governmental licensing entities identifying information of persons appearing on the list of the 500 largest tax delinquencies pursuant to Section 7063 for purposes of administering Section 494.5 of the Business and Professions Code. "Identifying information" means the name, social security number or taxpayer identification number, and the last known address of the persons appearing on the list of the 500 largest tax delinquencies.

(b) Neither the state governmental licensing entity, nor any officer, employee, or agent, or former officer, employee, or agent of a state governmental licensing entity, may disclose or use any information obtained from the board pursuant to this section, except to administer Section 494.5 of the Business and Professions Code or to inform the public of the denial, refusal to renew, or suspension of a license or the issuance of a temporary license pursuant to Section 494.5 of the Business and Professions Code.

(c) For purposes of this section, state governmental licensing entity means a state governmental licensing entity as defined in Section 494.5 of the Business and Professions Code.

SEC. 9. Section 7057.5 is added to the Revenue and Taxation Code, to read:

7057.5. (a) The board may disclose to state agencies identifying information of persons appearing on the list of the 500 largest tax delinquencies pursuant to Section 7063 for purposes of administering Section 10295.4 of the Public Contract Code. "Identifying information" means the name, social security number or taxpayer identification number, and the last known address of the persons appearing on the list of the 500 largest tax delinquencies.

(b) A state agency, and any officer, employee, or agent, or former officer, employee, or agent of a state agency, shall not disclose or use any information obtained from the board, pursuant to this section, except to administer Section 10295.4 of the Public Contract Code.

SEC. 10. Section 7063 of the Revenue and Taxation Code is amended to read:

7063. (a) Notwithstanding any other provision of law, the board shall make available as a matter of public record each quarter a list of the 500 largest tax delinquencies in excess of one hundred thousand dollars (\$100,000) under this part. For purposes of compiling the list, a tax delinquency means an amount owed to the board which is all of the following:

(1) Based on a determination made under Article 2 (commencing with Section 6481) or Article 3 (commencing with Section 6511) of Chapter 5 deemed final pursuant to Article 5 (commencing with Section 6561) of Chapter 5, or that is "due and payable" under Article 4 (commencing with Section 6536) of Chapter 5, or self-assessed by the taxpayer.

(2) Recorded as a notice of state tax lien pursuant to Chapter 14 (commencing with Section 7150) of Division 7 of Title 1 of the Government Code, in any county recorder's office in this state.

(3) For an amount of tax delinquent for more than 90 days.

(b) For purposes of the list, a tax delinquency does not include any of the following and may not be included on the list:

(1) A delinquency that is under litigation in a court of law.

(2) A delinquency for which payment arrangements have been agreed to by both the taxpayer and the board and the taxpayer is in compliance with the arrangement.

(3) A delinquency for which the taxpayer has filed for bankruptcy protection pursuant to Title 11 of the United States Code.

(c) Each quarterly list shall, with respect to each delinquency, include all the following:

(1) The name of the person or persons liable for payment of the tax and that person's or persons' last known address.

(2) The amount of tax delinquency as shown on the notice or notices of state tax lien and any applicable interest or penalties, less any amounts paid.

(3) The earliest date that a notice of state tax lien was filed.

(4) The type of tax that is delinquent.

(d) Prior to making a tax delinquency a matter of public record as required by this section, the board shall provide a preliminary written notice to the person or persons liable for the tax by certified mail, return receipt requested. If within 30 days after issuance of the notice, the person or persons do not remit the amount due or make arrangements with the board for payment of the amount due, the tax delinquency shall be included on the list.

(e) The quarterly list described in subdivision (a) shall include the following:

(1) The telephone number and address of the board office to contact if a person believes placement of his or her name on the list is in error.

(2) The aggregate number of persons that have appeared on the list who have satisfied their delinquencies in their entirety and the dollar amounts, in the aggregate, that have been paid attributable to those delinquencies.

(f) As promptly as feasible, but no later than 5 business days from the occurrence of any of the following, the board shall remove that taxpayer's name from the list of tax delinquencies:

(1) Tax delinquencies for which the person liable for the tax has contacted the board and resolution of the delinquency has been arranged.

(2) Tax delinquencies for which the board has verified that an active bankruptcy proceeding has been initiated.

(3) Tax delinquencies for which the board has verified that a bankruptcy proceeding has been completed and there are no assets available with which to pay the delinquent amount or amounts.

(4) Tax delinquencies that the board has determined to be uncollectible.

(g) A person whose delinquency appears on the quarterly list, and who satisfies that delinquency in whole or in part, may request the board to include in its quarterly list any payments that person made to satisfy the

delinquency. Upon receipt of that request, the board shall include those payments on the list as promptly as feasible.

(h) Notwithstanding subdivision (a), a person whose delinquency appeared on the quarterly list and whose name has been removed pursuant to paragraph (1) of subdivision (f) shall comply with the terms of the arranged resolution. If a person fails to do so, the board shall add that person's name to the list of delinquencies without providing the prior written notice required by subdivision (d).

SEC. 11. Section 19195 of the Revenue and Taxation Code is amended to read:

19195. (a) Notwithstanding any other provision of law, including Section 6254.21 of the Government Code, the Franchise Tax Board shall make available as a matter of public record at least twice each calendar year a list of the 500 largest tax delinquencies in excess of one hundred thousand dollars (\$100,000) under Part 10 and Part 11 of this division. For purposes of compiling the list, a tax delinquency means the total amount owed by a taxpayer to the State of California for which a notice of state tax lien has been recorded in any county recorder's office in this state, pursuant to Chapter 14 (commencing with Section 7150) of Division 7 of Title 1 of the Government Code.

(b) For purposes of the list, a tax delinquency does not include any of the following and may not be included on the list:

(1) A delinquency for which payment arrangements have been agreed to by both the taxpayer and the Franchise Tax Board and the taxpayer is in compliance with the arrangement.

(2) A delinquency for which the taxpayer has filed for bankruptcy protection pursuant to Title 11 of the United States Code.

(3) A delinquency for which the person or persons liable for the tax have contacted the Franchise Tax Board and for which resolution of the tax delinquency has been accepted by the Franchise Tax Board.

(c) Each list shall, with respect to each delinquency, include all the following:

(1) The name of the person or persons liable for payment of the tax and that person's or persons' address.

(2) The amount of tax delinquency as shown on the notice or notices of state tax lien and any applicable interest or penalties, less any amounts paid.

(3) The earliest date that a notice of state tax lien was filed.

(4) The type of tax that is delinquent.

(5) The type, status, and license number of any occupational or professional license held by the person or persons liable for payment of the tax.

(6) The names and titles of the principal officers of the person liable for payment of the tax if that person is a limited liability company or corporation. The Franchise Tax Board shall refer to the limited liability company's or the corporation's Statement of Information filed with the Secretary of State or to the limited liability company's or the corporation's tax return filed pursuant to this part to determine the principal officers of the limited liability

company or corporation. Principal officers appearing on a list solely pursuant to this paragraph shall not be subject to Section 494.5 of the Business and Professions Code, or Section 10295.4 of the Public Contract Code.

(d) Prior to making a tax delinquency a matter of public record as required by this section, the Franchise Tax Board shall provide a preliminary written notice to the person or persons liable for the tax by certified mail, return receipt requested. If within 30 days after issuance of the notice, the person or persons do not remit the amount due or make arrangements with the Franchise Tax Board for payment of the amount due, the tax delinquency shall be included on the list.

(e) The list described in subdivision (a) shall include the following:

(1) The telephone number and address of the Franchise Tax Board office to contact if a person believes placement of his or her name on the list is in error.

(2) The aggregate number of persons that have appeared on the list who have satisfied their delinquencies in their entirety and the dollar amounts, in the aggregate, that have been paid attributable to those delinquencies.

(f) As promptly as feasible, but no later than five business days from the occurrence of any of the following, the Franchise Tax Board shall remove that taxpayer's name from the list of tax delinquencies:

(1) Tax delinquencies for which the person liable for the tax has contacted the Franchise Tax Board and resolution of the delinquency has been arranged.

(2) Tax delinquencies for which the Franchise Tax Board has verified that an active bankruptcy proceeding has been initiated.

(3) Tax delinquencies for which the Franchise Tax Board has verified that a bankruptcy proceeding has been completed and there are no assets available with which to pay the delinquent amount or amounts.

(4) Tax delinquencies that the Franchise Tax Board has determined to be uncollectible.

(g) A person whose delinquency appears on the list, and who satisfies that delinquency in whole or in part, may request the Franchise Tax Board to include in its list any payments that person made to satisfy the delinquency. Upon receipt of that request, the Franchise Tax Board shall include those payments on the list as promptly as feasible.

(h) Notwithstanding subdivision (a), a person whose delinquency appeared on the list and whose name has been removed pursuant to paragraph (1) of subdivision (f) shall comply with the terms of the arranged resolution. If the person fails to do so, the Franchise Tax Board may add that person's name to the list of delinquencies without providing the prior written notice otherwise required by subdivision (d).

SEC. 12. Article 7 (commencing with Section 19291) is added to Chapter 5 of Part 10.2 of Division 2 of the Revenue and Taxation Code, to read:

Article 7. Collection of Tax Debts Due to the Internal Revenue Service  
or Other States

19291. (a) The Franchise Tax Board may enter into an agreement to collect any delinquent tax debt due to the Internal Revenue Service or any other state imposing an income tax or tax measured by income if, pursuant to Section 19377.5, the Internal Revenue Service or that state has entered into an agreement to collect delinquent tax debts due the Franchise Tax Board.

(b) Upon written notice to the debtor from the Franchise Tax Board, any amount referred to the Franchise Tax Board under subdivision (a) shall be treated as final and due and payable to the State of California, and shall be collected from the debtor by the Franchise Tax Board in any manner authorized under the law for collection of a delinquent income tax liability, including, but not limited to, the recording of a notice of state tax lien under Article 2 (commencing with Section 7170) of Chapter 14 of Division 7 of Title 1 of the Government Code, and the issuance of an order and levy under Article 4 (commencing with Section 706.070) of Chapter 5 of Division 2 of Title 9 of Part 2 of the Code of Civil Procedure in the manner provided for earnings withholding orders for taxes.

