State of California

State and Consumer Services Agency

MEDICAL BOARD OF CALIFORNIA

February 2-3, 2012

Panel A	**February 2**	**8:00 a.m. - 1:45 p.m.**
Panel B	**February 2**	**8:00 a.m. - 1:45 p.m.**
Enforcement Committee	**February 2**	**2:00 p.m. - 3:00 p.m.**
Licensing Committee	**February 2**	**3:00 p.m. - 4:00 p.m.**
Full Board	**February 2**	**4:00 p.m. - 5:00 p.m.**
Application Review Committee	**February 3**	**8:30 a.m. - 9:00 a.m.**
Full Board	**February 3**	**9:00 a.m - 3:00 p.m.**

MEDICAL BOARD OF CALIFORNIA
BOARD MEETING SCHEDULE

Embassy Suites
San Francisco Airport
150 Anza Blvd.
Burlingame, CA 94010

February 2-3, 2011

Thursday, February 2

- **8:00 a.m. – 11:30 a.m.** — **Panel A – Santa Cruz Room**
  (*Members: Duruisseau, Bishop, Carreon, Diego, Salomonson, Yaroslavsky)*
- **8:00 a.m. – 11:30 a.m.** — **Panel B – Mendocino / Burlingame Room**
  (Members: Chang,Gnanadev, Levine, Low, Schipske)
- **11:30 a.m. – 12:00 p.m.** — ***Lunch Break***
- **12:00 p.m. – 1:45 p.m.** — **Panel A – Santa Cruz Room**
  (*Members: Duruisseau, Salomonson, Diego, Carreon, Yaroslavsky)*
- **12:00 p.m. – 1:45 p.m.** — **Panel B – Mendocino / Burlingame Room**
  (Members: Chang, Levine, Low, Schipske)
- **2:00 p.m. – 3:00 p.m.** — **Enforcement Committee – Mendocino / Burlingame Room**
  (Members: Low, Levine, Schipske)
- **3:00 p.m. – 4:00 p.m.** — **Licensing Committee – Mendocino / Burlingame Room**
  (Members: Salmonson, Carreon, Chang, Diego, Duruisseau, Schipske)
- **4:00 p.m. – 5:00 p.m.** — **Full Board – Mendocino / Burlingame Room**
  (All Members)

Friday, February 3

- **8:30 a.m. – 9:00 a.m.** — **Application Review Committee – Mendocino / Burlingame Room**
  (*Members: Schipske, Diego, Low)*
- **9:00 a.m. – 3:00 p.m.** — **Full Board Meeting – Mendocino / Burlingame 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
Michael Bishop, M.D.
Hedy Chang
Jorge Carreon, M.D.
Silvia Diego, M.D.
Shelton Duruisseau, Ph.D.
Dev Gnanadev, M.D.
Sharon Levine, M.D.
Reginald Low, M.D.

QUARTERLY BOARD MEETING

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

February 2-3, 2012

Embassy Suites-San Francisco Airport
Mendocino / Burlingame Room
150 Anza Blvd.
Burlingame, CA 94010
650-342-4600 (directions only)

AGENDA

Thursday, February 2
4:00 p.m. – 5:00 p.m.

Friday, February 3
9:00 a.m. – 3:00 p.m.

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

ORDER OF ITEMS IS SUBJECT TO CHANGE

Thursday, February 2

1. 4:00 p.m. Call to Order / Roll Call

2. Introduction and Swearing in of New Board Members

3. 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)]

4. Approval of Minutes from the October 27-28, 2011 meeting

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

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5. Discussion of Strategic Plan Objective 5.4 Annual Review of Committees; Establishment of Board Committees – Ms. Yaroslavsky and Ms. Kirchmeyer

Recess

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Friday, February 3

6. 9:00 a.m. Call to Order / Roll Call

7. 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)]

8. Physician Assistant Committee Update – Dr. Low

9. Enforcement Committee Update – Dr. Low

10. Licensing Committee Update – Dr. Salomonson

11. Federation of State Medical Boards Update - Ms. Chang and Ms. Whitney

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

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

14. President's Report - Ms. Yaroslavsky

15. Executive Director's Report – Ms. Whitney
    A. Staffing and Administrative Update
    B. Budget Overview – Ms. Kirchmeyer
    C. BreEZe Update – Ms. Kirchmeyer
    D. FISMA Update – Ms. Kirchmeyer

16. Special Faculty Permit Review Committee Update and Consideration of Applicant – Dr. Low

11:30 Lunch Break

17. 12:00 (Noon) Presentation: California's Health Care Workforce – Are We Ready for the Affordable Care Act? – Ms. Dower

18. Licensing Chief's Report – Mr. Worden
    A. Staffing
    B. Program Statistics
    C. Status of International Medical School Program

19. Licensing Outreach/Education Report - Mr. Schunke

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20. Midwifery Advisory Council Update
    A. Licensed Midwife Update – Ms. Ehrlich
    B. Discussion and Consideration of the Following Regulatory Proposals:
        1) Section 1379.23 – Physician Supervision and Collaborative Relationship
        2) Section 1379.24 – Midwifery Practice: Tests, Drugs, and Devices
    C. Consideration of Proposal to Modify Appointment Process to the Council

21. 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

22. Vertical Enforcement Program Report – Mr. Ramirez
    A. Status on Statistics
    B. HQE Organization and Staffing

23. Legislation/ Regulation – Ms. Simoes
    A. 2012 Legislation
    B. Status of Regulatory Action – Mr. Schunke

24. Consideration of Delegation to the Department of Consumer Affairs – Approval of Sponsored Events (Business and Professions Code Section 901) – Ms. Scuri

25. Discussion and Consideration of RegulatoryProposal to Implement Assembly Bill 1267 (Misdemeanor Conviction-Inactive Licensure) – Mr. Heppler

26. Update of Pharmacy Board Actions – Ms. Herold

27. Discussion and Consideration of Co-Sponsoring Pain Management Summit With Pharmacy Board – Ms. Herold and Ms. Whitney

28. Discussion and Consideration of Final Draft Strategic Plan - Ms. Yaroslavsky

29. Discussion and Consideration of Proposed Chiropractic Regulations Related to the Use of Lasers and Comments Thereto – Mr. Heppler and Ms. Scuri

30. Agenda Items for May 3-4, 2012 Meeting in Los Angeles

31. 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 Tim Einer at (916) 263-2389 or tim.einer@mbc.ca.gov or send a written request to Tim Einer. Providing your request at least five (5) business days before the meeting will help ensure availability of the requested accommodation.

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MEDICAL BOARD OF CALIFORNIA
Executive Office

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

October 28, 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 October 28, 2011 at 9:15 a.m. A quorum was present and notice had been sent to interested parties.

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

Members Absent:
Hedy Chang

Staff Present:
Janie Cordray, Research Specialist
Kurt Heppler, Staff Counsel
Teri Hunley, Business Services Manager
Kimberly Kirchmeyer, Deputy Director
Armando Melendez, Business Services Staff
Cindi Oseto, Licensing Program Manager
Regina Rao, Business Services Staff
Mary Beth Rodriguez, Senior Investigator
Eric Ryan, Supervising Investigator
Kevin Schunke, Outreach Manager
Anita Scuri, Department of Consumer Affairs, Supervising Legal Counsel
Jennifer Simoes, Chief of Legislation

DRAFT

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

Members of the Audience:

Teresa Anderson, California Academy of Physician Assistants
Gloria Castro, Office of the Attorney General
Yvonne Choong, California Medical Association (CMA)
Zennie Coughlin, Kaiser Permanente
Frank Cuny, California Citizens for Health Freedom
Karen Ehrlich, L.M., Midwifery Advisory Council
Julie D'Angelo Fellmeth, Center for Public Interest Law (CPIL)
Mara Felson, Member of the Public
Amanda Friedman, CPIL
Stan Furmanski, M.D., Member of the Public
Dean Grafilo, CMA
Laurel Holmes, CPIL
Heather LeMaster, Nizhoni Midwifery Institute
Babry Oren, BAO Health Resources Corporation
Carlos Ramirez, Office of the Attorney General
Loren Reed, Department of Consumer Affairs
Harrison Robbins, M.D., CACS
Gerri Ryan, L.M., Nizhoni Midwifery Institute
Tracy Smith, Sharp Grossmont
John Toth, M.D., California Citizens for Health Freedom

Agenda Item 2 Public Comment on Items Not on the Agenda

Mara Felson requested the Board's attention to a situation involving a number of physicians in Calaveras County. Ms. Yaroslavsky recommended that Ms. Felson speak with the Chief of Enforcement.

Frank Cuny, California Citizens for Health Freedom, reported they hope to introduce a bill this year to legalize the integrative treatment of cancer and ask for the Board's support of the legislation. Currently, physicians who utilize integrative cancer treatment can be arrested, as it can be a criminal offense to provide treatment other than chemotherapy, radiation or surgery. He distributed a variety of written materials on integrative cancer treatment.

Dr. Stan Furmanski stated one of the standardized tests the Board utilizes is the Microcog test for cognitive screening; the test is used at the clinical assessment program where California physicians requiring assessment are referred. He noted there are now three "whistleblowers" who have reported problems with the way the Microcog test is administered. He suggested it might be appropriate for the Board to do an audit to see if there may be irregularities or fraud in the administration of the exam and also recommended a review of all standardized testing practices.

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Agenda Item 3 Approval of Minutes from the July 28-29, 2011 Meeting
Dr. Levine made a motion to approve the minutes from the July 28-29, 2011 meeting; s/Carreon; motion carried.

Agenda Item 4 Access to Care Update
Ms. Schipske reported the Access to Care Committee met on October 27, 2011. Dr. Toni Sullivan, author of *Collaboration: A Health Care Imperative,* provided a presentation on the parameters that need to be followed for successful collaborative practices with a particular focus on the relationship between physicians and nurses. She stated further discussion on the scope of practice for physicians and advance practice nurses is needed to make sure the "lines" are clearly delineated while still encouraging collaboration.

Agenda Item 5 Physician Assistant Committee Update
Dr. Low provided a brief overview of the role, scope, and training of physician assistants (PAs). The Physician Assistant Committee (PAC), which is part of the Medical Board, is responsible for consumer protection, making recommendations about the scope of practice of PAs, and providing information about PAs to the health care community and others. The Delegation of Services Agreement between the supervising physician and the PA is an essential document that must be in place before the PA is allowed to practice.

The PAC met on August 22, 2011. The Committee received approval on two regulatory files. The first file requires PAs to post a "Notice to Consumers", similar to the Board's requirement for physicians. The second file provides for enhancements in the PA Enforcement Program. The PAC will soon begin work on amending the Disciplinary Guidelines in order to incorporate SB 1441 standards; the Diversion Program contract is also being amended to include these standards. Work on regulations to allow out-of-state licensees to provide their professional services at sponsored free healthcare events will soon begin, as well. A subcommittee has been working on a draft of the 2012 Sunset Report. The full PAC reviewed the report on October 10, 2011.

The PAC discussed the interpretation of the supervising physician's personal presence. A subcommittee was appointed to review the regulation; they met on October 3, 2011 and will meet again on November 10, 2011. Dr. Low and Medical Board staff will work closely with the PAC staff to ensure mutual concerns are addressed.

The PAC, which is a small organization, has a staff vacancy in the licensing area. This has created a licensing backlog. Authorization has not been received to fill the position. The Executive Officer coordinated a temporary, but significant, reassignment of staff to clear the backlog. This reassignment creates consequences for other programs within the PAC.

Agenda Item 6 Enforcement Committee Update
Dr. Low reported he met with staff on September 14, 2011 to discuss a plan to assist the Enforcement Program with improvements to the timelines. As a result of the meeting, Dr. Low is appointing a subcommittee to work with staff to review the details of the enforcement statistics and process in order to develop a plan of improvement that may include legislative recommendations. The Enforcement Committee can also help with the development of the evaluation report on the Vertical Enforcement Program which is due to the Legislature in March 2012.

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Staff will be looking at additional medical training opportunities for administrative law judges, deputy attorneys general, and Enforcement Program staff and will report their findings back to the Committee. Dr. Low has volunteered to be the initial medical training liaison; as such, he will work with staff and the Office of Administrative Hearings to provide the training on medical subjects in the spring or summer of 2012.

Agenda Item 7 Special Faculty Permit Review Committee Update and Consideration of Applicants and Committee Member Change

A. 2168 Applicants

Dr. Low reported that per section 2168 of the Business and Professions Code, the Board is authorized to issue a special faculty permit to a person who is deemed to be academically eminent under the provisions of the statute and meet the other eligibility requirements for issuance of a permit. The review committee consists of one representative of each of the eight medical schools in California and two board members. A teleconference meeting of the Special Faculty Permit Review Committee (SFPRC) was held on September 15, 2011 to review applications for Daniel Hommes, M.D. (UCLA-DGSOM), and Georg Wieselthaler, M.D. (UCSF-SOM). Curt Worden, Chief of Licensing, provided a brief synopsis of each applicant's qualifications.

Dr. Low made a motion to approve Dr. Hommes for the issuance of a Special Faculty Permit at UCLA; s/Salomonson; motion carried.

Dr. Low made a motion to approve Dr. Wieselthaler for the issuance of a Special Faculty Permit at UCSF; s/Levine; motion carried.

Dr. Low requested that the chair of the Licensing Committee appoint a licensing subcommittee of one physician member to work with staff and legal counsel to research the need for a more defined Special Faculty Permit application and to revise the required supporting documentation, including the possible need to update the regulation. He noted that there was no follow-up once the physicians were issued a permit and felt this should be part of the Board's responsibility. Mr. Worden noted the permits must be renewed every two years, but there is no time limit on how long the permit may be held.

B. Stanford University Committee Member Change Request

Stanford University has requested to change their SFPRC member from Lawrence Shuer, M.D., to Clarence Braddock, M.D., M.P.H., Associate Dean for Graduate Medical Affairs.

Dr. Low made a motion to approve this change; s/Levine; motion carried.

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Agenda Item 8 Licensing Committee Update

Dr. Salomonson reported the Licensing Committee met on October 27, 2011. At the meeting, a presentation was made by Cindi Oseto, Licensing Manager, on the licensing process for international medical school graduates. Mr. Worden provided a presentation on the designation and recognition of international medical schools. Clarification was provided on the lists of international medical schools maintained by the World Health Organization (WHO)/ University of Copenhagen and the Educational Commission for Foreign Medical Graduates (ECFMG). Applicants from these schools may assume their school should be recognized by the Board by nature of being included on these lists, however these organizations do not accredit or approve medical schools.

A process is in place for the re-evaluation of previously recognized international medical schools, which by law must be reviewed every seven years, but has been postponed due to staffing shortages.

Agenda Item 9 Federation of State Medical Boards Update

Ms. Whitney reported that Ms. Chang will continue to provide updates to the Board on the License Portability Pilot Project that includes ten states. The American Board of Medical Specialties is working on a Maintenance of Certificate Program in collaboration with the FSMB. The FSMB board of directors is revising and updating its policy statements to be voted on at the April 2012 House of Delegates meeting.

Board staff has received the draft Reentry to Practice Report that will be presented at the FSMB's April meeting. Ms. Whitney reported she has assigned a medical consultant to assist staff in its review of this document so the Board's comments can be transmitted to the FSMB by December 12, 2011.

The Board has been contacted by the FSMB regarding attendance at an upcoming meeting. Dr. Ram Krishna, FSMB's Liaison Director to the Board, and Dr. Hank Chaudry, President and CEO of the FSMB, will attend the Board's May 2012 meeting in Los Angeles. This will immediately follow the FSMB's annual meeting, so they will be able to provide members with an update on the meeting and resolutions that were passed. As requested by Dr. Levine, an update will be provided on the maintenance of licensure issue at this time.

On October 20, 2011, staff participated in a roundtable discussion with the ECFMG that was sponsored by the FSMB. Discussion focused on ECFMG's plan to require all international medical schools to be accredited by 2023. Staff will monitor this closely and will work with the ECFMG as needed.

The FSMB is accepting nominations for the board of directors and nominating committee. No Board members have expressed an interest in being nominated for these elected positions.

On November 9-10, 2011 the FSMB is sponsoring a board attorney workshop in Florida. An out-of-state travel request was submitted for Kurt Heppler, Staff Counsel, to attend the meeting, but the request was denied by the DCA due to the travel freeze. On October 13, 2011, the new State Policy and Government Relations Associate of the FSMB contacted the Board to offer assistance in tracking federal and other state legislation.

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Per Ms. Schipske's request, Ms. Whitney contacted the FSMB regarding the collection of processing times for applications and licensure in other states. Unfortunately, the FSMB does not collect data on processing times, but referred staff to the composite requirements and statistics for 2012. They also suggested the Board pose a question to other state medical board's executive directors through the Administrators in Medicine. Responses that are received will be summarized and presented to Ms. Schipske.

The Board has received a draft report examining the metrics that are used by the FSMB related to the Composite Action Report. This will be presented at the April 2012 FSMB meeting. Ms. Whitney will assign a medical consultant to assist staff in its review of the document; comments will be transmitted to the FSMB by the December 15, 2011 due date.

Agenda Item 10 Health Professions Education Foundation Update
Ms. Yaroslavsky stated the HPEF Board of Trustees meeting was held in the fall; the Foundation is moving forward with its mission critical functions. The Steven M. Thompson Loan Repayment Program awarded 76 loan repayment awards for a total of $8,053,000 dollars; this includes almost $3 million from a fund matching program with the federal government.

Agenda Item 11 Board Member Communications with Interested Parties
No interested party communications were reported by members.

Agenda Item 12 President's Report
Ms. Yaroslavsky thanked Dr. Michel Sucher and Dr. David Greenberg for their informative presentation on the diagnosis of substance use disorders and determining when a physician is safe to practice medicine.

During the past quarter, Ms. Yaroslavsky attended a meeting with the Agency Secretary, the Director of the DCA, Ms. Whitney and Ms. Threadgill regarding the Board's Enforcement Program and the Public Citizen allegations. Staff has been working on an examination of the data mentioned in the Public Citizen's report. Two thirds of the data cited is past the statute of limitation and has been purged due to retention requirements. A follow up meeting with the Governor's Office, staff, and the Attorney General's Office is scheduled for November 9, 2011.

Ms. Yaroslavsky continues to have weekly calls with staff, as well as participate in monthly calls with the Director of the DCA, all executive officers, and board chairs. Discussions focus on travel restrictions, hiring freezes, board appointments from the Governor's Office, and other relevant updates. The next conference call is scheduled for December 8, 2011.

Agenda Item 13 Executive Director's Report
A. Staffing and Administrative Update
Ms. Whitney recognized staff that has been performing multiple jobs to cover vacancies that have gone unfilled due to the hiring freeze. She reported she participated in the Administrators in Medicine (AIM) Western and Center Regional meeting. Executive directors from approximately 20 licensing agencies discussed successes and issues related to how cases are reviewed, prioritized and evaluated, including the most likely cases to lead to discipline.

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Ms. Threadgill, Ms. Cady and Ms. Whitney met with the presiding judges of the Office of Administrative Hearings (OAH) to inform them of the Board's strategic planning process, the March 2012 deadline for the Vertical Enforcement Prosecution Report, and the schedule for the Board's sunset review process. The meeting also included discussion on training needs per the Government Code, re-licensure issues, international medical school issues, new laws that will be effective in 2012, and enforcement issues. The Board will send some of the OAH judges and deputies from the Attorney General's Office to the Coalition for Physician Enhancement Conference for presentations on the impact of aging on physician clinical performance and quality of care. The individuals attending will, in turn, provide the information from the conference to their staff.

Staff has begun examining statistics for the evaluation of the Vertical Enforcement process; the Attorney General's Office provided some data, but it was not prepared in the same manner as the board's which prevented a true comparison. Staff will continue to work with the AG's Office on the collection of data, with the issue hopefully resolved by the middle of November 2011.

Ms. Whitney reported she has been in contact with the Branch Manager of Policy and Research at the National Practitioners Data Bank (NPDB) regarding coming to California to provide training to staff on reporting requirements and other services. If NPDB representatives are able to come, other licensing agencies will be included in the training; if they are not able to come, a webinar will likely be scheduled for staff.

A meeting has been scheduled for November 9, 2011 with the Governor's Office, the Attorney General's Office, the Department, and staff to discuss the Board's Enforcement Program and timelines. Mr. Worden and Ms. Whitney met with the graduate medical education deans of the UC campuses to discuss various licensing issues and to update each of them on the Board's licensing activities. The next quarterly meeting is scheduled for February.

The Department has provided its implementation memo on the requirements for the expert reviewer contracts. These guidelines will be reviewed to determine the impact on timelines for enforcement and will be reported back to the Board at its next meeting.

Per a request from Dr. Low, staff has asked AIM to post a survey of other state boards regarding their use of faculty permits or similar programs related to licensure laws; the results of the survey will be reported back to the Licensing Committee.

Ms. Kirchmeyer reported that on October 11, 2011 the Board was informed that, based upon the Financial Integrity and State Manager's Accountability Act (FISMA), the Department needs to identify and report the most significant risks in the department and implement a plan to reduce or mitigate those risks. The Department has asked the Board to identify the three highest risks the Board is facing today; explain the probability and impact of each risk; and explain what steps have been taken to date to reduce or mitigate the risk. Ms. Whitney and Ms. Kirchmeyer will meet next week to discuss and provide a response to DCA.

Staff also responded to a request from the State Personnel Board (SPB) via the DCA regarding the translation of Board documents and forms, including those on its Web site. The State Personnel Board had identified a deficiency in the Spanish translated documents based upon the

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Board's reporting on the required Biennial Language Survey. The SPB asked for information on which documents have been translated and the Board's plan for translating any other documents into Spanish. Spanish-translated documents were identified, including the Board's complaint form, enforcement process brochures, tip sheets, and several other consumer pamphlets. However, forms specific to applicants and licensees will not be translated since those individuals must speak English to take the licensing examination and therefore would be required to be able to complete the forms in English. On October 24, 2011, staff was contacted by Senate Pro Tem Darrell Steinberg's Office with a similar request. According to the Pro Tem's staff, they are gathering information about the availability of multi-lingual services in various sectors of state government. Staff will be putting together a response for Senator Steinberg's Office next week and will also include all the languages spoken by investigative staff that has made presentations at ethnic organizations.

With regard to staffing, at the last meeting, Ms. Kirchmeyer reported the Board had 58 vacancies, including the Consumer Protection Enforcement Initiative positions. At the end of October, the Board will have 71 vacancies, including the CPEI positions. This number does not include 2 future vacancies occurring due to retirements or staff transferring out of the Board. 71 vacancies equates to a 25% vacancy rate at the Board.

The Board is still allowed to hire individuals within the Board and from the Department; however, freeze exemptions requests must be submitted to fill any positions with individuals outside of the Board or the Department. The Board has submitted eleven freeze exemptions to the DCA. Five of the freeze exemptions have been approved by the Governor's Office including Medical Consultants in Licensing and in Enforcement, four Supervising Investigators, five Investigators, and (on October 20, 2011) six office technicians in the Licensing Unit. Three of the freeze exemptions (for the Public Information Officer, three Associate Governmental Program Analysts in the Licensing Program, and an Administrative Assistant in the Executive Office) have been approved by the Department and by State and Consumer Services Agency and are currently pending at the Department of Finance. These were submitted to the Department of Finance on October 12, 2011. The State and Consumer Services Agency denied the Board's request for an Executive Assistant in the Executive Office. Lastly, three of the freeze exemptions are pending review by the Department; these are for Advisory Medical Consultants, four inspectors that do the probation monitoring, and seven more investigators.

There was discussion among members on the impact of the hiring freeze on staff and the Board's operations. Ms. Whitney noted that some functions and projects, such as the review and re-review of international medical schools, have been delayed due to staffing shortages. She reported that voluntary overtime has been implemented to ensure that licensing applications are reviewed in a timely manner, adjustments have been made in how incoming complaints are triaged, and the August Midwifery Advisory Council meeting had to be canceled.

Ms. Schipske suggested that the Board direct Ms. Yaroslavsky, as Board President, to contact both the Secretary of the SCSA and the Governor's Office regarding its concerns. In light of the fact that the Board's funds come from licensee fees, not the General Fund, she stated it does not make sense for the Board to be subject to the same cuts and reductions as departments that derive their revenue from the general fund. If staff cannot perform the functions for which the license fees have been paid due to staffing shortages, then negative public comment will be forthcoming.

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She expressed concern over the impact of staffing shortages to existing staff and the ability of the Board to perform its mandated public protection role.

Ms. Schipske made a motion for Ms. Yaroslavsky to personally contact and send a letter to the Governor's Office and the SCSA Secretary expressing the Board's concerns as discussed; s/Duruisseau.

Ms. Yaroslavsky noted she has had direct contact with the Darrell Steinberg, President Pro Tem of the Senate, John Perez, Speaker of the Assembly, as well as the Governor's staff on the current situation. She also has had conversations with members of the legislature to remind them that the Medical Board is a special funded board.

Dr. Salomonson and Dr. Levine spoke in support of the motion.

Karen Ehrlich, LM, suggested that a copy of the letter also be sent to the Los Angeles Times.

Ms. Yaroslavsky called for the vote. Motion carried.

Ms. Kirchmeyer noted that the Board is still under the travel freeze; any travel for staff that is not enforcement related requires the submission of a Travel Expense Claim that must be pre-approved by the DCA. Approval has been received for most requested trips, but submitting requests creates an additional workload. There has not been any information regarding when or if this freeze will be lifted.

B. Budget Overview

Ms. Kirchmeyer directed members to the budget reports on pages 114 through 121 of the meeting packet. Page 114 shows the most recent fund condition for the Board. The fund condition reflects anticipated costs due to re-establishment of the Operation Safe Medicine Unit, the BreEZe project, and also the cost for accepting payments via credit card.

Ms. Kirchmeyer noted that Board was audited by the Bureau of State Audits in 2007. At that time, the Board's fund was over the mandated two-month level of reserve and the Bureau recommended that the Board consider reducing licensing fees in order to not exceed its mandate. Since that audit, the Board has sponsored legislation that moved the mandate from two months to between a two to four month reserve. The Bureau continues to follow-up on the implementation of their recommendation on a yearly basis; on September 28, 2011 the Board received a letter from the Bureau requesting the status of the recommendation. The Board responded to the Bureau with the attached fund condition indicating that, at this time, the Board is projected to be at the mandated level at the end of Fiscal Year 2011/2012 and projected to be even lower in the following fiscal years. This is due in part to several items, including the $9 million loan to the General Fund and also the anticipated costs mentioned previously. It would not be prudent for the Board to consider a reduction at this time. Although the Board was at a 6.7 month reserve at the end of this past fiscal year, it is projected to be at 4 months at the end of this fiscal year and is projected to drop to 1.5 months reserve in fiscal year 2013/2014. The large increase in the reserve last year was largely due to the hiring freeze, the inability to hire staff and therefore the large vacancy rate, as well as the inability to travel and make purchases for large items, such as vehicles.

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The level of the reserve will be revisited at the end of this fiscal year when staff has a better idea of this year's spending and any other items that may impact the Board's fund condition.

Ms. Whitney indicated that, should the Board drop below the 2-4 month reserve level, license fees would not be increased; the Legislature would be required to address the return of part of the General Fund loan money to the Board. At this point, there is no set deadline for the return of the loan money; it will be returned to the Board on an as needed basis.

Page 115 of the packet shows the entire Board's actual expenditures as of August 31st. Ms. Kirchmeyer reported the Board is right on target for this time of year and there is nothing that raises any concerns.

C. BreEZe Update

The contract for BreEZe, the comprehensive licensing and enforcement IT system for all DCA boards and bureaus was signed with a company called Accenture at the end of September. Ms. Whitney and Ms. Kirchmeyer attended the BreEZe launch event on Wednesday, October 26th. SCSA Secretary Caballero spoke at the event as well as the Deputy Secretary from the California Technology Agency. The meeting was to introduce the project team and provide the boards and bureaus a demonstration of the system. Due to the delay in the contract being signed, the project is about one month behind schedule, however it is anticipated that the system will be running by this time next year.

Since the vendor is now on board, Board staff will need to become very involved to ensure that the system meets the Board's needs. Two staff members from the Information Systems Branch are working at DCA on the project. Additionally, core subject matter experts and managers attended meetings with the vendor this week where a demonstration of the detailed system was presented.

Staff from the Medical Board will be required to attend system configuration interviews with the vendor beginning November 28th through December 7th. This is the most important part of the project. However, with the freeze still in place and having multiple vacancies, attendance at these meetings will impact the Board's functions. If necessary, mission critical overtime will be authorized for employees to perform their core functions while they are involved in the BreEZe project.

The most significant risk for the project is data conversion. Staffing shortages will have a negative impact on this risk, as there must be enough staff to clean the data once reports have been run showing data that must be updated prior to conversion. The Board will know more once the vendor has identified the mitigation on the data conversion.

Agenda Item 14 Consideration of Modified Text for Polysomnographic Technologist Regulations

Kurt Heppler, Staff Counsel, reported the Board has previously discussed the implementation of the polysomnography program. Eligibility for registration was an issue in previous discussions, as there was concern that the initial recommendation would only grandfather in those persons who have been practicing polysomnography safely for five years from the examination requirement. The proponents of the measure thought the grandfathering should apply to all the

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registration requirements, not just the examination requirement. The statute was somewhat vague on the matter; as such, the proponents took the opportunity to clarify in legislation that the grandfathering of the safe practice of polysomnography for five years entitled the applicant release or waiver from all requirements. The Board has modified its current regulations to conform to the statute. Correspondingly, changes have also been made to the work experience form and the application form, so they, too, conform to the changes in the statute. Mr. Heppler distributed and directed members to the third modified text which will be submitted for a fifteen-day comment period. If any adverse comments are received, the matter will come back before the Board.

Dr. Levine made a motion to authorize the Executive Director to adopt the regulations at the conclusion of the fifteen day comment period if there are no adverse comments; s/Low.

David Gonzales, California Sleep Society, offered public comment in support of the regulation.

Ms. Yaroslavsky called for the vote; motion carried.

Agenda Item 15 Licensing Chief's Report

Mr. Worden reported staff has been working on a revision of the license application for physicians and surgeons. The first draft has been completed and submitted to other licensing staff and managers for comments and suggestions; the revised draft will then go to legal for review and approval. He hopes this process will be completed by January 2012.

There is one specialty board application pending; staff is waiting on a response from the applicant.

A. Staffing

Mr. Worden commended staff for the excellent job they have been doing in spite of the staffing shortages. Licensing Program managers have been working a lot of extra hours to keep things running and staff have provided back up support to each other. He noted that, on occasion, there are only two people working in the Call Center. There are eight US file reviewer positions; of these, two are experienced reviewers (one has been out on extended leave), four are new reviewers in training, and 2 positions are vacant. There are no applications for these vacancies (applications may only come from within the Department as there is no freeze waiver for these positions). There are 2.8 Associate Government Program Analyst vacancies in the Licensing Program. These positions are responsible for performing the more complex, higher level analytical duties such as senior level application review, international medical schools, training, and policies and procedures. Licensing managers are currently performing these duties in addition to their regular work, but delays are inevitable.

There will be a new vacancy for an international file reviewer on November 1, 2011; this position has been advertised. Another reviewer will be out on medical leave for at least two months. Two international reviewers are new and are in training; it typically takes 6-9 months to become fully trained. Again, staff is covering the duties, but it is very stressful.

Currently, Mr. Worden reported there are 14.6 vacant positions in the Licensing Program. This equates to a 26% vacancy rate.

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B. Program Statistics

Mr. Worden directed members to the Workload Report on page 124 of the meeting packet. The Board received 1,711 applications for physicians and surgeons during the first quarter of FY 11/12; 1,491 initial reviews were completed during this period. Pages 128 and 129 show a five year history of applications received and licenses issued.

There are currently 108 applications requiring a second level of review. Dr. Salomonson requested additional information on these files to see if there are any trends the Board should be aware of. Ms. Whitney noted information on the number of actions taken on license applications in previous years is included in the Annual Report to the Legislature.

The licensing statistics for the week ending on October 22, 2011 were emailed to members; there were 169 new applications received that week. The initial review was 44 days for US file applications and 30 days for international applications; pending mail was 7 days for both types of files.

C. Status of International Medical School Program

A detailed list of the international medical schools requiring review is included beginning on page 130.1 of the packet. The list, which grows weekly, includes schools who have submitted a self-assessment report as well as schools listed on applications for PTALs or licensure that are not on the Board's list of recognized schools. There are currently 62 medical schools in pending status. Some schools have been on pending status for a while due to the vacancy for the international medical school analyst position. Mr. Worden has been covering some of these duties, but there have been inevitable delays. The freeze waiver request for this position is currently at the Department of Finance for review.

During the past quarter, four international medical schools provided the necessary documentation to meet the requirements for recognition pursuant to 16 CCR 1314.1(a)(1); these are the government recognized schools that are owned and operated by the government or a non-profit agency whose primary goal is to train the citizens of its own country.

Ms. Yaroslavsky suggested that it might be appropriate to prioritize the list of schools requiring review so the schools with the most applicants awaiting a review of their school are given the highest priority.

Agenda Item 16 Licensing Outreach Report

Kevin Schunke, Outreach Manager, reported an exemption from the travel restrictions had been granted in order to continue the Board's outreach at licensing workshops and fairs for new residents. He thanked the members and staff for their work in securing the approval for travel. Since the last Board meeting, Mr. Schunke has traveled extensively throughout Southern California and the Bay Area conducting outreach to graduate medical education programs. He has received several requests for licensing outreach visits and licensing fairs in 2012. Future travel has not yet been approved, but he is hopeful that approvals will be granted.

Mr. Schunke and Mr. Worden will meet to discuss the July 1, 2012 licensing deadline for 2065/2066 applicants and whether or not to continue with the matrix that was developed to track

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these applicants. In previous years, the matrix has proven highly effective in ensuring that these individuals were licensed by the deadline. Each year, the number of programs and hospitals that participate in the matrix has increased. Mr. Schunke indicated, while out in the field, he receives highly positive feedback on the licensing staff and the improvements that have been made in the licensing timelines.

During public comment, Robin Meehan, House Officer and Administrative Manager for UC San Diego, expressed her appreciation for the valuable service Mr. Schunke provides. She also noted the value of the matrix to their program, with all applicants requiring licensure being licensed on time.

Agenda Item 17 Midwifery Advisory Council Update

A. Licensed Midwife Annual Report Statistics and Update

Karen Ehrlich, L.M., Chair of the MAC, directed members to the 2010 Licensed Midwife Annual Report Summary starting on page 131 of the packet. She noted that the number of clients served under the supervision of a licensed physician was only 6.5%. Physician supervision of licensed midwives is essentially unavailable in California, primarily due to malpractice insurance requirements that the physicians not assist anyone who is helping with a home birth. The percentage of clients served with physician collaboration was around 58%; a significant number of midwives are able to secure some level of cooperation and consultation with physicians to ensure the best possible care for mothers and babies. This number could be higher if malpractice insurance requirements allowed physicians to assist licensed midwives in home births. In 2010, the number of clients served by midwives who were considered good candidates for homebirth at the onset of labor was 2,245. The transfer rate of women or newborns requiring transfer to a hospital is about 20%; this is consistent with data from home birth practices throughout the United States, Canada, Holland, and other countries where home birth is accepted and supported. This shows that California midwives are doing their job in identifying mothers and babies in need of extra care during labor or birth or afterwards. This also means that 80% of the mothers who chose home birth are successfully giving birth at home and remain healthy throughout the process of birth and postpartum.

The cesarean rate for women who began labor at home but later transferred to a hospital is 8%. This is at a time when the U.S. cesarean rate is at 34% and rising (this number includes women who were unhealthy to begin with or who developed problems during the pregnancy, so a true comparison of the rates is not possible). This low rate of intervention represents a significant cost savings to the health care system. There is a major push within medicine to lower overall hospitalization rates, including for those who are very sick; Ms. Ehrlich suggested midwifery care as a way to lower hospitalization rates and medical costs for healthy women.

The reported maternal mortality rate for 2010 was zero. The perinatal mortality rate is unclear as in one location of the form it appears that there were 2 perinatal deaths reported (after the transfer of care) and in another location as many as 7 instances of fetal demise (after the transfer of care). Ms. Ehrlich stated this discrepancy in the collected data is reason to change the reporting system to the one used by the Midwives Alliance of North America (MANA) which is epidemiologically designed and overseen by specialists in the field of research and epidemiology. Ms. Ehrlich stated that the current reporting system is clearly flawed. She will be asking the MAC to discuss moving to the MANA statistics system.

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Ms. Ehrlich reported she has put together a summary of the results from the four years the Licensed Midwife Annual Report has been used; Ms. Thompson will put the summary into a computerized format. She noted the outcomes were remarkably consistent over the four year period, with the majority of transfers of care being due to non-emergency reasons, such as maternal exhaustion, dehydration, requests for pain medication, etc. Ms. Ehrlich indicated this was evidence that the midwives were doing their jobs well.

Ms. Ehrlich reported that the physician supervision requirement continues to create barriers for midwives caring for their clients. The Council will be addressing regulations to define the appropriate level of physician supervision at its next meeting. However, she is not convinced that regulations will correct the difficulties midwives face in obtaining lab accounts, renting office space, etc. Ms. Ehrlich expressed her hope that the Board would work with the midwives in the combined mission of protecting the consumers of California.

Dr. Carreon asked why physicians are unwilling to help or back-up midwives.

Ms. Ehrlich stated that the malpractice insurance companies prohibit physicians from providing home birth back-up. She noted that physicians who do so are threatened with the loss of their malpractice insurance, sometimes retroactively, if they provide back-up. There are a significant number of obstetricians who believe midwives should not be working, and that there should be no homebirths. She also recognizes that there are obstetricians who might help if midwives were to operate according to standards that they consider appropriate. However, Ms. Ehrlich noted the ACOG standards are obstetrical *medical* standards, which are not *midwifery* standards and do not necessarily work for home births. Further, a midwife operating according to the ACOG standards could be prosecuted for the unlicensed practice of medicine. Midwifery standards are different, as midwifery is a distinct and separate profession. These standards must be recognized as doing a good job; the statistics show this to be true.

Dr. Salomonson suggested that the statistics on outcomes be presented to the malpractice insurance carriers, as they base their rates on statistics.

Ms. Schipske recommended finding another legislative sponsor to support midwifery issues.

Ms. Ehrlich indicated she has tried on numerous occasions to find a sponsor, as has the California Association of Midwives, without success.

Agenda Item 18 Enforcement Chief's Report

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

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

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

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B. Expert Utilization Report

Ms. Threadgill reported the Board used 382 experts to review 672 cases during the past quarter. The number of experts in the Enforcement Program's database continues around 1,200. Experts are being sought in psychiatry, addiction medicine, and pain management specialties. The passage of SB 541 provides an exemption for the Board from the lengthy process that would otherwise have to be followed to obtain contracts with medical experts; however the manner in which the contracting must be done may increase timelines slightly.

She noted that providing adequate training for potential experts has been an on-going challenge. Deputy Chief Laura Sweet has been working on improvements which include providing interactive training to the reviewers. However, there have been technical obstacles that may prevent the interactive portion of the training as was originally envisioned. Deputy Chief Sweet will provide a status report regarding this at the next quarterly meeting.

C. Enforcement Program Update

1. Staffing

Ms. Threadgill announced the promotion of Eric Ryan to the Supervising Investigator position in the San Diego District Office.

The Enforcement Program has a current vacancy rate of approximately 25% for supervisor positions, 19% for investigator positions, and 21% overall. The Program received five investigator freeze exemptions and immediately conducted interviews and moved forward with the hiring process. Identified candidates are currently undergoing background checks. An additional seven investigator exemptions have been requested; these positions have been advertised and interviews are under way to fill those positions in anticipation of the receipt of the requested exemptions. A candidate has also been selected for the Fresno supervising investigator position and the background check is underway. Freeze exemptions were also received for medical consultant positions which are currently being filled.

The next priority for the Enforcement Program will be training for the new hires. Fortunately, the majority of the investigator candidates that are in background will not require a basic academy and will only need to have an abbreviated training course from the Medical Board.

The Department is currently conducting a pre-audit risk assessment of the Central Complaint Unit (CCU) that is anticipated to last approximately one month. The purpose of the risk assessment is to identify areas where process improvement is necessary. The individual conducting the assessment is from the DCA Audits Unit; he has been provided space at MBC headquarters to facilitate his access to procedure manuals, the complaint intake process, prioritization, and employee interviews.

The CCU continues to receive an increased number of consumer complaints. At the May 2011 quarterly Board meeting, Ms. Threadgill reported the CCU was experiencing an unprecedented number of vacancies resulting from retirements and promotions while faced with an increased number of complaints. As a result, staff re-examined priorities for the expenditure of resources and determined it was not possible to pursue certain complaints such as advertising violations, fictitious name permit and/or corporate practice of medicine issues, billing or fraud complaints from patients or insurance companies, patient abandonment, HIPAA / breach of confidentiality

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issues, or testimony as a medical expert. Ms. Threadgill stated she is pleased that the Complaint Unit is once again able to pursue these complaints. The vacant analyst positions have been filled. Additionally, an analyst was hired to staff the Citation and Fine Program.

2. Program Statistics

Ms. Threadgill directed members to page 143 of the meeting packet for statistics on the investigative prosecution timelines, noting that the statistics displayed on this page are based on the calendar year as opposed to the fiscal year. The average days to conclude an investigation not resulting in prosecution continues to decrease. Although the timeline remains over the Board's statutory goal, there has been improvement in this area. The average days to obtain a suspension order have decreased in comparison to the previous two years.

The number of citations issued decreased due to the vacant citation analyst position. She noted that the numbers for the past quarter show this problem is being resolved with the new analyst now in place. There has not been much variance from fiscal year to fiscal year in the average days to complete the Complaint Unit processes. In the investigative process, the length of time it takes to acquire medical records continues to be a problem. Although the timeline has not increased during periods of multiple challenges, there remains room for improvement. Staff will have the opportunity to work with members of the Enforcement Subcommittee to identify additional process improvements.

In July 2008, the Enforcement Program staff made recommendations to the Board and set goals to improve the investigation process timeline. Ms. Threadgill noted the Program is on track to meet these goals. The time it takes to complete the investigation process continues to decrease. The goal is 275 days; during the last fiscal year, the time was down to 312 days, reflecting a steady decrease. The overall time to complete the entire administrative process is still a problem that needs to be addressed.

Since the 2008 report, the Program has achieved significant accomplishments, which include: obtaining an amendment to B&P §2225.5 that requires the production of certified medical records; conducting statewide training for investigators and Deputy Attorneys General on the acquisition of medical records; holding meetings with Kaiser South and Kaiser North regarding implementation of efficiencies in producing medical records; and most recently, establishing a system with Kaiser North for the electronic exchange of requests and medical records. This system has been implemented in CCU as well as the District Offices. Staff anticipates this will improve timelines in the records acquisition area and will pursue establishing a similar system with Kaiser South and other facilities.

The Enforcement Program obtained an agreement with the Office of the Attorney General to assist with the preparation of subpoenas and also revised the subpoena policy to greatly reduce the preparation time. It is also anticipated that the time to complete the subject physician interview will decrease with the implementation of AB 1127 which provides incentives for physicians to attend and participate in physician conferences when requested. Additionally, policies have been modified to expedite the method of contact with physicians.

Staff has worked with the DCA Exam Unit to offer continuous testing for investigators. This change, in addition to the establishment of a new investigator classification, has facilitated the

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retention of investigators. Staff continues to seek freeze exemptions to hire investigators. Online continuous testing for medical consultants has also been implemented.