(c) Part 10 (commencing with Section 17001), this part, Part 10.7 (commencing with Section 21001), and Part 11 (commencing with Section 23001) shall apply to amounts referred under this section in the same manner and with the same force and effect and to the full extent as if the language of those laws had been incorporated in full into this section, except to the extent that any provision is either inconsistent with this section or is not relevant to this section.

(d) The activities required to implement and administer this section shall not interfere with the primary mission of the Franchise Tax Board to administer Part 10 (commencing with Section 17001) and Part 11 (commencing with Section 23001).

(e) In no event shall a collection under this section be construed as a payment of income taxes imposed under Part 10 (commencing with Section 17001) or Part 11 (commencing with Section 23001).

SEC. 13. Section 19377.5 is added to the Revenue and Taxation Code, to read:

19377.5. (a) The Franchise Tax Board may enter into an agreement with the Internal Revenue Service or any other state imposing an income tax or tax measured by income for the purpose of collecting delinquent tax debts with respect to amounts assessed or imposed under Part 10 (commencing with Section 17001), this part, or Part 11 (commencing with Section 23001), provided the agreements do not cause the net displacement of civil service employees. The agreement may provide, at the discretion of the Franchise Tax Board, the rate of payment and the manner in which compensation for services shall be paid.

(b) At the discretion of the Franchise Tax Board, the Internal Revenue Service or the other state collecting the tax debt pursuant to subdivision (a)

may, as part of the collection process, refer the tax debt for litigation by its legal representatives in the name of the Franchise Tax Board.

(c) For purposes of this section, "displacement" includes layoff, demotion, involuntary transfer to a new class, involuntary transfer to a new location requiring a change of residence, and time base reductions. "Displacement" does not include changes in shifts or days off, nor does it include reassignment to any other position within the same class and general location.

SEC. 14. Section 19533 of the Revenue and Taxation Code is amended to read:

19533. In the event the debtor has more than one debt being collected by the Franchise Tax Board and the amount collected by the Franchise Tax Board is insufficient to satisfy the total amount owing, the amount collected shall be applied in the following priority:

(a) Payment of any delinquencies transferred for collection under Article 5 (commencing with Section 19270) of Chapter 5.

(b) Payment of any taxes, additions to tax, penalties, interest, fees, or other amounts due and payable under Part 7.5 (commencing with Section 13201), Part 10 (commencing with Section 17001), Part 11 (commencing with Section 23001), or this part, and amounts authorized to be collected under Section 19722.

(c) Payment of delinquent wages collected pursuant to the Labor Code.

(d) Payment of delinquencies collected under Section 10878.

(e) Payment of any amounts due that are referred for collection under Article 5.5 (commencing with Section 19280) of Chapter 5.

(f) Payment of any amounts that are referred for collection pursuant to Section 62.9 of the Labor Code.

(g) Payment of delinquent penalties collected for the Department of Industrial Relations pursuant to the Labor Code.

(h) Payment of delinquent fees collected for the Department of Industrial Relations pursuant to the Labor Code.

(i) Payment of delinquencies referred by the Student Aid Commission.

(j) Payment of any delinquencies referred for collection under Article 7 (commencing with Section 19291) of Chapter 5.

(k) Notwithstanding the payment priority established by this section, voluntary payments designated by the taxpayer as payment for a personal income tax liability or as a payment on amounts authorized to be collected under Section 19722, shall not be applied pursuant to this priority, but shall instead be applied as designated.

SEC. 15. Section 19571 is added to the Revenue and Taxation Code, to read:

19571. (a) The Franchise Tax Board may disclose to state governmental licensing entities identifying information of persons appearing on the list of 500 largest tax delinquencies pursuant to Section 19195 for purposes of administering Section 494.5 of the Business and Professions Code. "Identifying information" means the name, social security number or taxpayer identification number, and the last known address of the persons appearing on the list of the 500 largest tax delinquencies.

(b) Neither the state governmental licensing entity, nor any officer, employee, or agent, or former officer, employee, or agent of a state governmental licensing entity, may disclose or use any information obtained from the Franchise Tax Board pursuant to this section, except to administer Section 494.5 of the Business and Professions Code or to inform the public of the denial, refusal to renew, or suspension of a license or the issuance of a temporary license pursuant to Section 494.5 of the Business and Professions Code.

(c) For purposes of this section, state governmental licensing entity means a state governmental licensing entity as defined in Section 494.5 of the Business and Professions Code.

SEC. 16. Section 19572 is added to the Revenue and Taxation Code, to read:

19572. (a) The Franchise Tax Board may disclose to state agencies identifying information of persons appearing on the list of the 500 largest tax delinquencies pursuant to Section 19195 for purposes of administering Section 10295.4 of the Public Contract Code. "Identifying information" means the name, social security number or taxpayer identification number, and the last known address of the persons appearing on the list of the 500 largest tax delinquencies.

(b) A state agency, and any officer, employee, or agent, or former officer, employee, or agent of a state agency, shall not disclose or use any information obtained from the Franchise Tax Board, pursuant to this section, except to administer Section 10295.4 of Public Contract Code.

SEC. 17. Section 34623.1 is added to the Vehicle Code, to read:

34623.1. The motor carrier permit of a licensee may be suspended pursuant to Section 494.5 of the Business and Professions Code if a licensee's name is included on a certified list of tax delinquencies provided by the State Board of Equalization or the Franchise Tax Board pursuant to Section 7063 or Section 19195, respectively of the Revenue and Taxation Code.

SEC. 18. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because a local agency or school district has the authority to levy service charges, fees, or assessments sufficient to pay for the program or level of service mandated by this act or because 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.

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** AJR 13  
**Author:** Lara  
**Chapter:** # 85  
**Bill Date:** June 2, 2011, introduced  
**Subject:** Graduate Medical Education  
**Sponsor:** California Medical Association  
**Position:** Support

**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 urges 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 also encourages 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

**IMPLEMENTATION:**

- Newsletter Article

October 5, 2011

**Assembly Joint Resolution No. 13**

**RESOLUTION CHAPTER 85**

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

[Filed with Secretary of State September 6, 2011.]

**LEGISLATIVE COUNSEL'S DIGEST**

AJR 13, 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.

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, reallocation 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

*Resolved by the Assembly and the Senate of the State of California, jointly,* That the Legislature urges the President and the Congress of the United States 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; and be it further

*Resolved,* That the Legislature encourages the President and the Congress of the United States to consider solutions that would increase the number of graduate medical education residency positions to keep pace with the growing numbers of medical school graduates and the growing need for physicians in California and the United States; and be it further

*Resolved,* That the Chief Clerk of the Assembly transmit copies of this resolution to the President and Vice President of the United States, to the Speaker of the House of Representatives, to the Majority Leader of the Senate, to each Senator and Representative from California in the Congress of the United States, and to the author for appropriate distribution.

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** SB 100  
**Author:** Price  
**Chapter:** # 645  
**Bill Date:** July 12, 2011, amended.  
**Subject:** Healing Arts  
**Sponsor:** Author  
**Board Position:** Support

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill covers a variety of subjects related to outpatient settings. This bill requires the Medical Board of California (the Board) to adopt regulations on or before January 1, 2013, on the appropriate level of physician availability necessary within clinics or other settings using laser or intense pulse light devices for elective cosmetic surgery; and revises the existing definition of "outpatient settings" to include fertility clinics that offer in vitro fertilization.

This bill also makes a number of changes regarding the approval, oversight and inspection of "outpatient settings" by the Board and accreditation agencies (AAs) approved by the board; requires all outpatient settings with multiple service locations to have all sites inspected; provides that all final inspection reports, which include the lists of deficiencies, plans of correction or requirements for improvements and correction, and corrective action completed, to be public records open to public inspection; and requires, when an accrediting agency denies an accreditation and the outpatient setting applies to a different accrediting agency, the new accrediting agency to ensure that all previous deficiencies have been corrected and a new onsite inspection must be conducted.

**ANALYSIS:**

This bill contains the following requirements:

**For the Board:**

- Requires the Board to obtain and maintain a listing of information on outpatient settings on its Internet Web site, including name and address of owners and the facility, name and number of the AA, and effective dates of accreditation. The Board must update its Web site if the outpatient setting's accreditation is revoked, suspended, placed on probation or if a reprimand is received.

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

- Requires the Board to adopt regulations on or before January 1, 2013, regarding the “appropriate level of physician availability” needed within clinics or other settings for use of prescriptive lasers or intense pulse light devices for elective cosmetic procedures
- Requires the Board to adopt standards it deems necessary for outpatient settings that offer in vitro fertilization.
- Allows 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.
- Requires the Board to evaluate the accreditation agencies every three years; evaluate responses to complaints against an agency; and evaluate complaints against the accreditation of outpatient settings.
- Requires the inspection results to be kept on file with the Board and the AA, along with the plan of correction and comments. It also specifies that the final reports are public documents. It 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 allows the Board to ensure that outpatient settings are being inspected timely and ensures that the final reports include valuable information, which will be made available to the public.
- Allows the Board to take any appropriate actions it deems necessary if an outpatient setting’s accreditation is suspended, revoked, or denied.
- Requires 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, 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. Specifies that if an outpatient setting is operating without accreditation, it 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.

**For Accreditation Agencies (AAs):**

- Requires AAs to conduct a reasonable investigation of the prior history of the outpatient setting, as part of the accreditation process, 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.

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.

- Requires AAs to periodically accredited outpatient settings. Inspections must be performed no less than once every three years. Inspections must be on-site (before wording was, “a survey shall not constitute an inspection”).
- Requires AAs, 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. AAs must 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.

- Requires AAs to notify and update the Board on all outpatient settings that are accredited.
- Requires AAs to notify the Board within 24 hours when an outpatient setting’s accreditation is reprimanded, suspended, revoked, or placed on probation. Requires AAs to notify the Board within three days if an outpatient setting’s accreditation is denied. When an outpatient setting’s accreditation is revoked, requires AAs to send a notification letter to the outpatient setting stating that the setting is no longer allowed to perform procedures that require accreditation and requires 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.

- Specifies that if one AA denies, revokes, or suspends accreditation, the outpatient setting must re-apply for accreditation and disclose the full accreditation report to the new AA (It is the responsibility of the outpatient setting to disclose the accreditation report).

The new AA must conduct a new onsite inspection before accrediting the outpatient setting to ensure that the deficiencies are corrected.

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.

**For Outpatient Settings:**

- Adds in vitro fertilization facilities or other assisted reproduction technology services to the definition of “outpatient setting.”
- Makes outpatient settings subject to adverse event reporting requirements and associated penalties.  
This subjects the outpatient setting to the never events reporting requirements and associated fines.
- Requires 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.  
This language has been added to address concerns that detailed procedures are not in place at these settings.
- Deletes the provision in existing law that allows outpatient settings with multiple service sites to have only a sample of the sites inspected. This bill 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.
- Requires an outpatient setting to comply with a corrective action identified in an inspection within a timeframe specified by the accrediting agency. If the outpatient setting does not comply, the accrediting agency shall issue a reprimand, and may place the outpatient setting on probation, or suspend or revoke the accreditation of an outpatient setting. The AA must notify the board of its action.

**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, and the requirements to adopt regulations. 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

**IMPLEMENTATION:**

- Newsletter Article
- Notify/Train Board Staff
- Notify AAs and outpatient settings of the new requirements in this bill.
- Work with AAs to obtain the necessary information for the required listing of outpatient setting data for the Web site, and ensure that they are in compliance with the requirements of this bill.
- Establish process for the reporting of changes to the data reported by the AAs.
- Set up a database that can be updated for the listing of outpatient settings.
- Meet with various stakeholders on standards and regulations for settings that offer in vitro fertilization.
- Reconvene the Board's Advisory Committee on Physician Responsibility in the Supervision of Affiliated Health Care Professionals to specifically address regulations for the "appropriate level of physician availability.
- Examine need for guidance to physicians or enhanced regulations related to procedures that need to be performed in an accredited setting.
- Establish process to evaluate complaints against AAs and provide feedback or take other action.
- Establish process to maintain inspection reports, track that they are completed and issues addressed. Work with the Board's Information Systems Branch to link to final reports for the outpatient settings on the Board's Web site.

October 10, 2011

Senate Bill No. 100

CHAPTER 645

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.

[Approved by Governor October 9, 2011. Filed with  
Secretary of State October 9, 2011.]

LEGISLATIVE COUNSEL'S DIGEST

SB 100, 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 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.

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

SECTION 1. Section 2023.5 of the Business and Professions Code is amended to read:

2023.5. (a) The board, in conjunction with the Board of Registered Nursing, and in consultation with the Physician Assistant Committee and professionals in the field, shall review issues and problems surrounding the use of laser or intense light pulse devices for elective cosmetic procedures by physicians and surgeons, nurses, and physician assistants. The review shall include, but need not be limited to, all of the following:

- (1) The appropriate level of physician supervision needed.
- (2) The appropriate level of training to ensure competency.
- (3) Guidelines for standardized procedures and protocols that address, at a minimum, all of the following:
  - (A) Patient selection.
  - (B) Patient education, instruction, and informed consent.
  - (C) Use of topical agents.
  - (D) Procedures to be followed in the event of complications or side effects from the treatment.

(E) Procedures governing emergency and urgent care situations.

(b) On or before January 1, 2009, the board and the Board of Registered Nursing shall promulgate regulations to implement changes determined to be necessary with regard to the use of laser or intense pulse light devices for elective cosmetic procedures by physicians and surgeons, nurses, and physician assistants.

(c) On or before January 1, 2013, the board shall adopt regulations regarding the appropriate level of physician availability needed within clinics or other settings using laser or intense pulse light devices for elective cosmetic procedures. However, these regulations shall not apply to laser or intense pulse light devices approved by the federal Food and Drug Administration for over-the-counter use by a health care practitioner or by an unlicensed person on himself or herself.

(d) Nothing in this section shall be construed to modify the prohibition against the unlicensed practice of medicine.

SEC. 2. Section 1248 of the Health and Safety Code is amended to read:

1248. For purposes of this chapter, the following definitions shall apply:

(a) "Division" means the Medical Board of California. All references in this chapter to the division, the Division of Licensing of the Medical Board of California, or the Division of Medical Quality shall be deemed to refer

to the Medical Board of California pursuant to Section 2002 of the Business and Professions Code.

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

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

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

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

SEC. 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 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 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.

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** SB 233  
**Author:** Pavley  
**Chapter:** # 333  
**Bill Date:** June 28, 2011, amended  
**Subject:** Emergency Services and Care  
**Sponsor:** California Academy of Physician Assistants  
**Position:** Support

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill specifically clarifies that appropriate licensed persons can provide treatment and consultation in an emergency care setting, under the supervision of a physician and surgeon and if their license allows them to do so. This bill further specifies that it does not expand the scope of licensure for licensed persons providing services under this bill.

**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 4<sup>th</sup> and May 18<sup>th</sup>, instead of only applying to PAs, the bill now applies to all appropriate licensed persons. The bill specifically clarified 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 specified 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 28<sup>th</sup> 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. The June 28<sup>th</sup> 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.

Board staff and legal counsel had concerns with this language because all individuals that are consulting in an emergency room should be licensed individuals. Staff has talked to the author’s office and they amended the bill to address this concern.

**The July 11<sup>th</sup> amendments are technical and don’t affect the Board’s position. The July 14<sup>th</sup> amendments address the Board’s concerns and specify in the definition of “consultation” the individual must be an “appropriate licensed person”. These amendments change the Board’s position back to support.**

**The August 25<sup>th</sup> amendments change the wording in the bill from “appropriate licensed persons acting within their scope of licensure” to “appropriate licensed persons” This change was made to address a concern raised by the nurses because they do not have a scope of licensure, their allowed services are specified in the protocols and procedures from the supervising physician. The wording in the bill still says “appropriate licensed persons” and licensed persons would still need to adhere to their licensing requirements and scope. As such, these amendments do not affect the Board’s support position.**

The purpose of this bill is to clarify existing law to explicitly authorize mid-level practitioners in emergency departments to perform consulting and treatment, under the supervision of a physician and surgeon. This is in conformance with the Federal Emergency Medical Treatment and Labor Act (EMTALA), which permits appropriate licensed persons, i.e. physician assistants, to provide consults in an emergency department. This bill does not expand the scope of licensure and makes it clear that mid-level practitioners can provide services in emergency departments that they are already allowed to provide under their license. This bill will expand access to care in the emergency room setting while adequately providing consumer protection.

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

**OPPOSITION:** (Verified 8/22/11) American College of Emergency Physicians, California Chapter; and California Nurses Association

**FISCAL:**           None

**IMPLEMENTATION:**

- Newsletter Article
- Notify/Train Board Staff

October 10, 2011

Senate Bill No. 233

CHAPTER 333

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

[Approved by Governor September 26, 2011. Filed with Secretary of State September 26, 2011.]

LEGISLATIVE COUNSEL'S DIGEST

SB 233, 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 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 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.

*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.

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 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 Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code).

(C) For the purposes of Section 1371.4, emergency services and care as defined in subparagraph (A) shall not apply to Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8

(commencing with Section 14200), and Chapter 8.75 (commencing with Section 14590) of Part 3 of Division 9 of the Welfare and Institutions Code, to the extent that those services are excluded from coverage under those contracts.

(D) This paragraph does not expand, restrict, or otherwise affect the scope of licensure or clinical privileges for clinical psychologists or other medical personnel.

(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 Public Health.

(f) "Medical hazard" means a material deterioration in medical condition 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 that 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 or advice, prescribing treatment, or the rendering of a 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 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. 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.

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** SB 380  
**Author:** Wright  
**Chapter:** # 236  
**Bill Date:** June 20, 2011, amended  
**Subject:** Continuing Medical Education  
**Sponsor:** California Academy of Preventive Medicine  
**Position:** Neutral

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill authorizes 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.

This bill requires 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 bill also requires 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 continuing medical education (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 27<sup>th</sup> amendments were made to address opposition's concerns related to mandating CME; this bill no longer mandates CME. This bill now 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. 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 20<sup>th</sup> 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 (GACH) in California. This will 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 (CDPH).

The June 20<sup>th</sup> 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.

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 has taken 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

**IMPLEMENTATION:**

- Newsletter Article
- Notify/Train Board Staff
- Develop newsletter article on the prevention and treatment of chronic disease by the application of changes in nutrition and lifestyle behavior.
- Work with CDPH to disseminate the newsletter article to GACHs.
- 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.

October 6, 2011

Senate Bill No. 380

CHAPTER 236

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.

[Approved by Governor September 6, 2011. Filed with Secretary of State September 6, 2011.]

LEGISLATIVE COUNSEL'S DIGEST

SB 380, 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.

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

SECTION 1. The Legislature finds and declares all of the following:

(a) In 2008, U.S. health care spending was about \$7,681 per resident and accounted for 16.2 percent of the nation's gross domestic product; this is among the highest of all industrialized countries. Expenditures in the United States on health care surpassed \$2.3 trillion in 2008, more than three times the \$714 billion spent in 1990, and over eight times the \$253 billion spent in 1980.

(b) It is estimated that health care costs for chronic disease treatment account for over 75 percent of national health expenditures.

(c) Seven out of 10 deaths among Americans each year are from chronic diseases. Heart disease, cancer, and stroke account for more than 50 percent of all deaths each year.