Additional accomplishments since the 2008 report include the implementation of the Aged Case Council in 2009, the placement of manuals and templates online for easier access, time management training for investigators, legislation was obtained to exempt the Board from the contract process for hiring expert reviewers (SB 541), revision of the Vertical Enforcement (VE) manual and guidelines to streamline processes and procedures, beginning the revision of the Expert Reviewer training program, and the revision of the Model Disciplinary Guidelines. Comprehensive statistical reporting was developed for reporting critical data markers. As mentioned by Ms. Whitney, Enforcement Program staff met with the Office of Administrative Hearings (OAH) presiding justices to discuss possible improvements to the administrative process, including providing an update on the Disciplinary Guidelines that will be filed with the Secretary of State in mid-January 2012.

Ms. Threadgill reported that each month, beginning November 1, 2011, staff will send to the Health Quality Enforcement Section a list of all cases that the Board shows as pending without an accusation for 60 days or more. This effort will assist in reconciling the data.

Ms. Yaroslavsky asked Ms. Threadgill to clarify whether a doctor who has signed a stipulation for terms and conditions of probation can choose which program he or she would like to go for remediation or if the Board chooses the program. Ms. Threadgill stated that if the term and condition is for assessment and clinical training, the program must be approved by the Board. The Board has approved the PACE program as a qualifying program but will accept any equivalent program.

Agenda Item 19 Vertical Enforcement Program Report

Carlos Ramirez, Senior Assistant Attorney General reported the HQES was created in 1991; in 2006 the Vertical Enforcement Program (VEP) was implemented. The VEP is a highly interactive system of service delivery, requiring investigators and deputies to work together on some of the most important aspects of the investigation process. Mr. Ramirez reported Attorney General Harris is both interested in and supportive of VE. There have been fiscal challenges such as furloughs and the hiring freeze that have impacted timelines.

B. Presentation on Statistics

Gloria Castro, Supervising Deputy Attorney General, directed members to pages 148.5 through 148.13 for information on the HQES program and statistics. She noted the statistics were initially compiled in response to a Medical Board evaluation (B. Frank report); the statistics continued to be compiled in the same format in order to allow comparisons with previously reported data. Ms. Castro acknowledged that there will be differences between the information presented by the AG's Office and the information presented by the Enforcement Program. HQES looks forward to continuing to work with the Board to decide on proper benchmarks on how statistics are reported.

Ms. Castro reported the data is collected in various ways. She stated that the AG's Office is getting better at documenting and auditing processes, so the Board receives the most correct representation of the AG's cases, both good and bad. The AG's Office uses a system called

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ProLaw, where the data is entered into the system by the DAG assigned to the case, according to set policies. A case management system is used to run reports from ProLaw. As the data continues to change as time goes forward and cases are closed and new ones are added, the numbers reported will continue to change. Every effort is made to be thorough. The AG's Office uses "average days" for reporting, since the Board also reports in average days. Ms. Castro noted that the AG begins their statistical computation from January 1, 2006 (when the VE was implemented), whereas the Board reports using the fiscal year; this is one of the items that the two entities will need to reach consensus on so reporting is consistent.

Page 148.5 indicates the length of time it took for the AG's Office to send a pleading to the Board for filing after receiving a completed investigation. The statistics for 2005 through 2009 represents data that was compiled by calendar year. The statistics for 2010 represent a thumbnail of the entirety of cases received and sent for pleading in 2010, reflecting an average of 42 days to send a pleading to MBC for filing; this represents a steady decline in the number of days required over previous years. Ms. Castro noted these are calendar days, not working days; hence 42 days (with furloughs) equates to 20 working days.

Pages 148.6 and 148.7 show the same statistics, but separates the data for "Accusations Only" and "Accusations/Petitions to Revoke Probation" and provides a breakdown of timelines by district office. Ms. Castro noted the statistics include out of state discipline cases, which brings the average down slightly. Mr. Ramirez stated that in the past year, an increased number of cases have been transmitted to the Sacramento and San Francisco offices; at the same time, these offices have hired new deputies which has led to a delay due to a learning curve. He noted that job offers have been made to additional deputies for these offices due to the heavy caseload. The AG's Office attempts to shift some of the work load to relieve busy offices, but travel restrictions sometimes make this unfeasible and can add time to the case.

Ms. Schipske requested that information on the median number of days, as well as the mode, be displayed, since the average can be very skewed by outliers.

Ms. Castro noted the complexity of cases varies significantly; although the statistics do not capture this information, it is tracked in the ProLaw system.

Dr. Salomonson stated it would be helpful to separate cases that involve medical care issues versus those involving physician impairment or boundary issues.

Ms. Yaroslavsky expressed a desire for the tracking system to be able to provide a level of detail that will allow trends to be identified in the types of cases that are being investigated and proceeding to discipline. She asked that Mr. Ramirez work with staff to determine the specific information needed.

Ms. Castro indicated the standard within HQES is to have these cases filed within 30 days. Page 148.8 reflects the number of days to complete a filed accusation or petition to revoke probation by way of hearing, stipulation or default. In 2010, the statewide average was 392 days for 144 cases. Although not reflected in the graph, as cases continue to be closed that were completed in 2010, the actual average is closer to 377 days for 184 decisions. This shows the addition of out of state discipline cases which lowers the average.

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Page 148.9 reflects how many days in the entire process from when a case is first received at a District Office to when a decision is signed by the Board. In 2010, the average number of calendar days was 836. Ms. Castro noted that the 151 cases indicated in the graph for 2010 does not show the spread over multiple calendar years. She distributed an additional graph that displays an amalgamation of everything that was completed for a particular calendar year that reflects the spread of cases over multiple calendar years. She suggested focusing on the numbers from 2006 – 2008, as the numbers for 2009 and 2010 represent a very small number of cases. Ms. Castro indicated the important point to note is the average number of days is moving downward. For 2006 the average number of days from the time a case was received in the district office to when a decision was signed by the Board was 943.3, in 2007 it was 861.28. Once all the older cases from a particular year are completed, the final data for that year will be available.

Ms. Whitney indicated that the Board collects and reports data differently. All cases closed during a calendar year (or fiscal year) are reported, regardless of when they were opened; data is collected on the total number of days the case has been opened to determine an average.

Ms. Castro reported, to date, the Board has signed off on at least 523 decisions that began as VE cases. Page 148.10 reflects the number of accusations that resulted in "serious discipline" which she defined as discipline that is not achievable in the investigative stage; hence the data does not include citations and fines, or public letters of reprimand. If the subject can be convinced to accept a public letter of reprimand without the filing of an accusation (usually the result of an agreement by the District Office and the AG's Office that this is the result that would probably be achieved if an accusation was filed), this results in a legal cost savings. This allows the AG's Office to focus its time on the more serious cases. The data on page 148.10 shows the percentage of cases that resulted in serious discipline divided by the total number of cases filed by a particular office in the calendar year (including withdrawals and dismissals), regardless of when the case was received.

Mr. Ramirez referred members to page 148.11 for a list of clients served by HQES, with the Medical Board being its largest client. Eighty-five percent of HQE's budget comes from the Medical Board.

Dr. Low stated it is important that HQES and the Board be on the same page in how data is collected and reported; it is imperative that the data bases be reconciled. The goal of both programs is to improve efficiency. He recognized the constraints with regard to manpower, travel, etc., but noted there are a lot of things that can be done to improve the timelines. He asked that HQE be represented on the Enforcement Subcommittee. He stated the time to acquire medical records and receive expert reviews is unnecessarily long. Changes need to be made to processes such as these to improve timelines.

Dr. Levine noted the data reported by the AG's Office and the Medical Board represents two different perspectives. The Board starts at the end and looks backward for a complete picture. The AG's data is a snapshot in time arrayed against one another; the whole picture isn't evident until three or four years out. She stated that this reporting of two different sets of numbers creates confusion.

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Mr. Ramirez reported the Vertical Enforcement Prosecution Manual has been approved by HQES and will soon be implemented.

C. HQE Organization and Staffing

As mentioned earlier, Mr. Ramirez reported HQES is in the process of hiring two additional deputies, one for the San Francisco Office and one for the Sacramento Office.

Agenda Item 20 Legislation / Regulation

A. 2011 Legislation Wrap-Up and Implementation Schedule

Jennifer Simoes, Chief of Legislation, referred members to the Legislative Packet and the Tracker List. She reported the three bills sponsored by the Board passed through the Legislature and were signed by the Governor.

Board Sponsored Bills:

- **AB 1127** (Brownley) Physicians & Surgeons: Physician Interview
  This bill makes it 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. For implementation, staff proposes to include an article in the Board's newsletter, notify and train Board staff, notify the AG's Office, and update the Citation and Fine regulations to include this requirement.

- **AB 1267** (Halderman) Physicians & Surgeons: Misdemeanor Incarceration
  This bill authorizes 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 the incarceration. For implementation, staff proposes to include an article in the newsletter, notify and train Board staff, notify the AG's Office, and 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 website as the reason for inactive status for misdemeanor incarcerations.

  Ms. Yaroslavsky suggested that the Department of Corrections and the court system be notified as well.

- **SB 541** (Price) Regulatory Boards: Expert Consultants
  This bill exempts all boards and bureaus in the Department of Consumer Affairs from the formal contracting process. For implementation, staff proposes to include an article in the newsletter, notify and train Board staff, notify and train expert consultants, work closely with the Department on the new simplified contracting process for utilizing expert consultants, and develop a tracking system to ensure no expert exceeds contract levels, and time for contract process.

Other 2011 Legislation

- **SB 100** (Price) Healing Arts: Outpatient Settings
  Ms. Simoes indicated the analysis in the Legislative packet includes a breakdown of the requirements for the Board, the accreditation agencies, and the outpatient settings.

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Ms. Yaroslavsky requested Board members review SB 100, as she will be assigning a review of the requirements to one of the committees in order to ensure the Board has a full understanding of the new requirements in law.

Ms. Simoes reported the Board will be required to obtain and maintain a listing of information on outpatient settings on its website; update its website if the outpatient setting's accreditation is revoked, suspended, placed on probation; or if a reprimand is received, for the purpose of providing information to the public.

The Board is also required to adopt regulations on or before January 1, 2013 regarding the "appropriate level of physician availability" needed within clinics for the use of prescriptive lasers or intense pulse light devices for elective cosmetic procedures.

The Board will be required to evaluate accreditation agencies every three years; evaluate responses to complaints against an agency; and evaluate complaints against the accreditation of outpatient settings.

For implementation, staff proposes to include an article in the Board's newsletter, notify and train Board staff, notify accreditation agencies and outpatient settings of the new requirements of the bill, work with accreditation agencies to obtain the necessary information for the required listing of outpatient setting data for the website, and ensure they are in compliance with the requirements of this bill. Further, staff proposes establishing a process for the reporting of changes to data reported by the accreditation agencies, and set up a database that can be updated for the listing of the outpatient settings.

In addition, staff proposes meeting 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, and examine the need for guidance to physicians or enhanced regulations related to procedures that need to be performed in an accredited setting.

Finally, staff proposes to establish a process to evaluate complaints against accreditation agencies and provide feedback or take other action, and establish a process to maintain inspection reports, track that they are completed and that the issues have been addressed, and work with the Board's Information Systems Branch to link to final reports for the outpatient settings on the Board's website.

Ms. Yaroslavsky suggested notifying the District Attorney's Office of the new provisions in the bill as well.

Dr. Salomonson stated she would like consumers to be aware of the need to check whether or not an outpatient setting was accredited before scheduling a procedure there.

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Ms. Simoes indicated that this is just the first phase of legislation; additional requirements will likely be addressed in the future.

Dr. Levine suggested estimating the budgetary impact of the new workload to the Board and then tracking the actual cost over time.

B. 2012 Legislative Proposals

Ms. Simoes reported the concept for the UCLA International Medical Graduate Program Pilot Project was previously approved by the Board. Staff is working with the UC Office of the President, who has decided to co-sponsor the bill, and is looking for an author for the bill.

New Proposals

- **Non-Practice License Status – Authority to Impose Discipline**

Ms. Simoes reported 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. This proposal also impacts the recently enacted legislation that automatically places a physician's license on inactive status when a physician is incarcerated after the conviction of a misdemeanor.

Dr. Levine made a motion to approve the Board's sponsoring of this legislation; s/Salomonson; motion carried.

- **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 the statute to allow these delinquency notifications to be sent via email if the physician chooses this method of communication.

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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.

Ms. Schipske made a motion to approve this legislative proposal; s/Low; motion carried.

- **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.

Dr. Levine made a motion to approve this concept; s/Low; motion carried.

Ms. Simoes reported that the California Medical Association will likely put forth a proposal related to a physician health program. As mentioned during public comment by Mr. Cuny, a potential bill may come forward related to the integrative treatment of cancer. Staff is also aware of potential legislation related to cardiovascular technologists or registered cardiovascular invasive specialists as a new licensure category.

C. Status of Regulatory Action

Mr. Schunke directed members to the matrix on page 150 of the packet detailing the status of pending regulations. He noted the regulations pertaining to Disciplinary Guidelines left the DCA and were submitted to the SCSA on October 12, 2011. Pursuant to law, the DCA Director granted an extension of the deadline for the file to be submitted to the Office of Administrative Law by December 14, 2011.

The regulations pertaining to the Sponsored Free Health Care Events were delivered to the DCA on October 25, 2011. The Board is the first board that has moved forward with a regulatory package to implement the new law. Assuming that the regulations move through the review process with the CA SCSA, and the Department of Finance, it is hoped that staff will be able to report approval of the package by the next board meeting in early 2012. Staff is beginning to meet and discuss regulations that will need to be set for hearing in 2012.

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Agenda Item 23 2012 Board Meeting Dates

Ms. Yaroslavsky reported she received a request to move the previously approved July 26-27, 2012 meeting date to July 19-20, 2012.

Dr. Low made a motion to change the July meeting date to July 19-20, 2012; s/Salomonson.

Ms. Whitney noted that, by moving the meeting date a week earlier, there may not be sufficient time to put together regulatory files that are approved at the May 2012 meeting to be heard in July. Regulations approved in May would be heard at the October 2012 meeting.

Ms. Yaroslavsky called for a vote; motion carried.

Agenda Item 21 Discussion and Consideration of Draft Strategic Plan Presented by the Executive Committee

Ms. Kirchmeyer presented members with the draft strategic plan objectives as revised by the Executive Committee at its October 27, 2012 meeting.

Dr. Duruisseau made a motion to accept the strategic plan objectives as a consent item; s/Levine; motion carried.

Ms. Kirchmeyer reviewed the changes made to the objectives by the Executive Committee.

Dr. Salomonson made a motion to accept all the changes to the strategic plan made by the Executive Committee as identified by Ms. Kirchmeyer; s/Levine.

Ms. Kirchmeyer noted public comment was received from Michele Monserratt-Ramos, Consumer Union Safe Patient Campaign, urging the Board to involve the public in discussions on the objectives.

Ms. Yaroslavsky called for the vote; motion carried.

Ms. Whitney informed the members that the revised Strategic Plan will be presented for a final vote at the February 2012 meeting.

Agenda Item 22 Discussion of Strategic Plan Objective 5.4 Annual Review of Committees; Establishment of Board Committees

At approximately 2:30 p.m., quorum was lost; the meeting continued as a task force.

Ms. Kirchmeyer directed members to pages 152-154 of the meeting packet for the language for objective 5.4 and a listing of the committees of the Board. Staff recommended that the Executive Committee and all the mandatory committees (Application Review Committee, Special Faculty Permit Review Committee, Special Programs Committees, and Midwifery Advisory Council) all remain as they are through 2012, with the exception of the Midwifery Advisory Council which has requested possibly increasing their membership by two additional members. Staff recommends that these committees continue to meet quarterly or on an 'as needed' basis.

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Ms. Whitney indicated that staff would send an email to members, asking them to indicate, other than the Licensing and Enforcement Committees, which of the remaining five committees they consider to be the three most important at this time, as well as how frequently they feel these committees should meet. This information should not be shared among members, but will be used to determine the needs of these committees and prepare information on available staffing to meet these needs. The information will be shared at the next Board meeting.

Agenda Item 24 Agenda Items for February 2-3, 2012 Meeting in San Francisco
Ms. Whitney reported that there are several requests from previous meetings for agenda items that will carry over to future meetings. These include:

- A request from Ms. Schipske for an update or clarification on medical marijuana. Ms. Schipske asked that CMA's recent position on medical marijuana be included in any update. Ms. Yaroslavsky recommended that a review of the Board's policy and previous work on this issue be included, as well.
- A request from Dr. Levine on the maintenance of licensure and certification. Ms. Whitney indicated that both the FSMB and ABMS are also looking at this issue.
- In anticipation that the Sponsored Free Health Care Event regulations are finalized, there will be an agenda item to adopt the resolution to delegate to the DCA the authority to receive sponsoring entity forms pursuant to §1331.1(a) and (b) of the regulations.

Dr. Salomonson requested an update on SB 100, either as part of the full Board agenda or the Licensing Committee agenda.

Ms. Yaroslavsky asked that members contact Ms. Whitney with any requests for agenda items.

Agenda Item 25 Adjournment
There being no further business, Dr. Duruisseau made a motion to adjourn; s/Levin; motion carried.
The meeting was adjourned at 2:47 p.m.

_____
Barbara Yaroslavsky, President

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

_____
Linda K. Whitney, Executive Director

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MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	January 25, 2012
ATTENTION:	Members, Medical Board of California
SUBJECT:	Strategic Plan Objective 5.4 – Annual Review of Board Committees, Establishment of Committees
STAFF CONTACT:	Kimberly Kirchmeyer, Deputy Director

RECOMMENDED ACTION:

Review and discuss the Board's Committees' to determine if changes need to be made to their structure, goals, and meeting times. Additionally, determine if there is a need for every Committee.

BACKGROUND AND ANALYSIS:

One of the new Objectives of the Strategic Plan, which was reviewed at the July 29th Board Meeting and approved at the October 28th Board Meeting, was an annual review of the Board Committees. Specifically, the Objective requires a review 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 if they should be merged with other committees. This review was scheduled for the October Board Meeting, however, due to time constraints, this agenda item was tabled until the February 2012 Board Meeting.

The Board currently has the following Committees that need to be reviewed (please see the attachment for a description of each committee):

Committees
Executive Committee
Licensing Committee
Enforcement Committee
Application Review Committee
Midwifery Advisory Council
Special Faculty Permit Review Committee
Special Program Committee
Access to Care Committee
Advisory Committee on Physician Responsibility in the Supervision of Allied Health Care Professionals
Education Committee
Physician Recognition Committee
Wellness Committee
Cultural and Linguistic Competency Work Group

The Board Members were asked to provide input on the above Committees. Board staff has gathered the comments from the Members and has put the answers together into a consolidated format for review and discussion. Below is the information obtained from the Members.

SURVEY QUESTIONS AND MEMBER RESPONSES/COMMENTS:

The **Executive, Licensing, and Enforcement Committees** are committees that are needed and staff made the assumption that the Board will want to keep these committees.

Executive Committee issues:
1. Legislation discussions and positions
2. Executive Officer Evaluation
3. Strategic Planning
4. Administrative Issues

The Executive Committee usually meets during the Quarterly Full Board Meeting, when needed; however, it may need to meet in between quarterly meetings if issues arise needing Board discussion and decisions.

Question: Do you agree with these issues, do you have any issues to add, or do you have any other suggestions for the Executive Committee?

MEMBER RESPONSE/SUGGESTION/COMMENT:

- Concur with Committee goals.
- There should be a Budget Committee as part of the Executive Committee where issues can be addressed, or at least a two-person oversight subcommittee with the responsibility of reviewing the budget with the Executive Director.
- Concur with Committee goals.
- The Executive Committee could do a periodic assessment of the Board members to identify perceptions of effectiveness and efficiency of Board meetings, suggestions for improvement in Board functioning, etc. Most Boards have a mechanism for Board self-assessment, and the Executive Committee could take responsibility for this.

Licensing Committee issues:
1. Implementation of the Reengineering Report's recommendations regarding
   a. Policy and Procedures
   b. Revised application and instructions for Web site
2. Other programs of the Board related to licensing:
   a. Special faculty permits
   b. Special programs
   c. Fictitious name permits
   d. RDO program
   e. CME and audit

The Licensing Committee should meet, when necessary, during the Quarterly Full Board Meetings. It should meet when it has issues that need Committee discussion and input.

Question: Do you agree with these issues, do you have any issues to add, or do you have any other suggestions for the Licensing Committee?

MEMBER RESPONSE/SUGGESTION/COMMENT:

- Concur with Committee goals.
- These all seem appropriate. The Licensing Committee could be the venue in which the issue of Maintenance of Licensure (MOL) could be evaluated, and the progress of the FSMB pilots regarding MOL tracked. If the Board decides to proceed in that direction after a careful study, the Licensing Committee could do that work on behalf of and in

concert with the Board. The first issue should be revised to say "Oversight of staff implementation of the Reengineering Report's recommendations regarding..."

- The licensing committee gives a broader voice to issues that it needs to be engaged with, the first one, is having a broader participation and understanding of the needs of the licensing process. With SB 100, there might be further connection with licensing and policy, process, and oversight that might be gleaned from this committee.
- Concur with Committee goals.

Enforcement Committee issues:

1. Review and reduction of time lines for processing complaints, investigations, and disciplinary actions
2. Training and recruitment of expert reviewers
3. Evaluation reports
4. Probation

The Enforcement Committee should meet, when necessary, during the Quarterly Full Board Meetings. It should meet when it has issues that need Committee discussion and input.

Question: Do you agree with these issues, do you have any issues to add, or do you have any other suggestions for the Enforcement Committee?

MEMBER RESPONSE/SUGGESTION/COMMENT:

- Agree that this committee is important and should be continued as long as progress can be made. Should have standardized training for medical consultants as well as for reviewers.
- Yes, it is important.
- The goals are accurate.
- Suggest that there also be engagement in policy around how enforcement is handled, how the different DAGs andMedical Board offices respond and oversee a plan as to ensure efficiency and similar timelines across the State. Review of policies and procedures that impact enforcement, review of laws that deal with enforcement, etc. Also suggest that policies and procedures of the process be evaluated on an ongoing manner, as issues evolve, but with insight and engagement of those individuals the Board depends on within its operation, so therefore, the Chief of Enforcement, and any designated members of the team, should be engaged and participatory as needed.
- Strongly agree with goals, particularly interested in expert recruitment and training.