(d) The last major report from the World Health Organization in March 2003 concluded diet was a major factor in the cause of chronic diseases.

(e) Dramatic increases in chronic diseases have been seen in Asian countries since the end of WWII with the increase in the gross national product and change to the western diet.

(f) Only 19 percent of students believed that they had been extensively trained in nutrition counseling. Fewer than 50 percent of primary care physicians include nutrition or dietary counseling in their patient visits.

(g) Practicing physicians continually rate their nutrition knowledge and skills as inadequate. More than one-half of graduating medical students report that the time dedicated to nutrition instruction is inadequate.

SEC. 2. Section 2190 of the Business and Professions Code is 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 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.

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** SB 543  
**Author:** Steinberg  
**Chapter:** # 448  
**Subject:** Omnibus  
**Sponsor:** Author

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill is the vehicle by which omnibus legislation has been carried, originally authored by the Senate Business and Professions Committee. This analysis will only cover the portions of the bill that impact the Medical Board of California (the Board).

This bill has two provisions that impact the Board. The first one is related to the Breeze project. This bill adds language to allow the Department of Consumer Affairs (DCA) to request that Department of Finance to augment the budgets of the Board (and other boards and bureaus under DCA), in order to allow payment of the Breeze project. This provision sunsets upon enactment of the Budget Act of 2012.

The next provision specifies that no physical therapist shall be subject to discipline by the Physical Therapy Board for providing physical therapy services as a professional employee of a professional medical corporation. This provision sunsets on January 1, 2013.

**ANALYSIS**

This bill allows DCA to request that Department of Finance to augment the budgets of all boards and bureaus under DCA, in order to allow payment of the BreEZe project. All boards and bureaus under DCA are required to provide funding to support the BreEZe project. Recently, the costs for the project increased, thereby increasing the amount needed from all boards and bureaus in order to fund the BreEZe project. This bill will allow DCA to request that the boards and bureaus budgets be augmented to allow them to have the necessary available funding in order to fund BreEZe. This provision sunsets upon enactment of the Budget Act of 2012.

This bill also specifies that no physical therapist shall be subject to discipline by the Physical Therapy Board for providing physical therapy services as a professional employee of a professional medical corporation. AB 783 (Hayashi) 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 therapist's to be employed by medical corporations. On September 29, 2010, the California Legislative 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. This issue came to the Legislature's attention when existing law was amended to add naturopathic doctor corporations and physical therapists were listed as professionals allowed to be employed by these corporations. Because the medical corporation section of law did not specifically list physical therapists, the issue was brought to the forefront and to the California Legislative Counsel for an opinion. On November 3, 2010, the Physical Therapy Board voted to rescind the 1990 resolution that authorized the forming of a general corporation employing physical therapists.

The Board took a support position on AB 783; however, this bill is a two-year bill and did not get passed out of the Legislature. The language in SB 543 was added because the Physical Therapy Board was attempting to take action against physical therapists employed by a medical corporation. This bill will put this issue in a holding pattern, until January 1, 2013, which will allow time for it to be fixed through a statute change.

**FISCAL:**               None to the Board

**SUPPORT:**           None in relation to the provisions affecting the Board

**OPPOSITION:**       Physical Therapy Association

**IMPLEMENTATION:**

- Newsletter Article
- Notify/Train Board Staff

October 7, 2011

Senate Bill No. 543

CHAPTER 448

An act to amend Sections 144, 205, 210, 5000, 5015.6, 5076, 5076.1, 5510, 5517, 5552.5, 5620, 5621, 5622, 6510, 6710, 6714, 6763.1, 7000.5, 7011, 7200, 7215.6, 7885, 7886, 7887, 8710, 18602, 18613, and 18618 of, to add Sections 5063.10 and 6582.2 to, and to add and repeal Section 2674 of, the Business and Professions Code, relating to business and professions, and making an appropriation therefor.

[Approved by Governor October 3, 2011. Filed with  
Secretary of State October 3, 2011.]

LEGISLATIVE COUNSEL'S DIGEST

SB 543, Steinberg. Business and professions: regulatory boards.

(1) Existing law authorizes a board to suspend or revoke a license on various grounds, including, but not limited to, conviction of a crime, if the crime is substantially related to the qualifications, functions, or duties of the business or profession for which the license was issued. Existing law requires applicants to certain boards to provide a full set of fingerprints for the purpose of conducting criminal history record checks.

This bill would make the fingerprinting requirement applicable to the Board for Professional Engineers, Land Surveyors, and Geologists. The bill would also make technical, nonsubstantive changes to those provisions to correct references to the names of various boards and would correct references to the name of a specified fund.

(2) Existing law authorizes the Department of Consumer Affairs to enter into a contract with a vendor for the licensing and enforcement BreEZe system no sooner than 30 days after written notification to certain committees of the Legislature. Existing law requires the amount of contract funds for the system to be consistent with costs approved by the office of the State Chief Information Officer, based on information provided by the department in a specified manner. Existing law provides that this cost provision is applicable to all Budget Act items for the department that have an appropriation for the BreEZe system.

This bill would authorize the Department of Finance to augment the budgets of those boards, bureaus, commissions, committees, programs, and divisions of the Department of Consumer Affairs for expenditure of non-General Fund moneys to pay BreEZe project costs, as specified, thereby making an appropriation.

(3) Existing law, the Physical Therapy Practice Act, creates the Physical Therapy Board of California and makes it responsible for the licensure and regulation of physical therapists. Existing law authorizes the board to discipline licensees, including the suspension and revocation of licenses.

Existing law regulating professional corporations provides that certain healing arts practitioners may be shareholders, officers, directors, or professional employees of a professional corporation, subject to certain limitations. A violation of these provisions by a licensee constitutes unprofessional conduct under the act.

This bill would, until January 1, 2013, prohibit the board from taking disciplinary action against a licensee providing physical therapy services as a professional employee of a medical corporation, podiatric medical corporation, or chiropractic corporation.

(4) Existing law provides for the licensure and regulation of various businesses and professions by boards within the Department of Consumer Affairs, including the California Board of Accountancy, the California Architects Board, the Landscape Architects Technical Committee, the Professional Fiduciaries Bureau, the Board for Professional Engineers, Land Surveyors, and Geologists, the Contractors' State License Board, the State Board of Guide Dogs for the Blind, and the State Athletic Commission. Existing law requires or authorizes these boards and the State Athletic Commission, with certain exceptions, to appoint an executive officer and existing law authorizes the Governor to appoint the chief of the Professional Fiduciaries Bureau. Existing law repeals these provisions on January 1, 2012. Under existing law, boards scheduled for repeal are required to be evaluated by the Joint Sunset Review Committee.

This bill would extend the operation of these provisions until January 1, 2016, except the State Board of Guide Dogs for the Blind and the State Athletic Commission, which would be extended until January 1, 2014, and except the Professional Fiduciaries Bureau, which would be extended until January 1, 2015. The bill would instead specify that these boards would be subject to review by the appropriate policy committees of the Legislature.

(5) With respect to accounting firms, existing law, until January 1, 2014, requires a firm, in order to renew its registration, to have a specified peer review report accepted by a California Board of Accountancy-recognized peer review group. Existing law, until January 1, 2014, requires the board to appoint a peer review oversight committee of certified public accountants to provide recommendations to the board relating to the effectiveness of mandatory peer review. Existing law also requires the board, by January 1, 2013, to provide the Legislature and the Governor with a report regarding specified peer review requirements that includes specified information.

This bill would extend the operation of the peer review report requirement and the peer review oversight committee indefinitely. The bill would require the report to the Legislature and the Governor to be submitted by January 1, 2015, and would require the report to include certain additional information and recommendations.

Existing law requires an accountant licensee to report to the board the occurrence of certain events taking place after January 1, 2003, including any restatement of a financial statement.

- (25) Geology and Geophysics Account of the Professional Engineer's and Land Surveyor's Fund.
- (26) Dispensing Opticians Fund.
- (27) Acupuncture Fund.
- (28) Physician Assistant Fund.
- (29) Board of Podiatric Medicine Fund.
- (30) Psychology Fund.
- (31) Respiratory Care Fund.
- (32) Speech-Language Pathology and Audiology and Hearing Aid Dispensers Fund.
- (33) Board of Registered Nursing Fund.
- (34) Psychiatric Technician Examiners Account of the Vocational Nursing and Psychiatric Technicians Fund.
- (35) Animal Health Technician Examining Committee Fund.
- (36) State Dental Hygiene Fund.
- (37) State Dental Assistant Fund.

(b) For accounting and recordkeeping purposes, the Professions and Vocations Fund shall be deemed to be a single special fund, and each of the several special funds therein shall constitute and be deemed to be a separate account in the Professions and Vocations Fund. Each account or fund shall be available for expenditure only for the purposes as are now or may hereafter be provided by law.

SEC. 3. Section 210 of the Business and Professions Code is amended to read:

210. (a) (1) The department may enter into a contract with a vendor for the BreEZe system, the integrated, enterprisewide enforcement case management and licensing system described in the department's strategic plan, no sooner than 30 days after notification in writing to the chairpersons of the Appropriations Committees of each house of the Legislature and the Chairperson of the Joint Legislative Budget Committee.

(2) The amount of BreEZe system vendor contract funds, authorized pursuant to this section, shall be consistent with the project costs approved by the office of the State Chief Information Officer based on its review and approval of the most recent BreEZe Special Project Report to be submitted by the department prior to contract award at the conclusion of procurement activities.

(3) Paragraph (2) shall apply to all Budget Act items for the department that have an appropriation for the BreEZe system.

(b) (1) If the department enters into a contract with a vendor for the BreEZe system pursuant to subdivision (a), the department shall, by December 31, 2014, submit to the Legislature, the Senate Committee on Business, Professions and Economic Development, the Assembly Committee on Business, Professions and Consumer Protection, and the budget committees of each house, a report analyzing the workload of licensing personnel employed by boards within the department participating in the BreEZe system.