The **Application Review Committee, Special Faculty Permit Review Committee, Special Program Committee, and Midwifery Advisory Council** are statutory committees and staff suggested these remain as they are and continue to meet on an as needed basis.

MEMBER RESPONSE/SUGGESTION/COMMENT:

- SFPRC - Recommend that the Board have a roster of all those that are in 2113 and 2168. Also, the Board should examine the performance and status of all 2168 candidates with data from their institutions.

For the other committees of the Board, staff requested information from the Members, including should the committee continue, when should the committee meet, and what should be the goal of the committee for 2012-2013?

Access to Care Committee

1. Continue to gather information on collaborative care models; however what should be done with this information: inform physicians via newsletter, link to articles?
2. Examine methods to enhance the use of physician volunteers in the workforce: gather information on volunteers in the workforce, inform the Board, and determine if the Board wants to pursue any action other than information.

Questions:

Should this committee continue?
What does the committee do with the information it gathers?
What is the goal of this committee?
Are there other issues this committee should be discussing?
How often does this committee need to meet?
Can this committee meet off-cycle of Board Meetings?

MEMBER RESPONSE/SUGGESTION/COMMENT:

- Access to Care Committee could be combined with the Education and/or Wellness Committees.
- Unsure what role the Board has in this or how it fits into the Board's mission and statutory requirements. The Board's role should be to ensure that the public is protected from sub-standard care by ensuring that physician volunteer endeavors are conducted by licensed physicians whose licenses are in good standing; and to identify opportunities to support and facilitate volunteerism and to work with those looking for ways to provide liability coverage to volunteers. This committee is not central to the mission of the Board; "access to care" has much more to do with how care delivery is organized than with assuring that physicians practicing in the state are qualified, competent and committed to lifelong learning. The goal of the committee is not clear; the committee has no authority to execute or any way to address what are admittedly significant issues regarding access to care. Any of the Committees could meet off cycle, pending staff and Board member availability. How often it meets depends on what work is being done.
- Any committee can always meet outside of the board meetings.
- The Committee needs to continue but it needs to formulate the question and then gather the answers and do something with the information gathered. Need to spread the word about the shortage of physicians; need to work with all related agencies to look for solutions.

Advisory Committee on Physician Responsibility in the Supervision of Allied Health Care Professionals

Note: At this time this committee does not have a Chair.

1. Implement certain aspects of Senate Bill 100 related to physician availability.

Questions:

Should this committee continue?
What is the goal of this committee?
Are there other issues this committee should be discussing?
How often does this committee need to meet?
Can this committee meet off-cycle of Board Meetings?

Note: Staff recommends this committee meet off-cycle of the Board Meetings.

MEMBER RESPONSE/SUGGESTION/COMMENT:

- The committee should include many aspects of SB 100 implementation, i.e. outpatient surgery centers, etc.
- The Committee could, on behalf of the Board, clarify the accountability of physicians, based on existing scope of practice laws and regulations, in supervising each category of allied health professional, and distribute the information to all California physicians on a periodic basis. How often the Committee meets should be determined based on the work it has. There is no problem with it meeting off schedule; actual scheduling may be a challenge given how busy Members are.
- This committee should be a task force with other like medical professionals participating. The goals of the committee should move beyond the botox and laser issues and encompass a broader idea of how do we share responsibilities, and what areas can the Medical professionals/doctors suggest opportunities for additional engagement. With SB 100 and what is overseen in that arena, there needs to be a broad review with stakeholders and a better discussion and understanding of the expectations for patient safety. There needs to be the ability to ensure that, similar to medical practices, there is identifying information in these locations that lets patients know who accredits the facility, when the last accreditation was done, and whom to contact if the patient has issues.
- This is going to be the most important issue after the new health care reform law becomes effective. Not just supervision, also how to work with other Allied Health Care workers to ensure quality care in the new concept of care.

Education Committee

1. Discuss the requirements of Senate Bill 380 related to educational material regarding the prevention and treatment of chronic disease

Questions:

Should this committee continue?
What is the goal of this committee?
Are there other issues this committee should be discussing?
How often does this committee need to meet?
Can this committee meet off-cycle of Board Meetings?

MEMBER RESPONSE/SUGGESTION/COMMENT:

- This can be a good committee but due to the shortage of manpower it became unproductive. If the Board wants to keep this committee, it needs to be real with goals and objectives.
- It's hard to see the value-added of a goal which is stated as " Discuss..." It contains no real action, and hard to see how the Committee's spending time doing this would add value to the Board's carrying out its core functions. The Committee could potentially review all the statutes related to physician education/CME, and develop recommendations to the legislature regarding the role CME (and its content) should play in assuring a competent and up-to-date physician workforce; how and by whom the content of CME should be developed; and how 21st century CME should be organized optimally. When the committee should meet depends on the work of the committee. Pending staff and Member availability this Committee could meet off-cycle.

- I think that the Education Committee has a valid bully pulpit opportunity, depending on what issues it wants to be engaged with. It should inform a broader constituency through the media, the newsletter, and elected officials, as well as other stakeholders. This could be a forum to discuss issues, make presentations, evolve a position on public opinion, and then disseminate it to the broader community. The committee could meet off cycle from Board meetings but it should meet regularly.

Physician Recognition Committee

1. Review applications for the Physician Humanitarian Award

Question: Should this committee continue?

MEMBER RESPONSE/SUGGESTION/COMMENT:

- This is a committee that might have finished its relevancy. It is not a Board Committee responsibility to recognize an individual at a Board meeting and in the Newsletter. Rather, the Board could use this time to consider thanking a public official for carrying legislation or a doctor for implementing something the Board wants to recognize.
- This Committee should continue.
- This Committee should not continue. Very few people are aware of the award, the selection process, etc. It's nice for the recipient, but not sure it's having the impact an award like this could or should have.
- This award is so arbitrary – consider discontinuing or consider awarding a "program" not an individual.

Wellness Committee

1. Educate physicians regarding physician wellness

Questions:

Does this committee want to continue to pursue development of articles for the newsletter?
Does the Committee want to have the Board site link to other sites and if so, what would those be?
Should this committee continue?
What is the goal of this committee?
Are there other issues this committee should be discussing?
Could this committee be consolidated with another committee or have its issues/goals addressed elsewhere?
How often does this committee need to meet?
Can this committee meet off-cycle of Board Meetings?

MEMBER RESPONSE/SUGGESTION/COMMENT:

- The Board should evaluate the impact of the Board's efforts in the area of educating physicians about wellness, and determine whether there has been any measurable result from the Board's effort. This Committee could benefit from a discussion about what the Board's role in promoting physician wellness is, and focus its efforts in that arena. One possible role would be an annual publication of resources, and contact information, regarding where a physician can turn for help for himself/herself, or a colleague, as well as resources (conferences, publications, etc.) related to promoting health and wellness. A valuable (and local to California) resource is Dr. Rachel Remen who has spent decades teaching, coaching, and counseling physicians in this area and developing models for physician resilience and mental, physical, and spiritual health.

- It is possible the stated reason for the committee, to educate physicians, is not the reason for this committee but to rather address how stakeholders can set methods for engagement given that the Diversion Program has been sunseted. If the committee were a forum for bringing together stakeholders and convening meetings to review best practices, etc., that may be a better use of time. Then these practices could be used for educational purposes and reported to a broad audience rather than through minutes or public meetings.
- Should discontinue this committee.

Cultural and Linguistic Competency Work Group

1. Encourage activities designed to promote the cultural and linguistic competency of physicians.

Questions:

Has this committee completed its purpose?
Should this committee continue?
What is the goal of this committee?
Are there other issues this committee should be discussing?
How often does this committee need to meet?
Can this committee meet off-cycle of Board Meetings?

MEMBER RESPONSE/SUGGESTION/COMMENT:

- This committee is very important as many more physicians are trained internationally. Foreign physicians need to be sensitive to US cultural issues and US born physicians need to know cultural issues of patient population.
- Not sure this committee needs to continue. If it does, it needs to have definite goals.
- This committee has a definite important purpose. The committee should identify what is being done, what needs to be improved upon, and how to better address the needs of an aging as well as culturally sensitive population. Suggest that meetings can always take place separate and apart from Board meetings.
- It is uncertain how impactful the Board's efforts can be in this arena, and how the Board can drive change through a goal of "encourage". The CME accrediting bodies have to ensure that this is addressed in CME, and the IMQ and ACCME do this work. If the Board wanted to get into the business of using the newsletter (or the Board website if that is an option) to publish CME offerings in this arena and notification to its readers of the newsletter opportunities. The Board needs to assess the feasibility of that effort and the staff resources needed to keep the information timely (most physicians work on at least a 3 to 4 month timeframe for scheduling patients, and so the notices would have to be available that far ahead of the actual meeting). Uncertain as to how much value is added given that all CME in California now has to include a component of this.

Are there other committees that need to be initiated in order to complete the mission and goals of the Board?
If so, what is the goal of that committee, how often should this committee meet, and can it meet off-cycle of the Board Meetings?

MEMBER RESPONSE/SUGGESTION/COMMENT:

- Not at this time.
- The Board should reconfigure/expand current committees – there is no need for additional committees.

If you have any questions concerning this memorandum, please telephone me at (916) 263-2389.

Consumer Affairs

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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

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
BEGINNING BALANCE	$ 27,903	$ 30,246	$ 18,855	$ 14,388	$ 8,128
Prior Year Adjustment	$ (556)	$ -	$ -	$ -	$ -
Adjusted Beginning Balance	$ 27,347	$ 30,246	$ 18,855	$ 14,388	$ 8,128
REVENUES AND TRANSFERS					
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	$ 51	$ 51	$ 51	$ 51
150300 Income from surplus money investments	$ 164	$ 202	$ 91	$ 49	$ 10
160400 Sale of fixed assets	$ 3	$ 3	$ 3	$ 3	$ 3
161000 Escheat of unclaimed checks and warrants	$ 22	$ 23	$ 23	$ 23	$ 23
161400 Miscellaneous revenues	$ 1	$ 1	$ 1	$ 1	$ 1
164300 Penalty assessments - Probation Monitoring		$ 900	$ 900	$ 900	$ 900
Totals, Revenues	$ 49,912	$ 52,234	$ 52,107	$ 52,647	$ 52,996
Transfers:					
GENERAL FUND LOAN		$ (9,000)			
TOTALS, REVENUES AND TRANSFERS	$ 49,912	$ 43,234	$ 52,107	$ 52,647	$ 52,996
TOTAL RESOURCES	$ 77,259	$ 73,480	$ 70,962	$ 67,035	$ 61,124
EXPENDITURES					
Disbursements:					
0840 State Controller (State Operations)	$ 80	$ 58	$ 53	$ -	$ -
8880 FSCU (State Operations)	$ 31	$ 168	$ 44		
1110 Program Expenditures (State Operations)	$ 46,902	$ 54,399	$ 55,199	$ 57,607	$ 58,759
2012-2013 Proposed BCPs					
Operation Safe Medicine			—	—	—
BreEZe (including credit card cost)			$ 1,278		
Anticipated Future Costs					
Antcipated BreEZe Cost				$ 1,300	$ 1,300
Totals, Disbursements	$ 47,013	$ 54,625	$ 56,574	$ 58,907	$ 60,059
FUND BALANCE					
Reserve for economic uncertainties	$ 30,246	$ 18,855	$ 14,388	$ 8,128	$ 1,066
Months in Reserve	6.6	4.0	2.9	1.6	0.2

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)

1/11/2012

Medical Board of California
FY 11/12
Budget Expenditure Report
(As of November 30, 2011)
(41.6% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENSES/ ENCUMB	PERCENT OF BUDGET EXP/ENCUMB	UNENCUMB BALANCE
PERSONAL SERVICES				
Salary & Wages				
(Staff & Exec Director)	15,883,389	5,379,228	33.9	10,504,161
Board Members	31,500	9,700	30.8	21,800
Phy Fitness Incentive Pay	29,623	11,750	39.7	17,873
Temp Help	1,137,513	578,871	50.9	558,642
Overtime	12,143	15,786	130.0	(3,643)
Staff Benefits	7,515,777	2,373,318	31.6	5,142,459
Salary Savings	(892,664)			(892,664)
TOTALS, PERS SERVICES	23,717,281	8,368,653	35.3	15,348,628
OPERATING EXP & EQUIP				
General Expense	770,168	166,000	21.6	604,168
Fingerprint Reports	333,448	119,270	35.8	214,178
Minor Equipment	187,500	21,196	11.3	166,304
Printing	685,755	254,926	37.2	430,829
Communications	372,190	80,918	21.7	291,272
Postage	282,511	68,196	24.1	214,315
Insurance	41,053	13,293	32.4	27,760
Travel In-State	482,298	31,736	6.6	450,562
Travel Out-of-State	1,000	0	0.0	1,000
Training	78,895	22,347	28.3	56,548
Facilities Operation (Rent)	2,702,140	2,261,232	83.7	440,908
Consult/Prof Services	982,594	1,324,124	134.8	(341,530)
Departmental Prorata	4,118,830	1,669,933	40.5	2,448,897
Interagency Services	5,142	0	0.0	5,142
Consolidated Data Center	646,809	176,886	27.3	469,923
Data Processing	129,492	63,241	48.8	66,251
Central Admin Svcs (Statewide Prorata)	2,140,440	1,070,220	50.0	1,070,220
Attorney General Services	13,347,280	5,524,416	41.4	7,822,864
Office of Administrative Hearings	1,595,080	529,710	33.2	1,065,370
Evidence/Witness	1,893,439	716,471	37.8	1,176,968
Court Reporter Services	155,000	62,105	40.1	92,895
Major Equipment	633,000	0	0.0	633,000
Other Items of Expense	81	21,560	26,617.3	(21,479)
Vehicle Operations	261,925	111,053	42.4	150,872
Court-ordered Payments	0	2,250		(2,250)
Board of Control Claim	0	1,350		(1,350)
TOTALS, OE&E	31,846,070	14,312,433	44.9	17,533,637
TOTALS, EXPENDITURES	55,563,351	22,681,086	40.8	32,882,265
Scheduled Reimbursements	(384,000)	(149,713)	39.0	(234,287)
Distributed Costs	(780,000)	(388,501)	49.8	(391,499)
NET TOTAL, EXPENDITURES	54,399,351	22,142,872	40.7	32,256,479
Unscheduled Reimbursements		(263,462)		
		21,879,410		

Budget Expenditure Report.xls
Date: January 5, 2012

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
BUDGET REPORT
JULY 1, 2011 - Nov 30, 2011

	FY 10/11 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	2,252,648	870,214	current
Staff Benefits	1,089,713	382,777	current
TOTAL PERSONAL SERVICES	3,342,361	1,252,990	
OPERATING EXPENSES & EQUIPMENT			
General Expense	80,434	3,373	1-2
Fingerprint Reports*	333,448	118,486	1-2
Printing	61,000	13,711	1-2
Communications	52,246	7,065	1-2
Postage	125,000	39,818	1-2
Travel In-State	25,000	2,335	1-2
Training	8,500	7,114	1-2
Facilities Operation	226,000	224,329	current
Consult/Professional Services	601,873	684,270	1-2
Departmental Services	402,825	162,484	current
Interagency Services	500	0	current
Data Processing	4,000	5,212	1-2
Statewide Pro Rata	209,335	104,666	current
Attorney General	190,000	35,697	current
Evidence/Witness Fees	7,500	169	1-2
Court Reporter Services	250	0	1-2
Major Equipment	26,000	0	1-2
Minor Equipment	66,000	1,306	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	2,419,911	1,410,035	
SCHEDULED REIMBURSEMENTS	(384,000)	(149,713)	
DISTRIBUTED COSTS	(42,257)	(21,128)	
TOTAL BUDGET/EXPENDITURES	**5,336,015**	**2,492,184**	

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

g/admin/licensn2.xls
1/5/2012

MEDICAL BOARD OF CALIFORNIA
ENFORCEMENT PROGRAM
BUDGET REPORT
JULY 1, 2011 - NOV 30, 2011

	FY 11/12 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	10,550,011	3,722,063	current
Staff Benefits	4,778,306	1,441,207	current
TOTAL PERSONAL SERVICES	15,328,317	5,163,270	
OPERATING EXPENSE & EQUIPMENT			
General Expense/Fingerprint Reports	436,406	96,464	1-2
Printing	305,755	221,283	1-2
Communications	224,358	56,467	1-2
Postage	70,000	23,482	1-2
Insurance	38,770	11,537	current
Travel In-State	290,298	13,510	1-2
Training	34,000	10,464	1-2
Facililties Operations	2,071,140	1,674,164	current
Consultant/Professional Services	300,000	213,915	1-2
Departmental Services	3,070,588	1,233,913	current
Interagency Services	3,833	0	1-2
Data Processing	19,000	775	1-2
Statewide Pro Rata	1,595,698	797,848	current
Attorney General 1/	13,157,280	5,488,719	current
OAH	1,595,080	529,710	1
Evidence/Witness Fees	1,820,939	697,386	1-2
Court Reporter Services	154,750	62,105	1-2
Major Equipment	511,000	0	1-2
Other Items of Expense (Law Enf. Materials/Lab, etc.)	81	19,985	1-2
Vehicle Operations	215,925	92,893	1-2
Minor Equipment	2,500	17,080	1-2
Court-Ordered Payments	0	3,070	current
TOTAL OPERATING EXPENSES & EQUIPMENT	25,917,401	11,264,770	
DISTRIBUTED COSTS	(735,630)	(366,315)	
TOTAL BUDGET/EXPENDITURES	**40,510,088**	**16,061,725**	
Unscheduled Reimbursements		(12,033)	
		16,049,692	

1/See next page for monthly billing detail

1/5/2012

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

		Number of Hours	Rate	Amount
July	Attorney Services	6,461.75	170.00	1,098,497.50
	Paralegal Services	247.00	120.00	29,640.00
	Auditor/Analyst Services	101.00	99.00	9,999.00
	Cost of Suit			
				1,138,136.50
August	Attorney Services	6,741.25	170.00	1,146,012.50
	Paralegal Services	233.50	120.00	28,020.00
	Auditor/Analyst Services	159.25	99.00	15,765.75
	Cost of Suit			275.00
				1,190,073.25
September	Attorney Services	6,117.75	170.00	1,040,017.50
	Paralegal Services	197.50	120.00	23,700.00
	Auditor/Analyst Services	197.00	99.00	19,503.00
	Cost of Suit			544.26
				1,083,764.76
October	Attorney Services	6,265.00	170.00	1,065,050.00
	Paralegal Services	142.50	120.00	17,100.00
	Auditor/Analyst Services	135.00	99.00	13,365.00
	Cost of Suit			794.80
				1,096,309.80
November	Attorney Services	5,619.00	170.00	955,230.00
	Paralegal Services	111.00	120.00	13,320.00
	Auditor/Analyst	99.00	99.00	9,801.00
	Cost of Suit			2,084.00
				980,435.00
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			0.00
				0.00
			Total July-Dec =	**5,488,719.31**
			FY 11/12 Budget =	**13,157,280.00**

Revised 1/05/2012

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	

	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	FYTD Total
Invest Cost Recovery	3,981	971	871	846	996	2,177	896	3,550	896	896	1,100	1,146	18,326
Criminal Cost Recovery	0	0	0	0	0	0	0	0	0	0	0	0	0
Probation Monitoring	43,697	74,202	31,474	35,029	120,104	157,971	332,595	170,590	72,520	94,712	71,738	47,283	1,251,913
Exam	2,475	3,730	1,750	9,456	4,031	1,158	1,237	2,621	1,400	4,235	2,500	627	35,219
Cite/Fine	5,500	9,000	10,075	4,000	2,600	5,700	5,000	2,896	1,950	5,650	950	200	53,521
MONTHLY TOTAL	55,653	87,903	44,170	49,331	127,731	167,006	339,728	179,656	76,766	105,493	76,288	49,255	1,358,980
FYTD TOTAL	55,653	143,557	187,727	237,058	364,788	531,794	871,522	1,051,178	1,127,944	1,233,436	1,309,725	1,358,980	

	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	300	100	50								1,100
Criminal Cost Recovery	0	0	0	0	0								0
Probation Monitoring	42,542	41,848	44,639	105,369	96,368								330,765
Exam	1,639	777	2,481	627	1,692								7,215
Cite/Fine	200	4,350	800	10,650	3,250								19,250
MONTHLY TOTAL	44,681	47,325	48,220	116,745	101,359	0	0	0	0	0	0	0	358,330
FYTD TOTAL	44,681	92,005	140,225	256,970	358,330	358,330	358,330	358,330	358,330	358,330	358,330	358,330	

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Medical Board of California
Board Members' Expense Report
Oct 1, 2011 -Dec 31, 2011

	*Per Diem**				*Travel Expenses**	*Total Oct-Dec*	***Total FYTD***
	Oct	Nov	Dec	*TOTAL*	*Oct-Dec*		
Dr. Carreon	0.00	0.00	0.00	0.00		0.00	3,500.00
Ms. Chang	200.00	0.00	0.00	200.00	0.00	200.00	1,352.94
Dr. Diego	1,000.00	1,400.00	0.00	2,400.00	994.68	3,394.68	4,594.68
Dr. Duruisseau	900.00	800.00	0.00	1,700.00	864.70	2,564.70	4,935.74
Dr. Levine	0.00	0.00	0.00	0.00	0.00	0.00	813.86
Dr. Low	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Dr. Moran	0.00	0.00	0.00	0.00	0.00	0.00	1,000.00
Dr. Salomonson	400.00	0.00	0.00	400.00	1,153.72	1,553.72	1,553.72
Ms. Schipske	900.00	0.00	0.00	900.00	444.58	1,344.58	3,262.64
Ms. Yaroslavsky	0.00	0.00	0.00	0.00		0.00	0.00
BOARD TOTAL	3,400.00	2,200.00	0.00	5,600.00	3,457.68	9,057.68	21,013.58

*includes claims paid/submitted through Dec, 2011
Board Members Expense Report.xls
Date: January 6, 2012

MEDICAL BOARD OF CALIFORNIA BUDGET OVERVIEW BY BOARD COMPONENT

	EXEC	ENFORCE	OPERATION SAFE MEDICINE	LICENSING	ADMIN SERVICES	INFO SYSTEMS	PROBATION MONITORING	BOARD TOTAL
FY 08/09								
$ Budgeted	2,158,000	36,659,000		4,599,000	2,048,000	3,370,000	1,914,000	50,748,000
$ Spent *	1,875,000	34,026,000		4,522,000	1,697,000	2,668,000	625,000	45,413,000 *
Positions Authorized	8.8	146.6		45.5	15.0	16.0	20.0	251.9
FY 09/10								
$ Budgeted	2,030,000	36,539,000	567,000	4,262,000	1,558,000	2,953,000	1,589,000	49,498,000
$ Spent *	2,920,000	34,130,000	494,000	4,772,000	1,547,000	2,728,000	500,000	47,091,000 *
Positions Authorized	8.8	146.6	6.0	45.5	15.0	16.0	25.0	262.9
FY 10/11								
$ Budgeted	1,944,000	37,720,000	577,000	5,045,000	1,688,000	3,118,000	1,735,000	51,827,000
$ Spent*	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
FY 11/12								
$ Budgeted	1,885,220	40,510,088		5,336,015	1,585,554	3,069,028	2,013,445	54,399,350
$ Spent thru 11/30*	974,078	16,049,692		2,492,184	665,315	1,147,041	551,100	21,879,410
Positions Authorized	8.8	164.1		53.3	15.0	17.0	25.0	283.2

* net expenditures (includes unscheduled reimbursements)

1/5/2012
Budget Overview by Program.xls

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • GOVERNOR EDMUND G. BROWN JR.
EXECUTIVE OFFICE
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DATE: December 31, 2011

TO: Anna Caballero, Secretary of the State and Consumer Services Agency

FROM: Brian Stiger, Acting Director, of the Department of Consumer Affairs

SUBJECT: Review of the Systems of Internal Control

In accordance with the Financial Integrity and State Manager Accountability Act of 1983, Government Code Sections 13400 through 13407, I am submitting the enclosed report describing the review of our systems of internal control for the biennial period ended December 31, 2011.