(2) A report to the Legislature pursuant to this subdivision shall be submitted in compliance with Section 9795 of the Government Code.

(3) This subdivision shall become inoperative on December 1, 2018, pursuant to Section 10231.5 of the Government Code.

(c) (1) Notwithstanding any other provision of law, upon the request of the Department of Consumer Affairs, the Department of Finance may augment the budgets of the boards, bureaus, commissions, committees, programs, and divisions that comprise the Department of Consumer Affairs, as defined in Section 101, for expenditure of non-General Fund moneys to pay BreEZe project costs. The augmentation may be made no sooner than 30 days after notification in writing to the chairpersons of the committees in each house of the Legislature that consider appropriations and the Chairperson of the Joint Legislative Budget Committee, or no sooner than whatever lesser time the chairperson of the joint committee may in each instance determine. The amount of funds augmented pursuant to the authority of this subdivision shall be consistent with project cost increases approved by the Secretary of California Technology based on the secretary's review and approval of the most recent BreEZe Special Project Report to be submitted at the conclusion of procurement activities. This subdivision shall apply to all Budget Act items for the boards, bureaus, commissions, committees, programs, and divisions that comprise the Department of Consumer Affairs, as defined in Section 101, that have an appropriation for the BreEZe system in the Budget Act of 2011.

(2) This subdivision shall become inoperative upon enactment of the Budget Act of 2012.

SEC. 4. Section 2674 is added to the Business and Professions Code, to read:

2674. (a) Notwithstanding any other provision of law, no physical therapist shall be subject to discipline by the board for providing physical therapy services as a professional employee of a professional corporation as described in subdivision (a), (b), or (k) of Section 13401.5 of the Corporations Code.

(b) Nothing in this section shall be construed to imply or suggest that a physical therapist providing physical therapy services as a professional employee of a corporation as described in subdivision (a), (b), or (k) of Section 13401.5 of the Corporations Code is in violation of or compliance with the law.

(c) This section shall remain in effect only until January 1, 2013, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2013, deletes or extends that date.

SEC. 5. Section 5000 of the Business and Professions Code is amended to read:

5000. There is in the Department of Consumer Affairs the California Board of Accountancy, which consists of 15 members, 7 of whom shall be licensees, and 8 of whom shall be public members who shall not be licentiates of the board or registered by the board. The board has the powers and duties conferred by this chapter.

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** SB 824  
**Author:** Negrete McLeod  
**Chapter:** # 389  
**Bill Date:** June 23, 2011, amended  
**Subject:** Opticians: Regulation  
**Sponsor:** LensCrafters (co-sponsor), Target Optical (co-sponsor), and Sears Optical (co-sponsor)  
**Position:** Support

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill would require a registered dispensing optician (RDO) assuming ownership of a business and the RDO selling or transferring ownership of a business to both 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.

**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.

The June 23<sup>rd</sup> amendments would have only put the 10 day time line on the RDO assuming ownership of the business. This amendment affected the Board's Support position because the bill no longer put the 10 time line on both parties and no longer assisted in making the Board's process run more smoothly and effectively. As such, the Board changed its position to Neutral.

The August 29<sup>th</sup> amendments went back to the original intent and specifically require a registered dispensing optician (RDO) assuming ownership of a business and the

RDO selling or transferring ownership of a business to both file the notice with the Medical Board of California (the Board) within 10 days of the completion of the transfer of ownership. Since the bill went back to the original intent that was supported by the Board, the Board's position changed back to Support.

Sometimes, the Board 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.

**SUPPORT:** LensCrafters (co-sponsor); Target Optical (co-sponsor); Sears Optical (co-sponsor); and Medical Board of California

**OPPOSITION:** None on file

**FISCAL:** None

**POSITION:** Support

**IMPLEMENTATION:**

- Newsletter Article
- Notify/Train Board Staff

October 6, 2011

Senate Bill No. 824

CHAPTER 389

An act to add Section 2553.1 to the Business and Professions Code, relating to opticians.

[Approved by Governor September 30, 2011. Filed with Secretary of State September 30, 2011.]

LEGISLATIVE COUNSEL'S DIGEST

SB 824, Negrete McLeod. Opticians: regulation.

Existing law requires that dispensing opticians register with 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 selling or transferring ownership of his or her place of business to return the certificate of registration to the board within 10 days of the completion of the transfer of ownership. The bill would also require the registered dispensing optician acquiring ownership of the business to file a notice with the board within 10 days of the completion of the transfer of ownership and would specify that until receipt of that notice by the board, the registered dispensing optician selling or transferring the interest remains responsible for complying with all laws regulating the optical dispensing 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.

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

SECTION 1. Section 2553.1 is added to the Business and Professions Code, to read:

2553.1. (a) If a registered dispensing optician sells or transfers ownership of his or her place of business, both of the following requirements shall be satisfied:

(1) The registered dispensing optician selling or transferring ownership of the business shall return the certificate of registration to the board no later than 10 calendar days after the change of ownership is completed. This registered dispensing optician shall be responsible for complying with all laws relating to the optical dispensing business until the notice described in paragraph (2) is received by the board.

(2) The registered dispensing optician assuming ownership of the business shall record with the board a written notice of the change of ownership, providing all information required by the board. This notice shall be filed with the board no later than 10 calendar days after the change of ownership is completed.

(b) This section does not apply to a change of location of business by a registered dispensing optician.

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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MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** SB 943  
**Author:** Senate Business, Professions and Economic Development  
Committee  
**Chapter:** # 350  
**Subject:** Omnibus  
**Sponsor:** Committee  
**Position:** Support provisions related to the Polysomnography Program.

**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.

This bill also requires the Board to report on the number of reports received pursuant to Section 805.01 of the Business and Professions Code in its Annual Report.

**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 grandfathering 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 clarifies existing law and allows 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 reflects the original intent of SB 132 and allows 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.

The August 29<sup>th</sup> amendments require the Board to report on the number of reports received pursuant to Business and Professions Code Section 805.01 in the Board's Annual Report. This information would be reported in addition to the number of 805 reports received, which is currently reported in the Board's Annual Report. Section 805.01 of the Business and Professions Code was added by SB 700 (Negrete McLeod, Chapter 505, Statutes of 2010). Section 805.01 requires peer review bodies to file a report with the relevant agency within 15 days after a peer review body makes a final decision or recommendation regarding the disciplinary action specified in Section 805, resulting in a final proposed action to be taken against a licensee based on the peer review body's determination. This is in addition to the 805 reports that the Board already receives.

The Board already intended on including the 805.01 report information in its Annual Report. This bill requires the Board to separate the reports received pursuant to the particular code section in two different categories in the Annual Report. The Board does not have concerns with this requirement and already intended to report this information. This amendment was taken at the end of August so it was not brought to the Board for a position.

**FISCAL:** None to the Board

**SUPPORT:** California Sleep Society

**OPPOSITION:** None on file

**POSITION:** Support provisions related to the Polysomnography Program.

**IMPLEMENTATION:**

- Newsletter Article
- Notify/Train Board Staff
- Reformat the Annual Report to include a separate category for reports received pursuant to Section 805.01 of the Business and Professions Code, beginning January 1, 2012
- Amend the pending regulations to include the grandfathering clause

October 6, 2011

**Senate Bill No. 943**

**CHAPTER 350**

An act to amend Sections 1916, 1917, 1917.2, 1918, 1922, 1927, 1950, 1952, 1955, 1957, 1959, 1961, 1962, 1963, 1966.1, 2313, 2736.5, 2836.2, 2936, 3519, 3575, 4200, 4836.1, 4980.36, 4980.37, 4980.40.5, 4980.42, 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.

[Approved by Governor September 26, 2011. Filed with  
Secretary of State September 26, 2011.]

**LEGISLATIVE COUNSEL'S DIGEST**

SB 943, 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.

This bill would require applicants to submit electronic fingerprint images.

Existing law requires the committee to license as a registered dental hygienist, a registered dental hygienist in extended functions, or a registered dental hygienist in alternative practice a person who meets certain educational, training, and examination requirements.

This bill would additionally require these applicants to complete an application and pay required application fees.

Existing law, until January 1, 2012, requires the committee to license as a registered dental hygienist a 3rd- or 4th-year dental student who is in good standing at an accredited California dental school, who satisfactorily performs on a clinical examination and an examination in California law and ethics as prescribed by the committee, and who satisfactorily completes a national written dental hygiene examination approved by the committee.

This bill would extend those provisions until January 1, 2014.

Under existing law, a licensee may have his or her license revoked or suspended, or may be reprimanded or placed on probation by the committee, for conviction of a crime substantially related to the licensee's qualifications,

functions, or duties. Existing law authorizes the committee to order a license suspended or revoked or to decline to issue a license if certain procedural events occur.

This bill would additionally authorize the committee to reprimand a licensee or order a license placed on probation.

Under existing law, a licensee or health care facility that fails to comply with a specified request from the committee for a patient's dental hygiene records is subject to a \$250 per day civil penalty for each day that the records have not been produced, as specified.

This bill would additionally require licensees and health care facilities to comply with a request for a patient's dental records and would make them subject to a civil or administrative penalty or fine up to a maximum of \$250 per day for each day that the records have not been produced, as specified.

(2) Existing law, the Nursing Practice Act, provides for the licensure and regulation of registered nurses by the Board of Registered Nursing.

Existing law requires applicants for licensure as a registered nurse to meet certain educational requirements, to have completed specified courses of instruction, and to not be subject to denial of licensure under specified circumstances. Existing law authorizes applicants who have served on active duty in the medical corps in the United States Armed Forces to submit a record of specified training to the board for evaluation in order to satisfy the courses of instruction requirement. Under existing law, if the applicant satisfies the other general licensure requirements and if the board determines that both education and experience establish competency to practice registered nursing, the applicant shall be granted a license upon passing a certain examination.

This bill would limit that board determination to be based on education only.

(3) Existing law, the Physician Assistant Practice Act, provides for the licensure and regulation of physician assistants by the Physician Assistant Committee. Existing law requires the committee to issue a license to a physician assistant applicant who, among other things, provides evidence of either successful completion of an approved program, as defined, or a resident course of professional instruction meeting certain requirements.

This bill would instead require applicants to provide evidence of successful completion of an approved program, as defined.

(4) Existing law provides for the registration and regulation of polysomnographic technologists by the Medical Board of California. Existing law requires the board to promulgate regulations relative to the qualifications for the registration of individuals as certified polysomnographic technologists. Existing law specifies that the qualifications for a certified polysomnographic technologist includes meeting certain educational requirements and the passage of a national certifying examination. Existing law authorizes, for a specified period, the examination requirement to be satisfied if the applicant submits proof that he or she has been practicing polysomnography for at least 5 years, as specified.

This bill would authorize, for a specified period, all of these qualifications to be satisfied if the applicant submits proof that he or she has been practicing polysomnography for at least 5 years, as specified.

(5) Existing law, the Veterinary Medicine Practice Act, until January 1, 2012, authorizes a registered veterinary technician and an unregistered assistant to administer a drug, including, but not limited to, a drug that is a controlled substance, except for the induction of anesthesia, under the direct or indirect supervision of a licensed veterinarian when done pursuant to the order, control, and full professional responsibility of the veterinarian.

This bill would extend the operation of that provision to January 1, 2013.

(6) Under existing law, the Board of Behavioral Sciences is responsible for the licensure, registration, and regulation of, among others, marriage and family therapists, licensed clinical social workers, and licensed professional clinical counselors.

(A) Existing law, the Marriage and Family Therapist Act, provides for the licensure and regulation of marriage and family therapists and makes a violation of the act a crime. Existing law, with respect to marriage and family therapists and marriage and family therapist interns, requires an applicant to possess a doctoral or master's degree in any of various disciplines, including, but not limited to, marriage, family, and child counseling.

This bill would add couple and family therapy to that list of acceptable disciplines.

Existing law requires that degree to contain a specified number of units of instruction that includes practicum involving direct client contact of a specified number of hours of face-to-face experience counseling individuals, couples, families, or groups and authorizes a portion of those hours to be gained performing client centered advocacy, as defined.

This bill would revise and recast that requirement and would authorize that portion of hours to be gained performing either client centered advocacy, as defined, or face-to-face experience counseling individuals, couples, families, or groups.

Existing law authorizes a licensed professional in private practice meeting certain requirements to supervise or employ no more than a total of 2 individuals registered as either a marriage and family therapist intern or associate clinical social worker.

This bill would authorize such a licensed professional to supervise or employ no more than a total of 3 individuals and would add clinical counsel interns to that list. Because the bill would change the definition of a crime, it would thereby impose a state-mandated local program.

Under existing law, a marriage and family therapy corporation may employ no more than a total of 2 individuals registered as either a marriage and family therapist intern or associate clinical social worker for each employee. Existing law prohibits the corporation from employing more than 10 individuals registered as either a marriage and family therapist intern or associate clinical social worker.

that states that the licensee understands that his or her violations of this article or other statutes, that would otherwise be the basis for discipline, may still be investigated and the subject of disciplinary action.

(d) If the reasons for a current investigation of a licensee are based primarily on the self-administration of any controlled substance or dangerous drugs or alcohol under Section 1951, or the illegal possession, prescription, or nonviolent procurement of any controlled substance or dangerous drugs for self-administration that does not involve actual, direct harm to the public, the committee shall close the investigation without further action if the licensee is accepted into the committee's diversion program and successfully completes the requirements of the program. If the licensee withdraws or is terminated from the program by a diversion evaluation committee, the investigation shall be reopened and disciplinary action imposed, if warranted, as determined by the committee.

(e) Neither acceptance nor participation in the diversion program shall preclude the committee from investigating or continuing to investigate, or taking disciplinary action or continuing to take disciplinary action against, any licensee for any unprofessional conduct committed before, during, or after participation in the diversion program.

(f) All licensees shall sign an agreement of understanding that the withdrawal or termination from the diversion program at a time when a diversion evaluation committee determines the licensee presents a threat to the public's health and safety shall result in the utilization by the committee of diversion treatment records in disciplinary or criminal proceedings.

(g) Any licensee terminated from the diversion program for failure to comply with program requirements is subject to disciplinary action by the committee for acts committed before, during, and after participation in the diversion program. A licensee who has been under investigation by the committee and has been terminated from the diversion program by a diversion evaluation committee shall be reported by the diversion evaluation committee to the committee.

SEC. 18. Section 2313 of the Business and Professions Code is amended to read:

2313. The board shall report annually to the Legislature, no later than October 1 of each year, the following information:

(a) The total number of temporary restraining orders or interim suspension orders sought by the board to enjoin licensees pursuant to Sections 125.7, 125.8 and 2311, the circumstances in each case that prompted the board to seek that injunctive relief, and whether a restraining order or interim suspension order was actually issued.

(b) The total number and types of actions for unprofessional conduct taken by the board against licensees, the number and types of actions taken against licensees for unprofessional conduct related to prescribing drugs, narcotics, or other controlled substances, including those related to the undertreatment or undermedication of pain.

(c) Information relative to the performance of the board, including the following: number of consumer calls received; number of consumer calls

or letters designated as discipline-related complaints; number of complaint forms received; number of Section 805 and Section 805.01 reports by type; number of Section 801.01 and Section 803 reports; coroner reports received; number of convictions reported to the board; number of criminal filings reported to the division; number of complaints and referrals closed, referred out, or resolved without discipline, respectively, prior to accusation; number of accusations filed and final disposition of accusations through the board and court review, respectively; final physician discipline by category; number of citations issued with fines and without fines, and number of public reprimands issued; number of cases in process more than six months from receipt by the board of information concerning the relevant acts to the filing of an accusation; average and median time in processing complaints from original receipt of complaint by the board for all cases at each stage of discipline and court review, respectively; number of persons in diversion, and number successfully completing diversion programs and failing to do so, respectively; probation violation reports and probation revocation filings and dispositions; number of petitions for reinstatement and their dispositions; and caseloads of investigators for original cases and for probation cases, respectively.

“Action,” for purposes of this section, includes proceedings brought by, or on behalf of, the board against licensees for unprofessional conduct that have not been finally adjudicated, as well as disciplinary actions taken against licensees.

(d) The total number of reports received pursuant to Section 805 and Section 805.01 by the type of peer review body reporting and, where applicable, the type of health care facility involved and the total number and type of administrative or disciplinary actions taken by the board with respect to the reports.

(e) The number of malpractice settlements in excess of thirty thousand dollars (\$30,000) reported pursuant to Section 801.01. This information shall be grouped by specialty practice and shall include the total number of physicians and surgeons practicing in each specialty. For the purpose of this subdivision, “specialty” includes all specialties and subspecialties considered in determining the risk categories described in Section 803.1.

SEC. 19. Section 2736.5 of the Business and Professions Code is amended to read:

2736.5. (a) Any person who has served on active duty in the medical corps of any of the Armed Forces of the United States and who has successfully completed the course of instruction required to qualify him or her for rating as a medical service technician—*independent duty*, or other equivalent rating in his particular branch of the Armed Forces, and whose service in the Armed Forces has been under honorable conditions, may submit the record of such training to the board for evaluation.

(b) If such person meets the qualifications of paragraphs (1) and (3) of subdivision (a) of Section 2736, and if the board determines that his or her education would give reasonable assurance of competence to practice as a

Board of Psychology  
2005 Evergreen Street, Suite 1400  
Sacramento, California 95815-3894”

SEC. 22. 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 successful completion of an approved program.
- (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. 23. 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:

(A) He or she shall have valid, current credentials as a polysomnographic technologist issued by a national accrediting agency approved by the board.

(B) He or she shall have graduated from a polysomnographic educational program that has been approved by the board.

(C) He or she shall have passed a national certifying examination that has been approved by the board.

(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. 24. 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 be substantiated by affidavits or other evidence as may be required by the board.

(c) Each person, upon application for licensure as a pharmacist under this chapter, shall pay to the executive officer of the board the fees provided by this chapter. The fees shall be compensation to the board for investigation or examination of the applicant.

SEC. 25. Section 4836.1 of the Business and Professions Code is amended to read:

4836.1. (a) Notwithstanding any other provision of law, a registered veterinary technician or an unregistered assistant may administer a drug, including, but not limited to, a drug that is a controlled substance, under the

## LEGISLATIVE PROPOSALS 2012

### Previously Approved Proposal

#### **UCLA International Medical Graduate Program Pilot Project**

This is the program co-founded by Dr. Dowling and Dr. Bholat - This issue was brought to the Board at the last meeting and the Board voted to co-sponsor this legislation with the University of California. As you know, it was brought to the Board's attention that legislation for this program is needed to allow the program's participants to obtain clinical experience; this would require a statute change and this could be accomplished by making UCLA's IMG program a pilot project. The Board approved this concept and agreed to be a co-sponsor, along with the University of California (UC), if all the details and parameters are developed. Board staff has been working with the University of California, Office of the President, and we will be meeting with them on this proposal in early November. Co-sponsoring this legislation with the UC looks promising at this point in time.

### New Proposals

#### **Non-Practice License Status – Authority to Impose Discipline**

The Medical Board recently lost a court of appeal case related to taking disciplinary action against a licensee that held a retired license. The respondent's attorney alleged the Board lacked jurisdiction to impose discipline because, as the holder of a retired license status, the respondent was not permitted to engage in the practice of medicine. Board staff and legal counsel believe that Board does have jurisdiction to impose discipline on any license it issues because that licensee can opt to change their license status by meeting limited requirements. If the Board lacked jurisdiction to impose discipline, it may create a retired status loophole that would insulate any licensee from discipline by transferring his or her license to a retired or inactive status. However, the court ruled that the holder of a retired status license is not a licensee under the Board's jurisdiction and that the Board's disciplinary authority is relevant to the holder of a retired license, "only if and when the retired licensee seeks to return to the practice of medicine and files an application" with the Board for restoration of his or her license. Board staff would like to sponsor legislation to make it clear that the Board retains jurisdiction over all licensees, regardless of the status of his or her license.