Enclosure(s)

INTRODUCTION

In accordance with the Financial Integrity and State Manager's Accountability (FISMA) Act of 1983, the Department of Consumer Affairs (DCA) submits this report on the review of our systems of internal control for the biennial period ended December 31, 2011.

Should you have any questions please contact Pam Wortman at (916) 574-7172.

BACKGROUND

The Department of Consumer Affairs (DCA) is comprised of 38 entities (23 boards, 8 bureaus, 4 committees, 2 programs, and 1 commission). DCA's mission is to protect and serve the interests of California consumers. To accomplish this mission, the entities establish minimum qualifications and levels of competency for licensure; investigate complaints; and discipline violators. The bureaus and programs are under my direct authority, while the boards, committees, and commission are semiautonomous bodies whose members are appointed by the Governor and the Legislature. DCA provides the semiautonomous bodies administrative support services.

RISK ASSESSMENT

An organization-wide risk assessment was performed by compiling the top risks from participating boards, bureaus, committees, programs and commission. Each was asked to submit their top risks within their entities that stand in the way of achieving their goals and objectives. They were also asked to consider the probability of the risk as well as its impact.

The methodology used to obtain this information included: meeting with executive officers, bureau chiefs, and designated staff for the boards, bureaus, committees, programs and commission to discuss the purpose and significance of their input; distributing a description of risk and instructions for identifying the risk, its probability and impact, as well as explaining the steps that have been taken to reduce or mitigate each risk; providing a deadline for submission of risk information; designating Internal Audit staff to answer questions and offer assistance to entities; evaluating the responses; grouping and labeling like risks; and identifying the most prevalent risks within the organization.

Based on the information received, DCA management has determined that the greatest vulnerabilities lie in the following areas:

- Staff resources
- Enforcement
- BreEZe implementation
- Appropriate Budget Funding

EVALUATION OF RISKS AND CONTROLS

Issue #1 Staff resources.

Risks: The DCA has struggled across the department with limited staffing. The limited staff has resulted in increased workload for existing staff, backlog of some processes and longer processing times for new applicants. In some cases, current staffing has not been sufficient to facilitate an increase in the licensing population or the consumer population an entity serves. The reduced staffing has caused delays to process licenses which results in delayed employment of professionals. In addition; staffing challenges have decreased effectiveness and efficiency to run its programs and provide adequate consumer protection. Needed redirection of staff to mission critical functions has resulted in backlogs in other areas, which add value, but can no longer be continued.

Issue #2: Enforcement.

Risks: The DCA's Consumer Protection Enforcement Initiative provided staffing to shorten the timeframe for enforcement; however, positions were authorized after the hiring freeze began; therefore, many programs were unable to hire the specially trained enforcement investigators, which now limits an entities ability to provide timely consumer protection. Additionally, in some programs enforcement staff are taking on other duties, which limits the amount of time they spend on enforcement caseloads; therefore, lengthening processing times. When processing times are increased, then a licensee in violation of the law may continue practicing for a longer period of time, potentially causing harm to others. In addition, DCA has limited control over processing times by outside agencies working collaboratively in the enforcement chain.

Issue #3: BreEZe Implementation.

Risks: BreEZe will provide the much needed replacement of DCA's Legacy databases to track licensing and enforcement information. There are always risks associated with replacing a mission critical system. Some entities have expressed concerns that the BreEZe might not meet the specific needs of each board, bureau committee, program and commission; that the BreEZe system may have challenges during development or implementation limiting access to stakeholders; and any unresolved challenges in the BreEZe system could result in a break in service to consumers, applicants, and licensees.

Issue #4: Appropriate Budgets Funding.

Risks: Entities have been required to take budget cuts, which hampers their ability to absorb costs with minor program changes, to match the growth of increased program costs due to inflation, and reduces their ability to redirect funding to meet increased costs, especially in the area of enforcement.

VACANT POSITIONS

I acknowledge that DCA is in compliance with GC Section 12439. Our compliance includes continuous emphasis to all boards, bureaus and divisions of the importance of filling vacant positions within six months of becoming vacant in order to avoid losing them. DCA's Office of

Human Resources (OHR) assists its clients by providing them with an updated position roster and vacancy report each month. OHR staff work closely with their clients to ensure timely recruitment and filling of vacant positions. Once a selection is made to fill the position, OHR requires a justification to be submitted. The justification is required to ensure that a position is being filled in order to meet operational needs and to prevent inappropriate hires in order to avoid losing the position subject to GC Section 12439. Additionally, OHR has strengthened its compliance efforts by hiring a retired annuitant to monitor vacant positions and oversee position control.

CONCLUSION

I certify that our systems of internal controls are adequate to mitigate potential threats identified in the Evaluation of Risks and Controls Section above.

Brian L. Stiger

Brian Stiger, Acting Director
Department of Consumer Affairs

12/31/11
Date

cc: Honorable Governor Edmund G. Brown Jr.
Ana J. Matosantos, Director, Department of Finance
Pam Wortman, Deputy Director, Office of Administrative Services, DCA
Cathleen Sahlman, Chief, Internal Audit Office, DCA
Bureau of State Audits
State Library
Legislature
State Controller's Office
State Treasurer's Office
Attorney General

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
BEGINNING BALANCE	$ 27,903	$ 30,246	$ 18,855	$ 14,388	$ 8,128
Prior Year Adjustment	$ (556)	$ -	$ -	$ -	$ -
Adjusted Beginning Balance	$ 27,347	$ 30,246	$ 18,855	$ 14,388	$ 8,128
REVENUES AND TRANSFERS					
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	$ 51	$ 51	$ 51	$ 51
150300 Income from surplus money investments	$ 164	$ 202	$ 91	$ 49	$ 10
160400 Sale of fixed assets	$ 3	$ 3	$ 3	$ 3	$ 3
161000 Escheat of unclaimed checks and warrants	$ 22	$ 23	$ 23	$ 23	$ 23
161400 Miscellaneous revenues	$ 1	$ 1	$ 1	$ 1	$ 1
164300 Penalty assessments - Probation Monitoring		$ 900	$ 900	$ 900	$ 900
Totals, Revenues	$ 49,912	$ 52,234	$ 52,107	$ 52,647	$ 52,996
Transfers:					
GENERAL FUND LOAN		$ (9,000) *			
TOTALS, REVENUES AND TRANSFERS	$ 49,912	$ 43,234	$ 52,107	$ 52,647	$ 52,996
TOTAL RESOURCES	$ 77,259	$ 73,480	$ 70,962	$ 67,035	$ 61,124
EXPENDITURES					
Disbursements:					
0840 State Controller (State Operations)	$ 80	$ 58	$ 53	$ -	$ -
8880 FSCU (State Operations)	$ 31	$ 168	$ 44		
1110 Program Expenditures (State Operations)	$ 46,902	$ 54,399	$ 55,199	$ 57,607	$ 58,759
2012-2013 Proposed BCPs					
Operation Safe Medicine			---	---	---
BreEZe (including credit card cost)			$ 1,278		
Anticipated Future Costs					
Antcipated BreEZe Cost				$ 1,300	$ 1,300
Totals, Disbursements	$ 47,013	$ 54,625	$ 56,574	$ 58,907	$ 60,059
FUND BALANCE					
Reserve for economic uncertainties	$ 30,246	$ 18,855	$ 14,388	$ 8,128	$ 1,066
Months in Reserve	6.6	4.0	2.9	1.6	0.2

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)
* This $9 million is part of the $15 million total loaned to the General Fund by the Board. $6 million was loaned to the General Fund in FY 08/09.

1/26/2012

SENATE BILL No. 957

Introduced by Senator Leno

January 10, 2012

An act making appropriations for the support of the government of the State of California and for several public purposes in accordance with the provisions of Section 12 of Article IV of the Constitution of the State of California, to take effect immediately, Budget Bill.

LEGISLATIVE COUNSEL'S DIGEST

SB 957, as introduced, Leno. 2012–13 Budget.

This bill would make appropriations for support of state government for the 2012–13 fiscal year.

This bill would declare that it is to take effect immediately as a Budget Bill.

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

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

1 SECTION 1.00. This act shall be known and may be cited as the
2 "Budget Act of 2012."
3 SEC. 1.50. (a) In accordance with Section 13338 of the Government
4 Code, as added by Chapter 1284 of the Statutes of 1978, and as amended
5 by Chapter 1286 of the Statutes of 1984, it is the intent of the Legislature
6 that this act utilize a coding scheme compatible with the Governor's
7 Budget and the records of the Controller, and provide for the appropriation
8 of federal funds received by the state and deposited in the State Treasury.
9 (b) Essentially, the format and style are as follows:
10 (1) Appropriation item numbers have a code which is common to all
11 the state's fiscal systems. The meaning of this common coded item number
12 is as follows:
13 2720—Organization Code (this code represents the California Highway
14 Patrol)
15 001—Reference Code (first appropriation for a particular fund for
16 support of each department)
17 0044—Fund Code (Motor Vehicle Account, State Transportation Fund)
18 (2) Appropriation items are organized in organization code order.

Item | Amount

1110-001-0758—For support of Medical Board of California, payable from the Contingent Fund of the Medical Board of California..... 56,477,000

Schedule:

(1) 55.10.010-Medical Board of California..... 57,641,000

(2) 55.15-Registered Dispensing Opticians..... 343,000

(3) 55.17-Outpatient Setting..... 27,000

(4) 55.02.020-Distributed Medical Board of California..... −780,000

(5) Reimbursements..... −384,000

(6) Amount payable from the Dispensing Opticians Fund (Item 1110-001-0175)..... −343,000

(7) Amount payable from the Outpatient Setting Fund of the Medical Board of California (Item 1110-001-0210)..... −27,000

Provisions:

1. The amount appropriated in this item may include revenues derived from the assessment of fines and penalties imposed as specified in Section 13332.18 of the Government Code.

1110-001-0759—For support of Physical Therapy Board of California, payable from the Physical Therapy Fund..... 3,222,000

Schedule:

(1) 58-Physical Therapy Board of California..... 3,321,000

(2) Reimbursements..... −99,000

Provisions:

1. The amount appropriated in this item may include revenues derived from the assessment of fines and penalties imposed as specified in Section 13332.18 of the Government Code.

1110-001-0761—For support of Board of Registered Nursing, payable from the Board of Registered Nursing Fund, Professions and Vocations Fund..... 29,441,000

Schedule:

(1) 78-Board of Registered Nursing.... 30,455,000

(2) Reimbursements..... −1,014,000

Provisions:

1. The amount appropriated in this item may include revenues derived from the assessment of fines and penalties imposed as specified in Section 13332.18 of the Government Code.

Agenda Item 16

Special Faculty Permit Review Committee Update and Consideration of Applicant

will be sent under separate cover

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Catherine Dower, JD

Catherine Dower is the Associate Director for Research at the UCSF Center for the Health Professions where for over 15 years she has led health professions' research and policy efforts. At the Center, she directs a national Innovative Workforce Models in Health Care project and co-directs the Health Workforce Tracking Collaborative, which assesses health care workforce challenges including mal-distribution, shortages and scopes of practice. She has also directed studies on emerging professions, health care personnel in the military, allied health professions and new practice models in primary care and medical specialties. Catherine co-directed the Pew Health Professions Commission's national Taskforce on Health Care Workforce Regulation and was a principal author of its reports on health professions regulation. Catherine served on the Committee of the Robert Wood Johnson Foundation Initiative on the Future of Nursing at the Institute of Medicine; and on the National Commission for Certifying Agencies. Catherine received her undergraduate and law degrees from the University of California at Berkeley and is licensed to practice law in the State of California.

California's Health Care Workforce — Are We Ready for the ACA?

Catherine Dower

Burlingame, February 3, 2012

CENTER
FOR THE HEALTH PROFESSIONS

California's Health Care Workforce: Readiness for the ACA Era

Team:

Tim Bates, MPP; Lisel Blash, MPA;

Susan Chapman, BSN, MSN, PhD; Catherine Dower, JD; and Edward O'Neil, FAAN, MPA, PhD.

Sponsor:

Funded by The California Wellness Foundation

Impetus:

PPACA and Governor's taskforce

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CENTER FOR THE HEALTH PROFESSIONS

RESEARCH REPORT

California's Health Care Workforce: Readiness for the ACA Era

Prepared by the
Center for the Health Professions, UCSF
With a Grant from
The California Wellness Foundation

by Tim Bates, MPP; Lisel Blash, MPA, MS; Susan Chapman, BSN, MSN, PhD; Catherine Dower, JD; and Edward O'Neil, FAAN, MPA, PhD.

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CENTER FOR THE HEALTH PROFESSIONS

RESEARCH BRIEF

California's Health Care Workforce—Are We Ready for the ACA?

Tim Bates, MPP; Lisel Blash, MPA, MS; Susan Chapman, BSN, MSN, PhD; Catherine Dower, JD; and Edward O'Neil, FAAN, MPA, PhD
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ABSTRACT

This research brief summarizes the report *California's Health Care Workforce: Readiness for the ACA Era*. The brief and corresponding report explore the current and future capacity of California's health care workforce to meet the expected increase in demand resulting from expanded insurance coverage under the Patient Protection and Affordable Care Act (ACA). Both documents present data, analyses, and policy recommendations for addressing the workforce challenges presented by the ACA.

The Patient Protection and Affordable Care Act (ACA) provides an unprecedented opportunity to address structural issues in the US health care system. Much of the work will reside at the state level, and California is taking a lead in improving financing and organizational structures. Meaningful decisions about expanding coverage and moving to new practice models require solid workforce data and analysis. *California's Health Care Workforce: Readiness for the ACA Era* uses key informant interviews, detailed analyses of the California Department of Consumer Affairs (DCA) Professional License Masterfile, a literature review, and an environmental scan to highlight the challenges of comparing data across professions and identifying and analyzing the options for meeting workforce needs in the context of the current economic environment.

- There are over a million individuals in California's health care workforce.
- Geographic maldistribution of health care professionals has resulted in shortages in some areas of the state, and surpluses in others.
- Existing datasets are not standardized across the health professions and contain significant gaps.
- The health professions are overall not reflective of the state's ethnic and racial diversity.
- California has numerous health professions education programs, but many are oversubscribed.
- Practice models are changing in response to new pressures and opportunities.

What are the drivers that affect the quantity and quality of California's health care workforce?

Several forces are exerting pressure on the state's health workforce to expand and evolve. Demographic factors include a population that is projected to grow 15% in the next 20 years, an increasingly culturally diverse and aging population, and an increase in chronic disease burden.

Market forces are also bringing about change. Advances in health information technology both facilitate and demand workflow redesign, providing unprecedented opportunity and challenge. New models of care such as retail clinics and school- and work-based clinics are emerging to offer enhanced access to health care.

Perhaps most dramatically, the state is poised to implement the Patient Protection and Affordable Care Act, which will in part expand coverage to four to six million more Californians. Undocumented residents are not covered by the ACA, and this continues to provide special challenges to the state's safety net providers.

Methodology

- Key informant interviews
- CA Department of Consumer Affairs Professional License MasterFile
- Literature review
- Environmental scan

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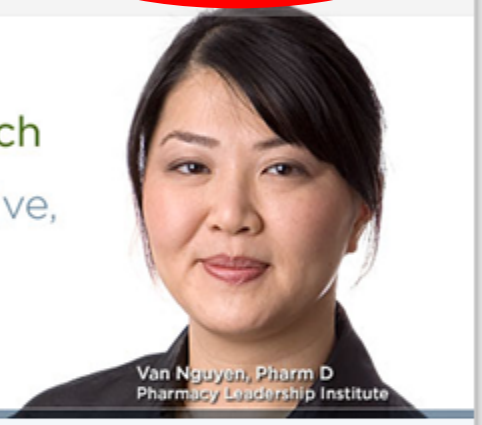

MONTHLY HOT TOPIC

Is Primary Care Necessary?

AUTHOR: Ed O'Neil

No, it is essential. At the most macro level it has always been interesting to me that those nations that seem to take better care of their citizens for less money have the exact reverse proportions of providers--greater numbers of primary care providers than specialists;

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California's Health Care Workforce: Readiness for the ACA Era

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California's Health Care Workforce: Readiness for the ACA Era

November 09, 2011

CATEGORIES: Workforce, Supply & Demand, Recruitment and Retention, Education and Training, Forecast, Diversity, Health Policy, Economics and Financing, Laws and Regulations, Language Services, Cultural Competence, Population Demographics, Quality Improvement, Scopes of Practice
TAGS: Allied Health, Dentistry, Complementary Medicine, Medicine, Nursing, Pharmacy, Public Health, Mental/Behavioral Health
AUTHOR: Timothy Bates, Lisel Blash, Susan Chapman, Catherine Dower, Ed O'Neil

REPORT: This comprehensive report, sponsored by the California Wellness Foundation, explores the current and future capacity of California's health care workforce to meet the expected increase in demand resulting from expanded insurance coverage under the Patient Protection and Affordable Care Act (ACA). California's Health Care Workforce: Readiness for the ACA Era uses key informant interviews, detailed analyses of the California Department of Consumer Affairs (DCA) Professional License Masterfile, a literature review, and an environmental scan to highlight the challenges of comparing data across professions and identifying and analyzing the [illegible] for meeting workforce needs in the context of the current economic environment. A series of policy recommendations is included.

Report (.pdf)

ISSUE BRIEF: This research brief summarizes the report *California's Health Care Workforce: Readiness for the ACA Era*. The brief and corresponding report explore the current and future capacity of California's health care workforce to meetthe expected increase in demand resulting from expanded insurance coverage under the Patient Protection and Affordable Care Act (ACA). Both documents [illegible] data, analyses, and policy recommendations for addressing the workforce challenges presented by the ACA.

Issue Brief (.pdf)

RELATED CONTENT

CATEGORIES: Workforce, Supply & Demand, Recruitment and Retention, Education and Training, Forecast, Diversity, Health Policy, Economics and Financing, Laws and Regulations, Language Services, Cultural Competence, Population Demographics, Quality Improvement, Scopes of Practice
TAGS: Allied Health, Dentistry, Complementary Medicine, Medicine, Nursing, Pharmacy, Public Health, Mental/Behavioral Health

California's Health Care Workforce: Readiness for the ACA Era

AUTHORS: Timothy Bates, Lisel Blash, Susan Chapman, Catherine Dower, Ed O'Neil

California's Health Care Workforce—Are We Ready for the ACA?

AUTHORS: Timothy Bates, Lisel Blash, Susan Chapman, Catherine Dower, Ed O'Neil

Southcentral Foundation—Nuka Model of Care Provides Career Growth for Frontline Staff

AUTHORS: Lisel Blash, Susan Chapman, Catherine Dower

Nurse Practitioners and Physician Assistants Providing Primary Care in California Community Clinics

AUTHORS: Susan Chapman, Catherine Dower

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  - Pharmacy

CENTER FOR THE HEALTH PROFESSIONS

RESEARCH REPORT

California's Health Care Workforce: Readiness for the ACA Era

Prepared by the
Center for the Health Professions, UCSF
With a Grant from
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by Tim Bates, MPP; Lisel Blash, MPA, MS; Susan Chapman, BSN, MSN, PhD; Catherine Dower, JD; and Edward O'Neil, FAAN, MPA, PhD.

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and Retention, Education and Training,
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mprovement, Scopes of Practice
TAGS: Allied Health, Dentistry, Complen
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Southcentral Foundation—
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Nurse Practitioners and Ph

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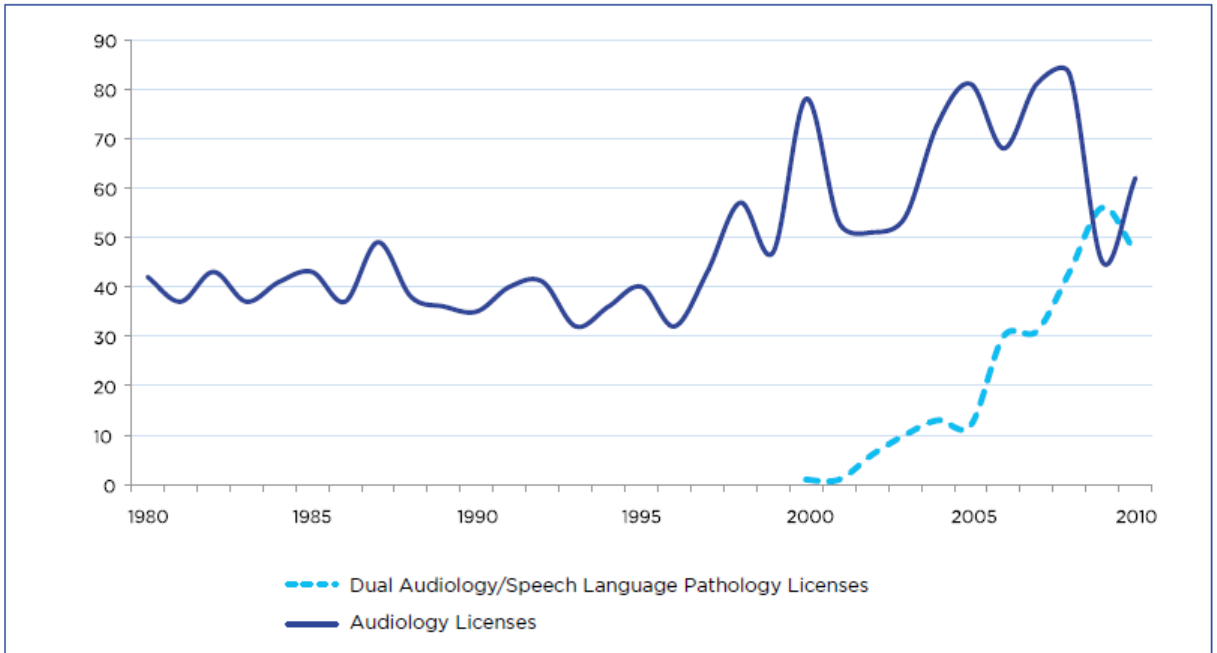
Allied Health

California Licensed Audiologists

Between 1980 and 1995 the number of new licenses issued annually to practice as an audiologist in California was consistent. Since 1995, annual licenses issued have generally increased, but with very large fluctuations; the reasons for this are unknown but may be related to training program capacity. Applicants for licensure after 2008 were required to have a doctoral degree (as opposed to a master's degree), which could explain the drop in new licenses issued per year at that point. However, Figure 2 also shows an increasing number of dual audiology/speech-language pathology licenses issued annually (a recently established license type), which mirrors the recent decline in new audiology-alone licenses.

Figure 2. California licensed audiologists – new licenses issued per year: 1980 – 2010



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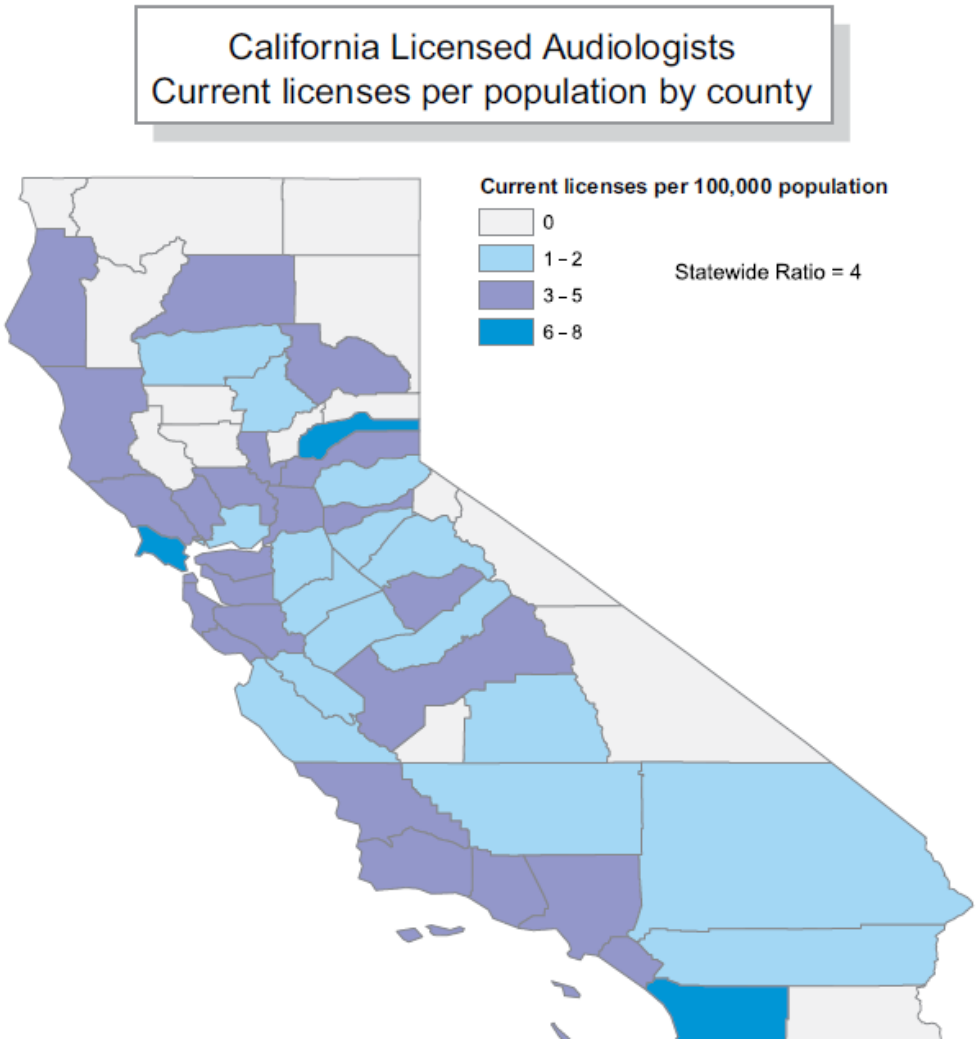
IV. HEALTH PROFESSIONS WORKFORCE DATA
Labor Market

As of February 2011, there were 1,323 individuals with a California address in possession of a current and valid license to practice as an audiologist in the state. Audiology is a small workforce and these data show that approximately one-quarter of the counties in the state do not have any currently practicing audiologists, and another 25 percent have audiologist per population ratios less than one-half the state-wide ratio. This raises the question of whether California's supply of audiologists is adequate to meet the demand for services.

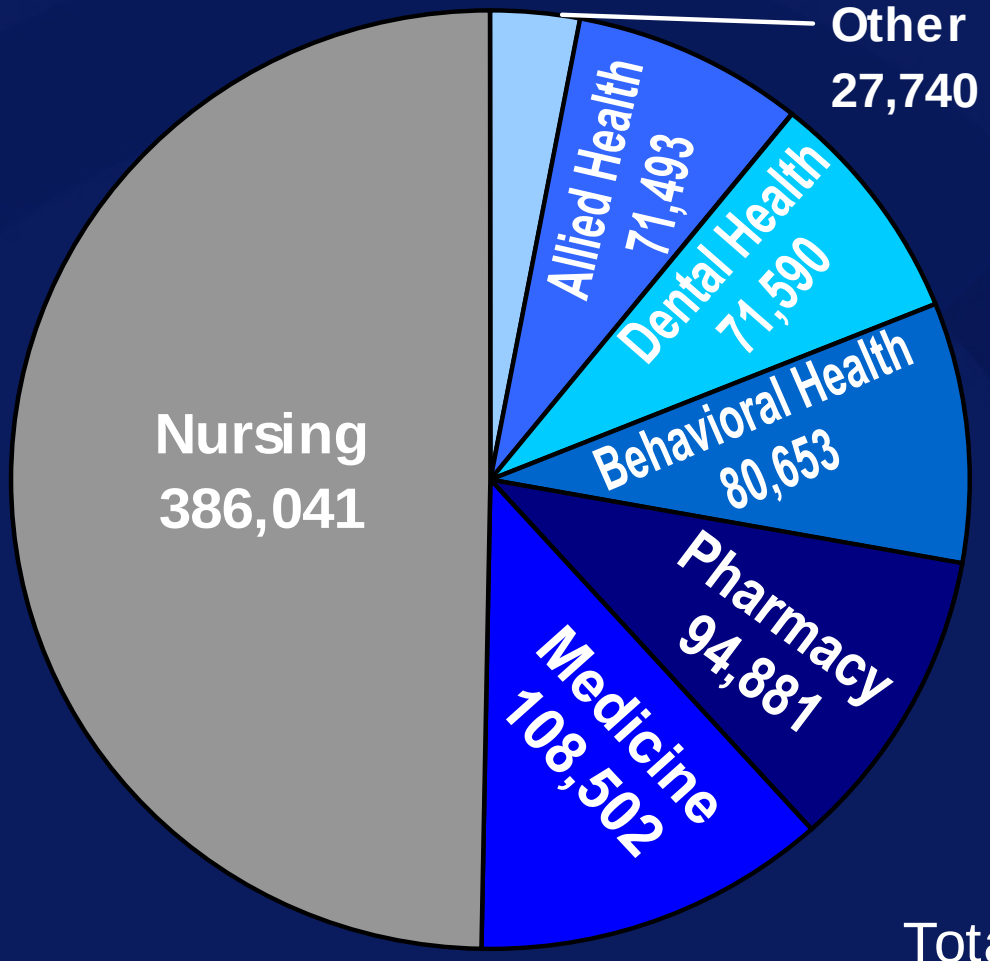
Map 2. Current California audiologist licenses per population by county



Key Findings

- Health workforce major part of labor sector
- Continued growth
- Significant maldistribution
- Growing population, more diverse population, aging population, changing disease burden
- ACA implementation will strain primary care providers first

California's Licensed and Registered Health Care Workforce—February 2011



Total = 840,900

Source: California DCA Professional License Masterfile

Big Questions

1. What are the drivers that affect workforce quantity and quality?
2. Can the current health care workforce meet the changes in demand?
3. Are there other sources of health workers?
4. Do we educate enough providers to meet the state's growing needs?
5. Are our health care professionals reflective of the state's racial and ethnic diversity?
6. What policy solutions can help California meet changing demands?

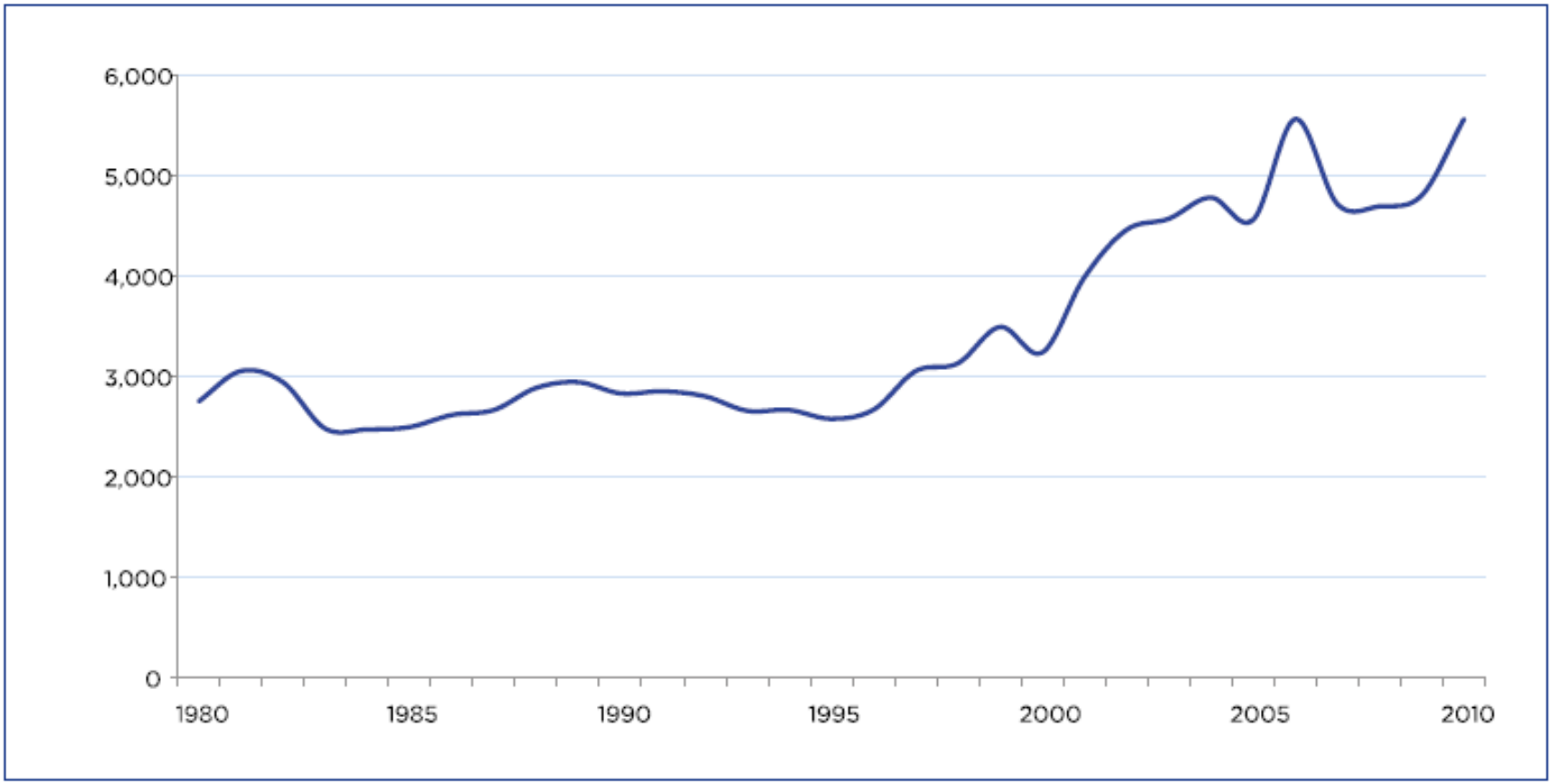
What drivers affect the quantity & quality of California's health care workforce?

- Demographic shifts
  - Aging, growing population
  - Increasingly diverse, ESL population
- Growth in health information technology (EHR)
- New models of care
- Patient Protection and Affordable Care Act
  - 3-4 million newly insured in California

Can the current health care workforce meet the changes in demand?

- Maldistribution is the biggest challenge
- Lack of cultural / linguistic concordance may limit access
- Incomplete or insufficient data limits workforce planning
- Primary care is likely to be the most impacted by the increase in demand

Figure 36. California licensed physicians – new licenses issued per year: 1980 – 2010



Source: CA Dept. of Consumer Affairs, Professional License Masterfile, February 2011

Table 2. California physicians per 100,000 population ratios by county: Comparing data from the DCA Masterfile and California Medical Board survey

County	DCA Masterfile	Medical Board	County	DCA Masterfile	Medical Board
Alameda	288	211	Orange	293	185
Alpine	85	0	Placer	266	219
Amador	168	145	Plumas	135	111
Butte	205	177	Riverside	120	99
Calaveras	108	71	Sacramento	300	201
Colusa	47	53	San Benito	47	58
Contra Costa	271	190	San Bernardino	173	121
Del Norte	140	116	San Diego	294	187
El Dorado	149	111	San Francisco	719	370
Fresno	190	135	San Joaquin	147	128
Glenn	36	43	San Luis Obispo	273	197
Humboldt	201	182	San Mateo	355	213
Imperial	77	80	Santa Barbara	256	183
Inyo	216	200	Santa Clara	387	239
Kern	130	111	Santa Cruz	247	170
Kings	90	76	Shasta	238	191
Lake	111	118	Sierra	0	27
Lassen	106	94	Siskiyou	165	150
Los Angeles	272	176	Solano	205	181
Madera	123	125	Sonoma	259	200
Marin	521	272	Stanislaus	176	142
Mariposa	60	53	Sutter	193	170
Mendocino	214	173	Tehama	74	82
Merced	88	81	Trinity	36	47
Modoc	21	28	Tulare	104	98
Mono	211	160	Tuolumne	222	167
Monterey	197	155	Ventura	195	159
Napa	322	231	Yolo	234	142
Nevada	288	170	Yuba	60	60
California	**259**	**174**			

Source: CA Dept. of Consumer Affairs, Professional license masterfile, February 2011; 2010 Census Summary File 1; Grumbach, K., Chattopadhyay, A., Bindman, A. (2009). Fewer and More Specialized: A New Assessment of Physician Supply in California. Oakland, CA: California HealthCare Foundation.

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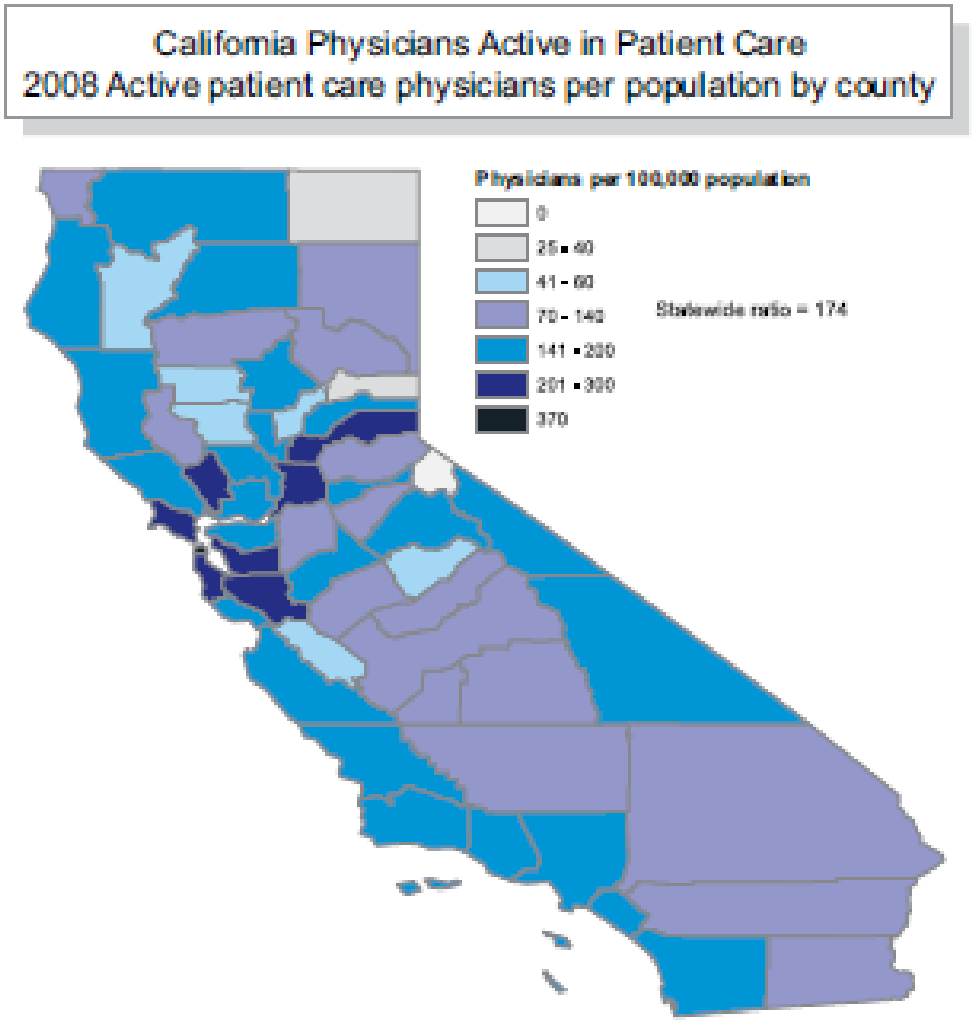
County	DCA Materfile	Medical Board	County	DCA Masterfile	Medical Board
Alameda	288	211	Orange	293	185
Alpine	85	0	Placer	266	219
Amador	168	145	Plumas	135	111
Butte	205	177	Riverside	120	99
Calaveras	108	71	Sacramento	300	201
Colusa	47	53	San Benito	47	58
Contra Costa	271	190	San Bernardino	173	121
Del Norte	140	116	San Diego	294	187
El Dorado	149	111	San Francisco	719	370
Fresno	190	135	San Joaquin	147	128
Glenn	36	43	San Luis Obispo	273	197
Humboldt	201	182	San Mateo	355	213
Imperial	77	80	Santa Barbara	256	183
Inyo	216	200	Santa Clara	387	239
Kern	130	111	Santa Cruz	247	170
Kings	90	76	Shasta	238	191
Lake	111	118	Sierra	0	27

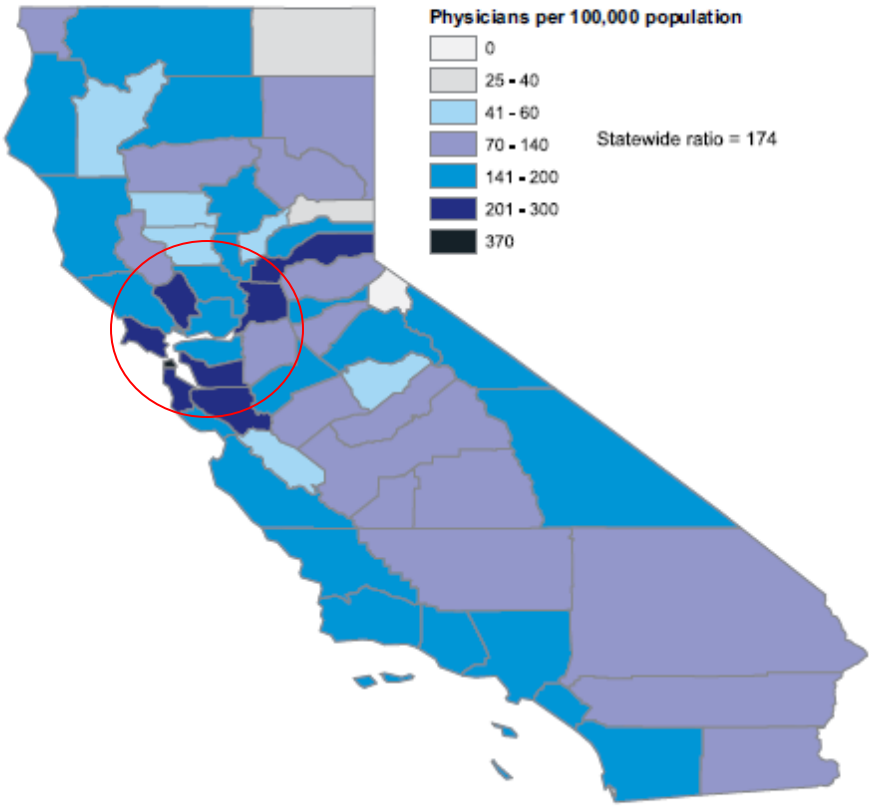
Map 35. 2008 California active patient care physicians per population by county