#### **Renewal Notices – Ability to Send via E-Mail**

The Board will be moving to a new information technology (IT) system that will allow physicians and surgeons to receive notifications via email. Currently physician and surgeons can pay their renewal fees online; however, they receive their renewal notice via US postal service. The new IT system will allow individuals the opportunity to choose the best method (i.e. electronically or via US Postal Service) of receiving information from the Board. The instructions will be specific that if they identify the electronic method, this will be the only notification tool used. In reviewing the Board's laws, it has been determined that Business and Professions (B&P) Code section 2424(a) will impede this process as currently written. The statute requires the Board to send a delinquent notice via US postal service and it must be sent

certified mail. In order to save mailing costs, mailing time, printing costs, etc., the Board would like to amend statute to allow these delinquency notifications to be sent via email if the physician

chooses this method of communication. This could be done by deleting this subdivision in its entirety, or amending it to add e-mail communication as an option. This statute change may be considered as part of the omnibus bill.

### **Omnibus**

The following changes were requested and approved last year and will be included in the 2012 omnibus bill:

- Section 2064 – changing “and” to “or” in the section of law that relates to allowing a foreign medical student enrolled in an approved medical school “and” clinical training program to allow them to practice medicine. The statute should read “or”, it was not meant to require an individual to be enrolled in medical school and a clinical training program.
- Section 2184 – Adding clinical training to postgraduate training programs, as one of the ways the Board is allowed to extend the passing scores of the USMLE.
- Section 2516 – Changing the word “infant” to “neonate” in the licensed midwife annual report, neonate is a more appropriate term.

The following change is a new omnibus bill provision:

- Adding a new provision that will establish a retired license status for licensed midwives, similar to the retired license status for physicians. This appears to have been left out due to an oversight. For most practitioners, there is a status that allows for retirement where fees are not required, but the licensee can still use the initials of a licensee after his or her name.

**Medical Board of California  
Tracker II - Legislative Bills  
10/18/2011**

<b>BILL</b>	<b>AUTHOR</b>	<b>TITLE</b>	<b>STATUS</b>	<b>AMENDED</b>
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	VETOED	09/07/11
AB 174	Monning	Health Information Exchange	2-year	03/21/11
AB 186	Williams	Reportable Diseases and Conditions	CHAPTERED, #540	08/31/11
AB 242	Rev. & Tax	Income Taxes: Federal Health Care	CHAPTERED, #727	08/31/11
AB 273	Valadao	Regulations: Economic Impacts Review	2-year	
AB 300	Ma	Safe Body Art Act	CHAPTERED, #638	08/24/11
AB 377	Solorio	Pharmacy	2-year	04/14/11
AB 386	Galgiani	Prisons: Telehealth Systems	2-year	05/11/11
AB 389	Mitchell	Bleeding Disorders	2-year	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	CHAPTERED, #652	
AB 530	Smyth	Regulations: Economic and Technical Information	2-year	03/31/11
AB 655	Hayashi	Healing Arts: Peer Review	CHAPTERED, #380	07/06/11
AB 673	Perez, J.	Office of Multicultural Health: LGBT Communities	CHAPTERED, #639	06/01/11

**Medical Board of California  
Tracker II - Legislative Bills  
10/18/2011**

<b>BILL</b>	<b>AUTHOR</b>	<b>TITLE</b>	<b>STATUS</b>	<b>AMENDED</b>
AB 675	Hagman	Continuing Education	2-year	04/05/11
AB 678	Pan	Medi-Cal: Supplemental Provider Reimbursement	CHAPTERED, #397	08/15/11
AB 714	Atkins	Health Care Coverage: California Health Benefit Exchange	2-year	06/30/11
AB 740	Blumenfield	Personal Services Contracts	CHAPTERED, #684	
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	2-year	08/15/11
AB 917	Olsen	State Agencies: Sunset Review	2-year	
AB 922	Monning	Office of Patient Advocate	CHAPTERED, #552	09/02/11
AB 951	Perea	State Employees: Memorandum of Understanding	2-year	06/13/11
AB 972	Butler	Substance Abuse: Treatment Facilities	2-year	08/15/11
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	CHAPTERED, #689	08/30/11
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	2-year	08/15/11
AB 1296	Bonilla	Health Care Eligibility, Enrollment, and Retention Act	CHAPTERED, #641	09/01/11
AB 1322	Bradford	Regulations: Principles of Regulation	2-year	04/15/11
AB 1328	Pan	Clinical Laboratories	2-year	03/31/11
ABX1 3	Logue	Regulations: 5-Year Review and Report	DEAD	

**Medical Board of California  
Tracker II - Legislative Bills  
10/18/2011**

<b>BILL</b>	<b>AUTHOR</b>	<b>TITLE</b>	<b>STATUS</b>	<b>AMENDED</b>
ABX1 4	Logue	Regulations: Effective Date	DEAD	
ABX1 5	Logue	Regulations: Legislative Notice	DEAD	
ABX1 6	Logue	Regulations: Economic Impacts Review	DEAD	
AJR 10	Brownley	School-Based Health Centers	CHAPTERED, #68	05/02/11
SB 38	Padilla	Radiation Control: Health Facilities and Clinics: Records	CHAPTERED, #139	03/29/11
SB 41	Yee	Hypodermic Needles and Syringes	CHAPTERED, #738	08/15/11
SB 103	Liu	State Government: Meetings	2-year	07/12/11
SB 173	Simitian	Healing Arts: Mammograms	2-year	08/15/11
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	CHAPTERED, #418	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	2-year	08/30/11
SB 442	Calderon	Hospitals: Interpreters	VETOED	04/26/11
SB 538	Price	Nursing	VETOED	08/15/11
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  
10/18/2011**

<b>BILL</b>	<b>AUTHOR</b>	<b>TITLE</b>	<b>STATUS</b>	<b>AMENDED</b>
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	CHAPTERED, #664	08/30/11
SB 747	Kehoe	Continuing Education: LGBT Patients	VETOED	08/26/11
SB 791	Simitian	Health Care: Mammograms	VETOED	09/09/11
SB 850	Leno	Medical Records: Confidential Information	CHAPTERED, #714	09/01/11
SB 924	Walters	Physical Therapists: Direct Access	2-year	05/24/11
SB 946	Heath Comm.	Public Health	CHAPTERED, #650	09/09/11
SJR 6	Kehoe	Survivors of Torture	CHAPTERED, #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***
Polysomnography Program	Pending review at DOF; DCA Director has granted extension: file must be submitted to OAL by 12/8/11	7/30/10	9/10/10	11/5/10	2/22/11	To DCA 9/8/11; To SCSA 9/27/11; approved by SCSA and to DOF on 10/6/11		
Limited Practice License	Effective 9/17/11	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	8/18/11
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	Effective 8/31/11	1/28/11	3/11/11	5/6/11	5/6/11	To DCA 6/8/11; to SCSA 6/28/11; DOF review not required	7/15/11	8/1/11
Non-substantive changes from all units (Section 100 changes)	Next review of MBC regulations - 2012							

Prepared by Kevin A. Schunke  
Updated October 5, 2011  
For questions, call (916) 263-2368

\* - 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

# Medical Board of California

Department of Consumer Affairs

**Date:** October 10, 2011  
**To:** Members, Medical Board  
**From:** Janie Cordray, Research Consultant  
**Subject:** Strategic Plan Discussions on October 28, 2011

The first draft of the Strategic Plan can be found in the members' Executive Committee meeting package. In addition to the draft plan, there is a chart that shows the priorities of the draft objectives.

The Executive Committee will meet on October 27<sup>th</sup> to discuss the draft and priorities and will adopt recommendations that will be presented to the full board on October 28<sup>th</sup>. At the full Board meeting, the members will be given an opportunity to fully discuss the plan, agree upon priorities, and determine what future work may need to be performed.

The draft strategic plan incorporates members' discussions at the July 27<sup>th</sup> Executive Committee and July 28<sup>th</sup> Board meetings. As you may recall, the members adopted the mission statement and goals, and reached a consensus on ideas and concepts to be developed into objectives. Staff has incorporated those ideas into objectives, as well as developed activities and tasks to fulfill and measure the objectives to meet the goals.

We have worked to draft objectives that rightly reflect the conceptual ideas agreed upon by the members. In addition, we have categorized the objectives into priorities in light of the mission statement and the Board's legal authority and responsibilities. Please note that the dates and priorities may not appear to coincide. That is to say, the highest priority may not have been assigned the most immediate date. This is due to a number of factors, including timing of mandated reports, Sunset Review, the ability to hire personnel, and so forth.

The dates for the activities have been categorized by season and year, and the season coincides with the Board's meeting dates. (Winter = February, Spring = May, Summer = July, and Fall = October)

I will be at the October 28<sup>th</sup> meeting to answer the members' questions. In the meantime, if you have any questions or suggestions, feel free to contact me at [janie.cordray@mbc.ca.gov](mailto:janie.cordray@mbc.ca.gov).

**Objective 5.4** 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 of which they were established, and determine if they should continue, be eliminated, or be merged with other committees.