Source: Grumbach, K. Chattopadhyay, A., Bindman, A. 2009. *Fewer and More Specialized: A New Assessment of Physician Supply in California.* California HealthCare Foundation, Oakland, California

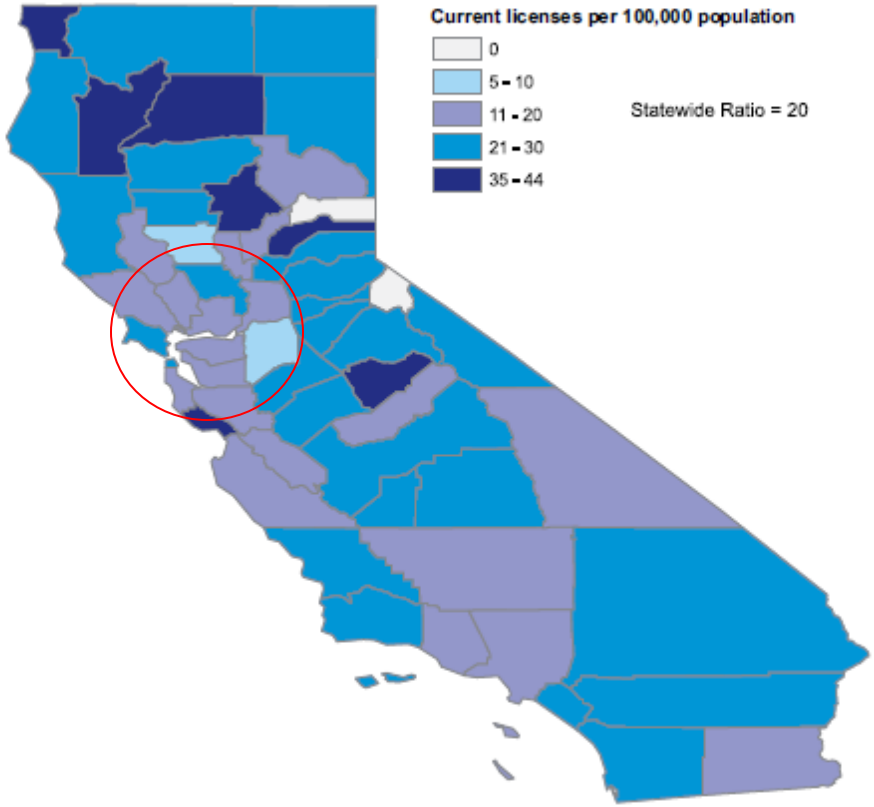
Distribution of Primary Care Physicians and Physician Assistants

California Physicians Active in Patient Care
2008 Active patient care physicians per population by county



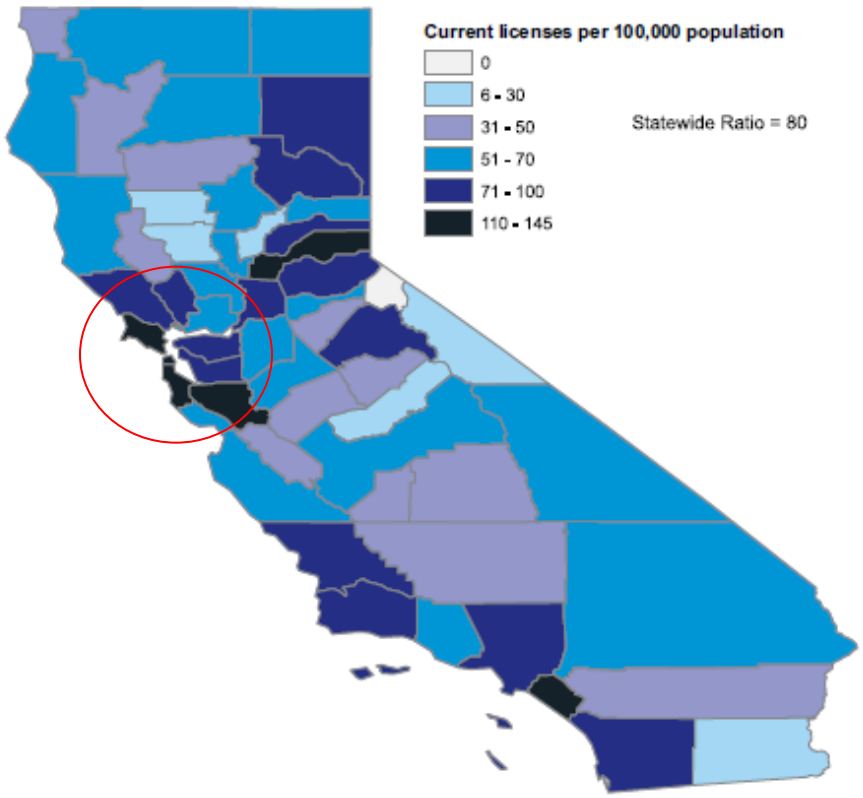
Source: Grumbach, K. Chattopadhyay, A., Bindman, A. 2009. *Fewer and More Specialized: A New Assessment of Physician Supply in California*. California HealthCare Foundation, Oakland, California

California Licensed Physician Assistants
Current licenses per population by county

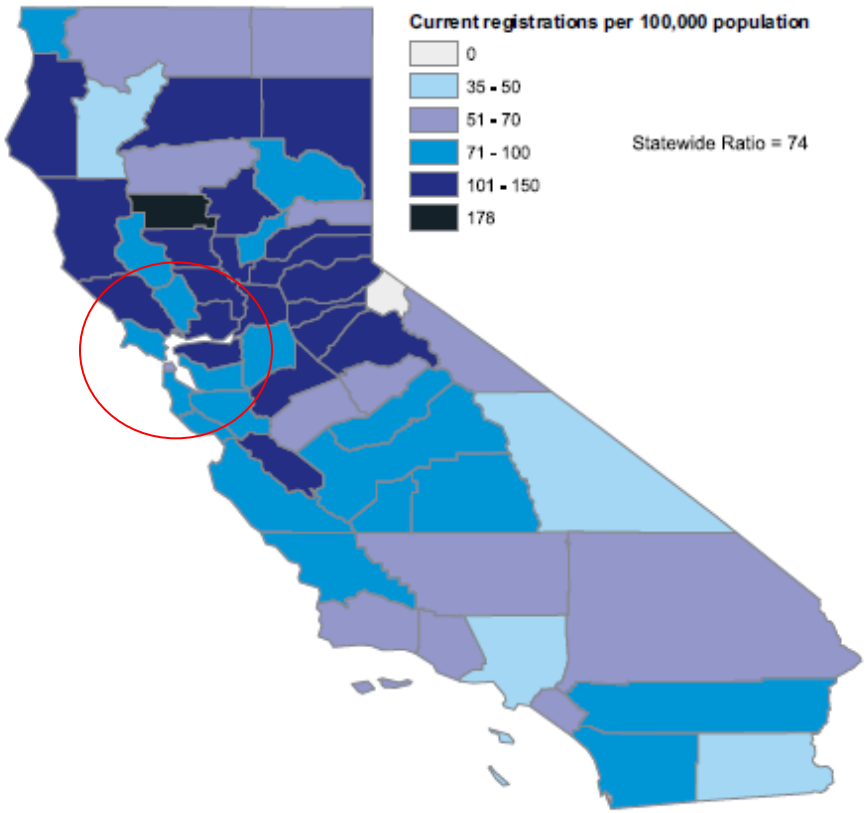


Includes active licenses reported as "clear" or "valid" (primary status code = 1000)
County distribution is based on individual's address of record
Sources: CA Dept. of Consumer Affairs, Professional License Masterfile, February 2011; 2010 Census Summary File 1

Distribution of Dentists and Dental Assistants



Includes active licenses reported as "clear" or "valid" (primary status code = 1000)
County distribution is based on individual's address of record
Sources: CA Dept. of Consumer Affairs, Professional License Masterfile, February 2011;
2010 Census Summary File 1



Includes active licenses reported as "clear" or "valid" (primary status code = 1000)
County distribution is based on individual's address of record
Sources: CA Dept. of Consumer Affairs, Professional License Masterfile, February 2011;
2010 Census Summary File 1

Solutions: ***Improving Supply, Distribution, and Workforce Practice Models***

- Increase training & residency opportunities in under-served areas
- Expand loan repayment programs for practicing in underserved areas
- Enhance telehealth
- Expand legal scope of practice for NPs & PAs
- Improve workforce data collection
- Strengthen the capacity of safety net providers

Are there other sources of health professionals?

- California relies on foreign trained professionals, particularly in primary care:
  - 31% of primary care physicians
  - 24% of nurses
- Need better data on emigration of health professionals trained in California

Do we educate enough providers to meet the state's growing needs?

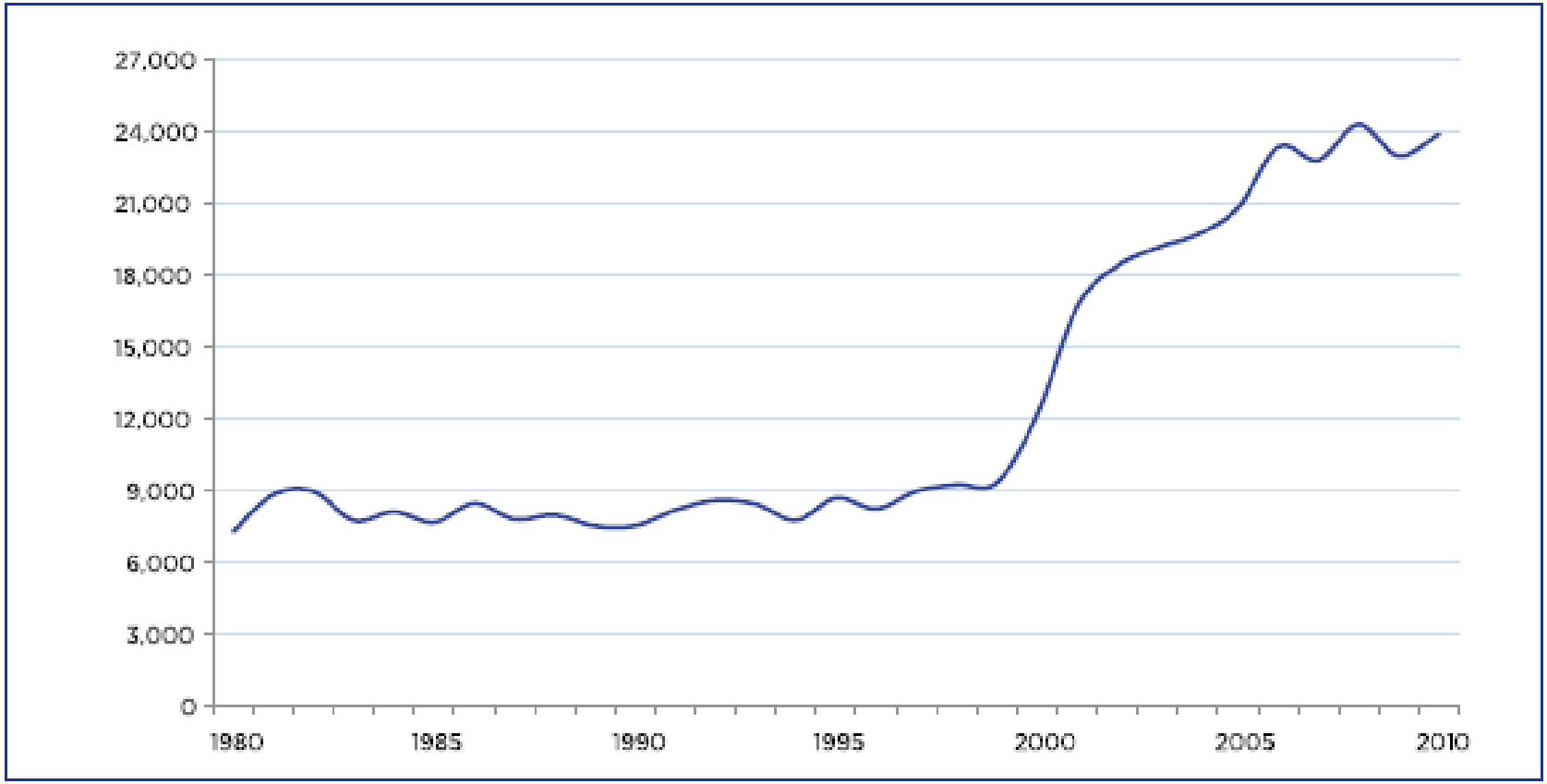
- Decrease in family medicine residency slots
- Oversubscribed training programs
- High attrition rates in many CC allied health training programs
- Low graduation rates for URMs make it difficult to diversify some health professions
- More HIT professionals and trainining needed

Solutions: ***Improving the Education Pipeline***

- Encourage medical students to practice in primary care
- Refocus some education resources on NP & PA training
- Enhance retention in CC health careers programs
- Invest more equitably in primary and secondary (K-12) education programs

Expansion of nursing programs *has* increased the supply of nurses

Figure 24. California licensed registered nurses – new licenses issued per year: 1980 – 2010



Source: CA Dept. of Consumer Affairs, Professional License Masterfile, February 2011

Are our health care professionals reflective of the state's racial and ethnic diversity?

- 5 percent of MDs are Latino
- 7 percent of DDSs are Latino
- 21 percent of PAs are Latino
- 37 percent of CA residents are Latino

- Newly eligible for subsidies or Medi-Cal (CPEHN 2010):
  - More than half will be people of color
  - 32-51% of the adults speak English less than well

Solutions: Increasing Diversity

- Invest in interpretation
- Train CHWs, promotorás, & health educators
- Build career ladders for the (diverse) allied health professions
- Evaluate & replicate models that work to enroll & retain URMs in training programs
- Including communities of color in the planning processes for ACA implementation

California's Health Care Workforce: Moving Forward

Challenge

- Growing pressure on safety net providers
- Geographic maldistribution of workforce
- Diversity challenges

Promise

- Continued job growth despite the recession
- New finance and delivery models may decrease costs --improve access and quality of care
- HIT leveraged to facilitate new models of care

California's Health Care Workforce: Readiness for the ACA Era

Contact: Catherine Dower
cdower@thecenter.ucsf.edu
415-476-1894

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WORKLOAD REPORT

as of December 31, 2011

CONSUMER INFORMATION UNIT FY 11/12					
	FY 11/12	Q1	Q2	Q3	Q4
Total Calls Answered	***36,181***	15,725	20,456		
Calls Requesting Call Back	***9,669***	4,647	5,022		
Calls Abandoned	***8,972***	4,356	4,616		
Address Changes Completed	***5,584***	3,451	2,133		

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

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

PHYSICIAN & SURGEON DATA FY 11/12					
	FY 11/12	Q1	Q2	Q3	*Q4*
Applications Received	***3,377***	1,711	1,666		
Initial Reviews Completed	***3,180***	1,491	1,689		
Total Pending	***N/A***	4,012	4,225		
Reviewed	***N/A***	3,273	3,530		
Not Reviewed	***N/A***	739	795		
(SR2s Pending)	***N/A***	108	121		
Licenses Issued	***2,562***	1,359	1,203		
Renewals Issued	***30,159***	16,092	14,067		

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

* 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.

WORKLOAD REPORT

as of December 31, 2011

SR 2 - CATEGORIES					
	FY 11/12	Q1	Q2	Q3	Q4
Alcohol/Drugs	***42***	30	12		
PG/Medical Knowledge	***99***	59	40		
Convictions	***61***	43	18		
Other	***136***	92	44		

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	2			5	2			5	5			8	4			3	2		
2112	0	0			0	0			0	0			0	0			0	0		
2113	5	5			2	5			2	3			10	12			2	2		
2168	3	3			2	2			0	2			2	0			3	1		
2072	0	0			0	0			0	0			1	0			0	0		
1327	0	0			0	0			0	0			0	1			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		Q3	Q4	Q1	Q2	Q3	Q4
2111	19	9	2	3	18	4	2	3	16	4	2	2	13		2	14	4	14	1	2
2112	0	1	0	1	0	0	0	1	0	0	1	0	0		0	0	0	1	1	1
2113	7	1	7	9	5	3	7	6	4	4	1	5	20		12	10	6	3	6	13
2168	0	0	0	0	0	0	0	0	0	0	0	0	3		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
1327	1	0	0	1	1	0	0	1	0	0	0	1	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

WORKLOAD REPORT

as of December 31, 2011

INTERNATIONAL MEDICAL SCHOOL APPLICATIONS FY 11/12					
	FY 11/12	Q1	Q2	Q3	Q4
New Self-Assessment Report Received	***2***	2	0		
Pending Self-Assessment Report	***N/A***	3	5		
New Applications Received w/o Recognized Schools	***36***	22	14		
Pending Application Received w/o Recognized Schools	***N/A***	35	56		
School Recognized Pursuant to CCR 1314(a)(1)	***6***	4	2		
School Recognized Pursuant to CCR 1314(a)(2)	***1***	1	0		
TOTAL Pending Applications w/o Recognized Schools	***N/A***	**62**	**75**		

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	***14***	9	5		
Applications Pending	***N/A***	6	3		
Licenses Issued	***12***	4	8		
Licenses Renewed	***55***	24	31		

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	0		
RP Licenses Issued	***3***	3	0		

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

WORKLOAD REPORT

as of December 31, 2011

FICTITIOUS NAME PERMITS FY 11/12					
	FY 11/12	Q1	Q2	Q3	*Q4*
P&S - FNP Issued	***764***	384	380		
P&S - FNP Pending	***N/A***	59	63		
Podiatric FNP Issued	***12***	3	9		
Podiatric FNP Pending	***N/A***	0	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

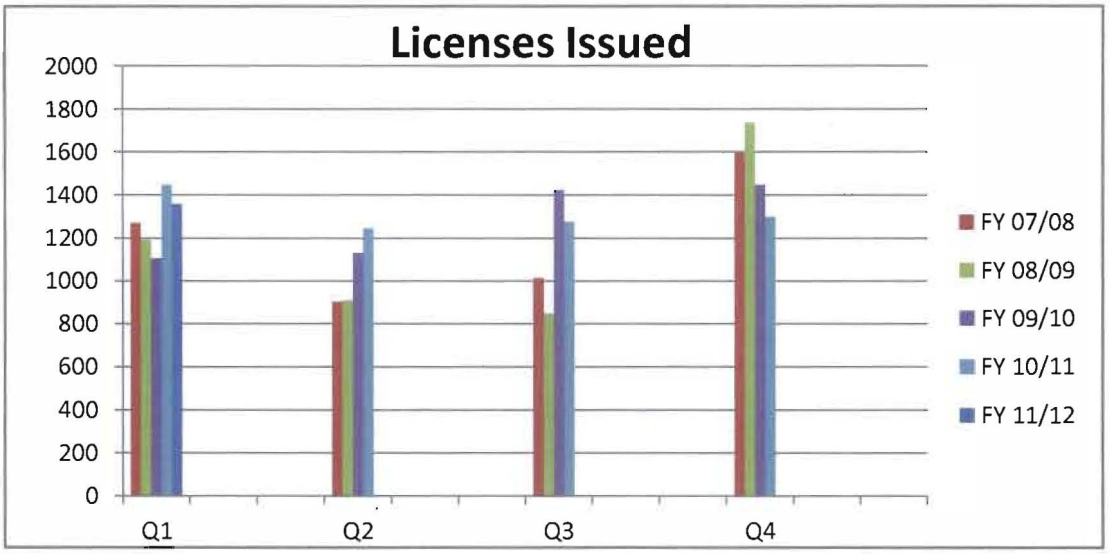
SPECIALTY BOARD APPLICATIONS FY 11/12					
	FY 11/12	Q1	Q2	Q3	*Q4*
Applications Received	***0***	0	0		
Applications Pending	***N/A***	1	1		

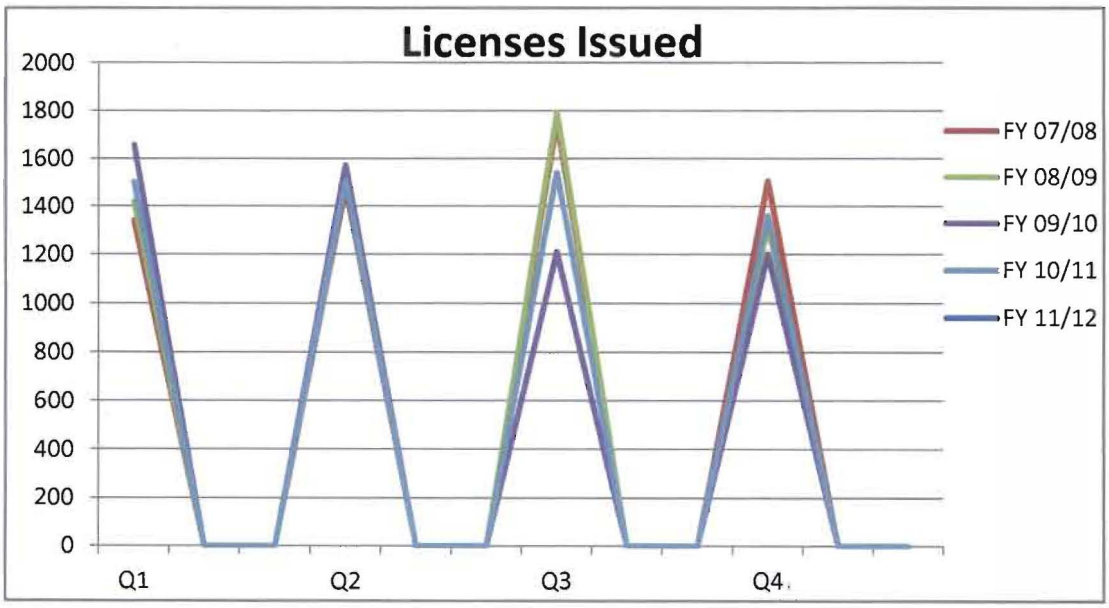
SPECIALTY BOARD APPLICATIONS FY 10/11					
	FY 10/11	Q1	Q2	Q3	*Q4*
Applications Received	***0***	0	0	0	0
Applications Pending	***N/A***	1	1	1	1