Activity	Date	Staff	Priority
<ul style="list-style-type: none"> <li>At the fall meeting of the Board, prior to new committee appointments by the president, the Board should conduct a review of all committees/subcommittees/task forces.</li> </ul>	Every Fall Board Meeting	Deputy Executive Director	A

**MEDICAL BOARD OF CALIFORNIA**

EXECUTIVE OFFICE

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[www.mbc.ca.gov](http://www.mbc.ca.gov)**COMMITTEES OF THE BOARD**

October 2011

**REQUIRED COMMITTEES****Executive Committee**

- Membership:** President of the Board, Chair  
Vice President of the Board  
Secretary of the Board  
Immediate Past President of the Board  
(The president may select additional members at his/her discretion.)
- Responsibility:** To oversee various administrative functions of the board, such as budgets and personnel, and to review legislation. The Executive Committee provides recommendations to the full Board, annually evaluates the performance of the Executive Director, and acts for the Board in emergency circumstances (as determined by the Chair) when the full board cannot be convened.
- Staff:** Linda Whitney, Executive Director  
Kim Kirchmeyer, Deputy Director
- Current Members:** Barbara Yaroslavsky (Chair), Janet Salomonson, M.D. (Vice President), Gerrie Schipske, R.N.P., J.D. (Secretary), Hedy Chang, Shelton Duruisseau, Ph.D., Sharon Levine, M.D.

**Application Review Committee**

- Membership:** Determined by the President
- Responsibility:** To evaluate the credentials of licensure applicants, where statute provides the Board to exercise discretion, and make recommendations to the Licensing Program regarding eligibility for licensure. For example, postgraduate training hardship petitions (Section 1321(d)), and written licensing exam waiver requests (B&P Code Section 2113).
- Staff:** Curt Worden, Chief of Licensing
- Current Members:** Gerrie Schipske, R.N.P., J.D. (Chair), Silvia Diego, M.D., Reginald Low, M.D.

## REQUIRED COMMITTEES – CONTINUED

### Midwifery Advisory Council

Membership:	Determined by the President
Responsibility:	To develop solutions to various regulatory, policy, and procedure issues with the midwifery program, including physician supervision, challenge mechanisms, and examinations.
Staff:	Curt Worden, Chief of Licensing
Current Members:	Karen Ehrlich, L.M. (Chair), William Frumovitz, M.D., Faith Gibson, L.M., Ruth Haskins, M.D., Carrie Sparrevohn, L.M., Barbara Yaroslavsky

### Special Faculty Permit Review Committee

Membership:	A physician member and public member determined by the President. One representative from each California medical school, nominated by the school dean and approved by the Board.
Responsibility:	To evaluate the credentials of applicants proposed by a California medical school to meet the requirements of Section 2168.1. The Committee must determine whether the candidate meets the requirements of an academically eminent physician, or an outstanding physician in an identified area of need. The Committee submits a recommendation to the Board for each proposed candidate for a final approval or denial.
Staff:	Curt Worden, Chief of Licensing
Current Members:	Reginald Low, M.D. (Chair), Hedy Chang, Neal Cohen, M.D., Daniel Giang, M.D., F. Allan Hubbell, M.D., James Nuovo, M.D., Frank Sinatra, M.D., Neil Parker, M.D., Andrew Ries, M.D., Lawrence Shuer, M.D.

### Special Programs Committee

Membership:	Determined by President
Responsibility:	To provide guidance, recommendation and expertise to Board staff regarding special program laws and regulations, specific applications, medical school site visits, and issues of concern. The committee makes recommendations; the delegation is the Chief of Licensing.
Staff:	Curt Worden, Chief of Licensing
Current Members:	Chair (Vacant), Hedy Chang, Jorge Carreon, M.D., Shelton Duruisseau, Ph.D.

## COMMITTEES CREATED BY THE BOARD

### **Access-to-Care Committee**

- Membership:** Determined by the President
- Responsibility:** The Access to Care Committee will identify opportunities for the Medical Board of California, consistent with the Board's consumer protection mission, to promote and assist physician involvement in access to care issues in California, and may include work with governmental, private, trade and association, and funding agencies as part of the committee's efforts. The committee will provide policy and program direction and recommendations to the board in the area of access to care and will establish measurable goals and milestones for its work.
- Staff:** Kevin Schunke, Outreach Manager
- Current Members:** Gerrie Schipske, R.N.P., J.D. (Chair), Hedy Chang, Jorge Carreon, M.D., Shelton Duruisseau, Ph.D., Barbara Yaroslavsky

### **Advisory Committee on Physician Responsibility in the Supervision of Allied Health Care Professionals**

- Membership:** Determined by the President
- Responsibility:** To study the responsibility of physicians in the supervision of allied health professionals delegated to perform procedures in order to ascertain what actions should be taken to ensure responsible supervision. The goal of the Committee is to determine what regulatory, legislative, or enforcement actions need to be taken to ensure patient safety and report those to the Board.
- Staff:** Jennifer Simoes, Chief of Legislation
- Current Members:** Chair (Vacant), 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.

## COMMITTEES CREATED BY THE BOARD - CONTINUED

### Education Committee

- Membership: Determined by the President
- Responsibility: To serve the board as an advisory body on public and licensee information issues. Develops informational materials for publication and Internet posting, works with the media, and develops and recommends communications strategies, policies and programs for the board. Monitors and reports on the board's strategic communications plan.
- Staff: Jennifer Simoes, Acting Public Information Officer
- Current Members: Barbara Yaroslavsky (Chair), Jorge Carreon, M.D., Hedy Chang, Sharon Levine, M.D., Janet Salomonson, M.D., Gerrie Schipske, R.N.P., J.D.

### Enforcement Committee

- Membership: Determined by the President
- Responsibility: To serve as an expert resource and advisory body to members of the Board and its Enforcement Program by educating board members and the public on enforcement processes and by identifying program improvements in order to enhance protection of health care consumers.
- Staff: Renee Threadgill, Chief of Enforcement
- Current Members: Reginald Low, M.D. (Chair), Sharon Levine, M.D., Gerrie Schipske, R.N.P., J.D.

### Licensing Committee

- Membership: Determined by the President
- Responsibility: To provide oversight of the Board's licensing function by reviewing regulations, policies and procedures, and making improvement recommendations to the Board.
- Staff: Curt Worden, Chief of Licensing
- Current Members: 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.

## COMMITTEES CREATED BY THE BOARD - CONTINUED

### Physician Recognition Committee

Membership:	Determined by the President
Responsibility:	To solicit and review nominations for the board's award program to recognize physicians who provide outstanding service to the medically underserved. This committee meets annually to review nominations and select awardees.
Staff:	Kevin Schunke, Outreach Manager
Current Members:	None

### Wellness Committee

Membership:	Determined by President
Responsibility:	To achieve the Board's mission of consumer protection, the Wellness Committee shall keep the Board, licensees, and health care administrators informed on the benefits of available activities and resources which renew and balance a physician's life; further, to help licensees and administrators acknowledge that when a physician's personal and professional lives are balanced on all levels (physical, emotional, psychological, and spiritual), excellent patient care outcomes are best achieved.
Staff:	Kevin Schunke, Outreach Manager
Current Members:	Shelton Duruisseau, Ph.D. (Chair), Jorge Carreon, M.D., Silvia Diego, M.D., Daniel Giang, M.D., Laurie Gregg, M.D., William Norcross, M.D., Gary Nye, M.D.

## SUBCOMMITTEES OF TWO MEMBERS OR LESS

### Budget Subcommittee

Membership:	Determined by the President
Responsibility:	To meet with the Executive Director and Deputy Director to review budget documents, expenditures, and revenues.
Staff:	Linda Whitney, Executive Director Kim Kirchmeyer, Deputy Director
Current Members:	Barbara Yaroslavsky

### Cultural and Linguistic Competency Work Group

Membership:	Determined by the President
Responsibility:	To encourage activities designed to promote the cultural and linguistic competency of physicians.
Staff:	Jennifer Simoes, Chief of Legislation
Current Members:	Jorge Carreon, M.D. (Chair), Sergio Aguilar-Gaxiola, M.D., Ph.D., Shelton Duruisseau, Ph.D., David Hayes-Bautista, Ph.D., Barbara Yaroslavsky

### Full Board Evaluation Subcommittee

Membership:	Determined by the President
Responsibility:	To meet with the Executive Director and Deputy Director to review sunset review questions and responses.
Staff:	Linda Whitney, Executive Director Kim Kirchmeyer, Deputy Director
Current Members:	Janet Salomonson, M.D.

### Legislation Subcommittee

Membership:	Determined by the President
Responsibility:	To vet legislative proposals, amendments, and pending legislation with the Executive Director and Chief of Legislation; to participate in "meet and greet" events with legislators.
Staff:	Linda Whitney, Executive Director Jennifer Simoes, Chief of Legislation
Current Members:	Sharon Levine, M.D., Shelton Duruisseau, Ph.D.

## **SUBCOMMITTEES OF TWO MEMBERS OR LESS - CONTINUED**

### **Special Task Force on International Medical School Recognition**

Membership: Determined by the President

Responsibility: To work with the Chief of Licensing and licensing medical consultants to address the issues related the evaluation and re-evaluation of international medical schools.

Staff: Curt Worden, Chief of Licensing

Current Members: Reginald Low, M.D.

### **Strategic Plan Subcommittee**

Membership: Determined by the President

Responsibility: To revise the Board's Strategic Plan every three to four years.

Staff: Linda Whitney, Executive Director  
Kim Kirchmeyer, Deputy Director

Current Members: Sharon Levine, M.D., Barbara Yaroslavsky

### **Telemedicine Subcommittee**

Membership: Determined by the President

Responsibility: To promote access to health care and educate health care providers on the application of telemedicine, videoconferencing, and store and forward technology in the delivery of care.

Staff: Kevin Schunke, Outreach Manager

Current Members: Barbara Yaroslavsky



**MEDICAL BOARD OF CALIFORNIA**  
**Executive Office**



**APPROVED BOARD MEETING DATES  
FOR 2012**

<b>February 2 -3</b>	San Francisco
<b>May 3-4</b>	Los Angeles
<b>July 26-27</b>	Sacramento
<b>October 25-26</b>	San Diego