OPTICAL REGISTRATIONS FY 11/12					
	FY 11/12	Q1	Q2	Q3	Q4
Business Registrations Issued	***19***	10	9		
Pending Applications Business	***N/A***	30	30		
Out-of-State Business Registrations Issued	***0***	0	0		
Pending Applications Out of State Bus.	***N/A***	0	0		
Spectacle Lens Registrations Issued	***76***	47	29		
Pending Applications-Spectacle Lens	***N/A***	78	107		
Contact Lens Registrations Issued	***24***	13	11		
Pending Applications-Contact Lens	***N/A***	22	33		
Spectacle Lens Registrations Renewed	***433***	216	217		
Contact Lens Registrations Renewed	***174***	95	79		

OPTICAL REGISTRATIONS FY 10/11					
	FY 10/11	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.	***N/A***	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	1,203			***2,562***
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***



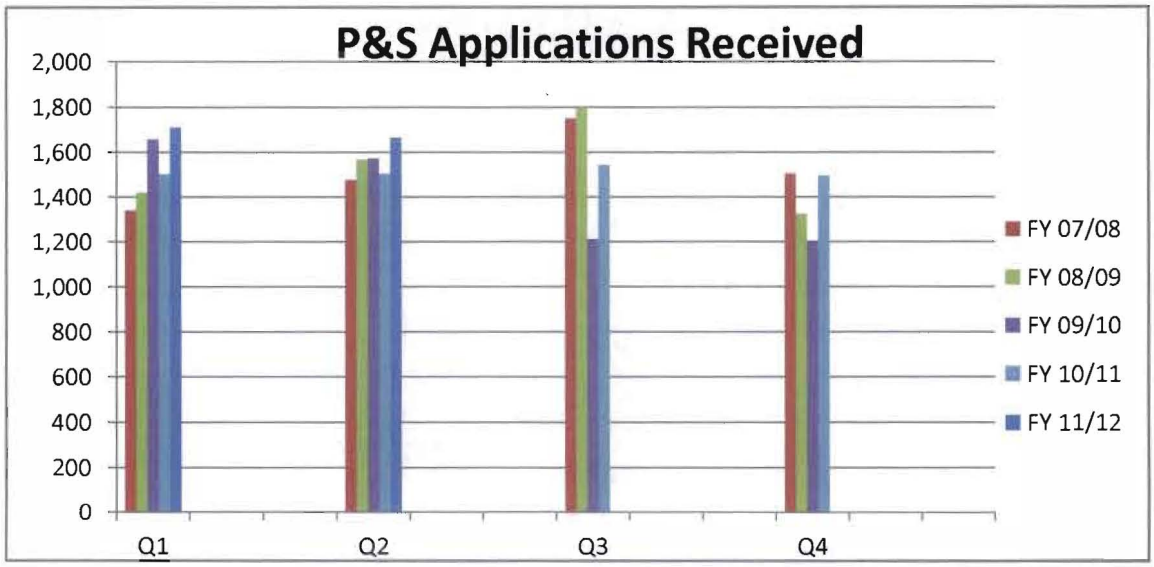


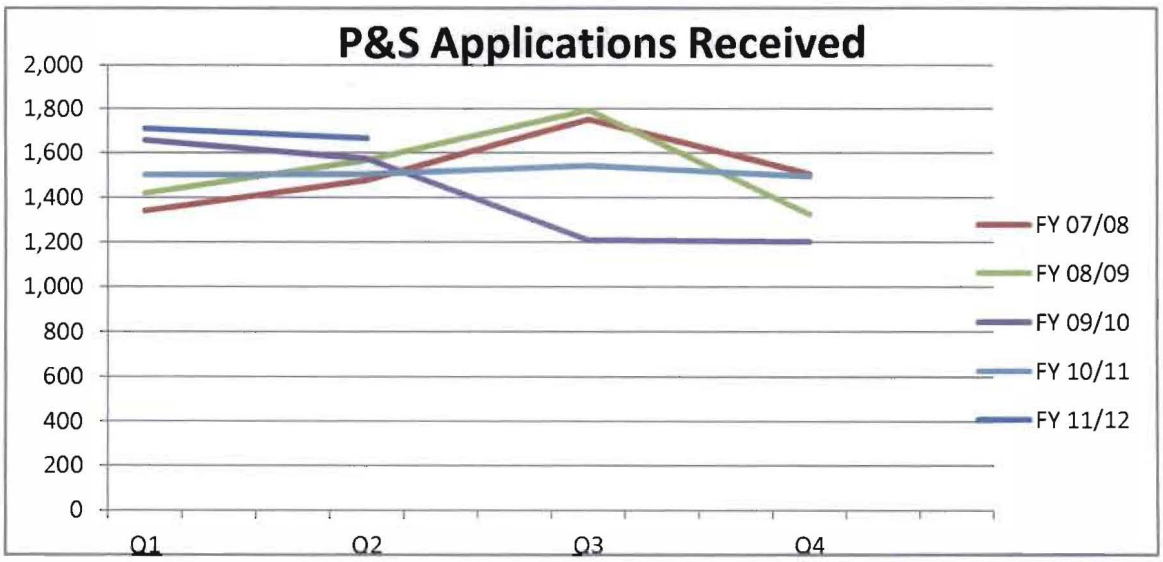
WORKLOAD REPORT

as of December 31, 2011

*PHYSICIAN'S AND SURGEON'S LICENSE AND PTAL APPLICATIONS RECEIVED Five Fiscal Year History					
Fiscal Year	QTR 1	QTR 2	QTR 3	QTR 4	TOTAL
FY 11/12	1,711	1,666			***3,377***
FY 10/11*	1,503	1,505	1,543	1496	***4,551***
FY 09/10	1,658	1,573	1,211	1,203	***4,442***
FY 08/09	1,420	1,568	1,794	1,325	***4,782***
FY 07/08	1,341	1,478	1,751	1,506	***4,570***

* 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 -->	15-Oct	22-Oct	29-Oct	5-Nov	12-Nov	19-Nov	26-Nov	3-Dec	10-Dec	17-Dec	24-Dec	31-Dec	7-Jan
Number of Workdays -->	5	5	5	5	4	5	5	5	5	5	5	4	4
Applications Received													
US/CAN	74	127	89	101	101	157	58	63	119	85	64	58	62
IMG - License	11	16	16	17	13	19	24	14	33	18	18	13	20
IMG - PTAL	28	26	19	29	17	12	10	12	13	10	10	11	12
Total	***113***	***169***	***124***	***147***	***131***	***188***	***92***	***89***	***165***	***113***	***92***	***82***	***94***
Applications Completed (License or PTAL Issued)													
US/CAN - Licensed	57	67	51	105	61	49	20	119	81	71	59	43	85
IMG - Licensed	19	29	24	35	30	9	15	40	21	25	14	21	29
Total - Licensed	**76**	**96**	**75**	**140**	**91**	**58**	**35**	**159**	**102**	**96**	**73**	**64**	**114**
Total - PTAL's Issued	***31***	***25***	***20***	***29***	***22***	***32***	***14***	***25***	***30***	***23***	***19***	***16***	***21***
Applications Processed (Initial Review Completed)													
Application Complete Upon Initial Review (TBL)													
US/CAN	23	10	18	9	14	35	5	13	7	42	7	7	21
IMG - License	0	0	0	0	0	0	0	0	0	0	0	0	1
IMG - PTAL	0	0	3	0	1	1	0	1	0	0	0	0	0
Subtotal	***23***	***10***	***21***	***9***	***15***	***36***	***5***	***14***	***7***	***42***	***7***	***7***	***22***
Application Deficient Upon Initial Review													
US/CAN	71	56	75	70	80	130	13	92	37	154	28	37	124
IMG - License	21	26	25	17	11	18	13	14	20	16	38	10	18
IMG - PTAL	32	34	31	31	27	28	11	21	30	7	14	11	11
Subtotal	***124***	***116***	***131***	***118***	***118***	***176***	***37***	***127***	***87***	***177***	***80***	***58***	***153***
Total	***147***	***126***	***152***	***127***	***133***	***212***	***42***	***141***	***94***	***219***	***87***	***65***	***175***
*Applications Awaiting Initial Review - Current as of: -->	18-Oct	25-Oct	1-Nov	8-Nov	15-Nov	22-Nov	29-Nov	6-Dec	13-Dec	20-Dec	28-Dec	3-Jan	10-Jan
NEW: 0-30 days	520	575	549	555	570	526	557	503	549	453	452	440	392
AGING: 31-60 days	199	165	192	165	110	183	192	201	238	215	243	265	220
AGING: 61-90 days	0	0	0	0	0	0	0	0	0	0	0	0	0
BACKLOG: Over 90 days	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	***719***	***740***	***741***	***720***	***680***	***709***	***749***	***704***	***787***	***668***	***695***	***705***	***612***
Date of Oldest US Appl Awaiting Initial Review-->	*09/06/11*	*09/12/11*	*09/15/11*	*09/26/11*	*10/03/11*	*10/17/11*	*10/17/11*	*10/19/11*	*10/25/11*	*11/08/11*	*11/10/11*	*11/14/11*	*11/22/11*
Number of calendar days for US Initial Reviews	*43*	*44*	*49*	*44*	*44*	*38*	*44*	*49*	*50*	*43*	*49*	*52*	*50*
Days out of Compliance	*0*	*0*	*4*	*0*	*0*	*0*	*0*	*4*	*5*	*0*	*4*	*7*	*5*
Date of Oldest IMG Appl Awaiting Initial Review-->	*09/14/11*	*09/26/11*	*10/03/11*	*10/10/11*	*10/17/11*	*10/24/11*	*10/27/11*	*11/04/11*	*11/14/11*	*11/17/11*	*11/30/11*	*12/06/11*	*12/09/11*
Number of calendar days for IMG Initial Reviews	*35*	*30*	*31*	*30*	*30*	*31*	*34*	*33*	*30*	*34*	*29*	*29*	*33*
Days out of Compliance	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Date of Oldest US Pending Mail Awaiting Review-->	*10/12/11*	*10/19/11*	*10/26/11*	*11/02/11*	*11/09/11*	*11/16/11*	*11/23/11*	*11/30/11*	*12/07/11*	*12/12/11*	*12/21/11*	*12/28/11*	*01/04/12*
Number of calendar days for US Pending Mail	*7*	*7*	*7*	*7*	*7*	*7*	*7*	*7*	*7*	*9*	*7*	*7*	*7*
Date of Oldest IMG Pending Mail Awaiting Review-->	*10/12/11*	*10/19/11*	*10/26/11*	*11/02/11*	*11/09/11*	*11/16/11*	*11/23/11*	*11/30/11*	*12/07/11*	*12/14/11*	*12/21/11*	*12/28/11*	*01/04/12*
Number of calendar days for IMG Pending Mail	7	7	7	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
Algeria	Universite Mouloud Mammeri de Tizi-Ouzou Faculty of Medicine	10/20/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Antigua and Barbuda	American University of Antigua College of Medicine		Recognized		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	X		Chief/Legal Counsel verified medical school is owed and operated by the government, therefore, it is eligible for recognition pursuant to CCR 1314.1(a)(1).
Australia	Queensland 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, Medical College for Women & Hospital	10/21/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).

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
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	Centro Universitario Serra dos Orgaos Faculdaded Unificadas (UNIFESO)	1/4/2012	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 6/3/2011	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	X		ULBRA provided all of the necessary documents to verify eligibility for recognition pursuant to CCR 1314.1(a)(1).
Brazil	Universidade Sao Francisco (USF) Faculdade de Ciencias Medicas	12/1/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
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).

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
China	Anhui Medical University Faculty of Medicine	10/12/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
China	Guangdong Pharmaceutical University	11/9/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
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	Shandong University School of Medicine	11/2/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
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	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

Country	Medical School Name	Date Request Received	Status of Application	CCR 1314.1(a)(1)	CCR 1314.1(a)(2)	Comments/Decision
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.
Ecuador	Universidad San Francisco de Quito Colegio de Ciencias de la Salud	12/19/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
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
France	Faculte Libre de Medecine, Universite Catholique de Lille	12/28/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
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).
India	Baba Farid University of Health Sciences, Government Medical College, Amritsar	1/14/2011	Recognized	X		Chief/Legal Counsel verified medical school is owed and operated by the government, therefore, it is eligible for recognition pursuant to CCR 1314.1(a)(1).

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
India	Baba Farid University of Health Sciences, Government Medical College, Patiala	1/14/2011	Recognized	X		Chief/Legal Counsel verified medical school is owed and operated by the government, therefore, it is eligible for recognition pursuant to CCR 1314.1(a)(1).
India	Chhatrapati Shahu Ji Maharaj University, G.S.V.M. Medical College	3/8/2011	Recognized	X		Chief/Legal Counsel verified medical school is owed and operated by the government, therefore, it is eligible for recognition pursuant to CCR 1314.1(a)(1).
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	India University of Mumbai, Thane Municipal Corporation Medical College	9/23/2010	Recognized	X		Chief/Legal Counsel verified medical school is owed and operated by the government, therefore, it is eligible for recognition pursuant to CCR 1314.1(a)(1).
India	Kannur University, Academy of Medical Sciences, Pariyaram	5/2/2011	Recognized	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, Government Medical College Aurangabad	7/6/2010	Recognized	X		Chief/Legal Counsel verified medical school is owed and operated by the government, therefore, it is eligible for recognition pursuant to CCR 1314.1(a)(1).

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
India	Maharashtra University of Health Sciences, Government Medical College Nagpur	9/14/2010	Recognized	X		Chief/Legal Counsel verified medical school is owed and operated by the government, therefore, it is eligible 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, Nashik, Dr. Shankar Rao Chavan Government Medical College	8/10/2010	Recognized	X		Chief/Legal Counsel verified medical school is owed and operated by the government, therefore, it is eligible 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).

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
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).
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	Swami Ramanand Teerth Marathwada University, Government Medical College, Nanded	8/10/2010	Recognized	X		Chief/Legal Counsel verified medical school is owed and operated by the government, therefore, it is eligible 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	Tamil Nadu Dr. M.G.R. Medical University, Coimbatore Medical College	12/28/2010	Recognized	X		Chief/Legal Counsel verified medical school is owed and operated by the government, therefore, it is eligible for recognition pursuant to CCR 1314.1(a)(1).
India	Tamil Nadu Dr. M.G.R. Medical University, Madras Medical College	9/8/2010	Recognized	X		Chief/Legal Counsel verified medical school is owed and operated by the government, therefore, it is eligible for recognition pursuant to CCR 1314.1(a)(1).

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
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, Jehlum Valley College 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	University of Madras, Madurai Medical College	5/31/2011	Recognized	X		Chief/Legal Counsel verified medical school is owed and operated by the government, therefore, it is eligible 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

Country	Medical School Name	Date Request Received	Status of Application	CCR 1314.1(a)(1)	CCR 1314.1(a)(2)	Comments/Decision
Iran	Shiraz University of Medical Sciences	9/12/2011	Recognized	X		Chief/Legal Counsel verified medical school is owed and operated by the government, therefore, it is eligible for recognition pursuant to CCR 1314.1(a)(1).
Iran	Urmia University of Medical Sciences Faculty of Medicine	1/18/2010	Recognized	X		Chief/Legal Counsel verified medical school is owed and operated by the government, therefore, it is eligible for recognition pursuant to CCR 1314.1(a)(1).
Iraq	Al-Anbar University College of Medicine	10/19/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
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).
Ireland	The National University of Ireland (NUI) - Penang Medical College (PMC) - Royal College of Surgeons in Ireland (RCSI) - University of Dublin (UCD)	6/29/2010	Recognized	X		NUI, PMC, RCSI, & UCD provided all of the necessary documents to verify eligibility for recognition pursuant to CCR 1314.1(a)(1).
Israel	Technion Israel Institute of Technology (TeAMS)	2/16/2011	Recognized		X	Approved at the January 2011 Board Meeting. Approval is retroactive to the start of Technion American Medical Students Program (TeAMS) in 2006.
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).

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
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	Fukuoka University School of Medicine (FUSM)		Recognized	X		FUSM provided all of the necessary documents to verify 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).
Mauritius	University of Mauritius, SSR Medical College	11/9/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).

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
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).
Nepal	Universal College of Medical Sciences, Paklihawa Campus	7/15/2011	Pending	?	?	Staff needs to review Self-Assessment Report
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).
Norway	Norwegian University of Science and Technology (NUST), Faculty of Medicine	10/25/2010	Recognized	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 Lahore, Nishtar Medical College and Hospital (NMCH)	9/1/2010	Pending	?	?	Staff needs to request additional information from NMCH.

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
Poland	Medical University of Bialystok	1/4/2012	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Poland	Medical University of Silesia School of Medicine (English Language Program)	1/2009	Recognized		X	Approved at the January 2011 Board Meeting. Approval is retroactive to the beginning of the English Language Program in 1996.
Poland	Medical University of Warsaw English Language Program		Pending		X	Staff is reviewing Medical Consultant's request for additional information.
Qatar	Weill Cornell Medical College in Qatar		Recognized	X		WCMC - Q provided all of the necessary documents to verify eligibility for recognition pursuant to CCR 1314.1(a)(1).
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 needs to request information from DNUS.
South Africa	Walter Sisulu University Faculty of Health Sciences	10/20/2011	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	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).

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
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).
South Korea	Dongguk University College of Medicine	4/28/2011	Recognized	X		Dongguk University COM provided all of the necessary documents to verify eligibility for recognition pursuant to CCR 1314.1(a)(1).
South Korea	Konkuk University College of Medicine	10/31/2011	Pending	?	?	Staff needs to send correspondence to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
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).
Turkey	Istanbul University, Cerrahpasa School of Medicine (Turkish and English)	11/12/2010	Recognized	X		UICSM provided all of the necessary documents to verify 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).

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
Venezuela	Universidad Central de Venezuela Escuela de Medicina Jose Marie Vargas		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		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).

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	January 13, 2012
ATTENTION:	Medical Board of California
SUBJECT:	Regulations on Physician Supervision of Licensed Midwives (Business and Professions Code §2507(f).
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing

REQUESTED ACTION:

The Midwifery Advisory Council (MAC) has requested the Board to direct staff to set the matter of defining the appropriate level of physician supervision of licensed midwives for regulatory hearing. The proposed regulation is attached.

BACKGROUND:

Business and Professions Code §2507(f) requires the Board to adopt regulations defining the appropriate standard of care and level of supervision required for the practice of midwifery by July 1, 2003. Due to the inability to reach consensus on the supervision issue, the Board bifurcated this requirement and in 2006 adopted Standards of Care for Midwifery (16 CCR, §1379.19). Three previous attempts to resolve the physician supervision issue via legislation and/or regulation have been unsuccessful.

Although required by law, physician supervision is essentially unavailable to licensed midwives as California physicians are generally prohibited in their insurance agreements from providing supervision of midwives who perform home births lest they lose their hospital privileges and insurance coverage. The MAC has previously reported to the Board on the barriers to care the physician supervision requirement creates, such as difficulty securing diagnostic lab accounts, obtaining syringes, IV equipment, oxygen, and necessary injectable medications, etc. California is currently the only state that requires physician supervision of licensed midwives.

On March 31, 2011, the American College of Obstetricians and Gynecologists and the American College of Nurse Midwives issued a joint statement as part of an ongoing initiative to promote collaborative practice between obstetrician-gynecologists and certified nurse-midwives and/or certified midwives.

At the December 13, 2011 MAC meeting, Council members discussed draft language to define the appropriate level of physician supervision of licensed midwives via regulation and voted to request that the Board set the matter for regulatory hearing.

ANALYSIS:

The proposed regulation sets forth a more collaborative approach to the physician supervision issue by providing that the supervision requirement in law is met if the licensee established a

collaborative relationship with a physician who agrees to provide guidance and instructions in the specified circumstances. As is apparent, this is a different approach than saying that a physician has to be on a site at a specified location or available by pager, telephone or other device within a certain time period.

Whenever this issue is discussed, the subjects of liability and insurance (and the cost and availability thereof) always arise. The proposed regulation does provide that a business relationship is not created solely by a physician providing consultative services to or by accepting a referral from a licensed midwife.

A full analysis of possible objections to the proposed regulation is not possible at this time, since both of licensed physicians that were on the MAC had officially resigned prior to the December 13, 2011 MAC meeting. Therefore, Council members and staff did not have input from a licensed physician at the meeting. A California Medical Association representative was present at the meeting; however, she did not provide any public comment. In addition, no one representing the insurance industry was present at the meeting.

FISCAL CONSIDERATIONS

No fiscal impact.

STAFF RECOMMENDATION:

Given the Board's prior unsuccessful attempts to develop regulations on the appropriate level of physician supervision of licensed midwives and the widely divergent opinions of interested parties, staff recommends that the Board consider directing staff to schedule an interested parties meeting to discuss concerns and issues. The issues and concerns brought forth at the meeting could then be summarized and analyzed by staff and brought back to the Board or MAC for further discussion and consideration. To the extent practicable, resolving issues prior to commencing the formal rulemaking process may lead to a more successful effort.

Medical Board of California
Physician Supervision of Midwives
Specific Language of Proposed Changes
Draft—11-29-11

Adopt section 1379.23 in Article 3.5 of Chapter 4 of Division 13, Title 16 Cal.Code Regs. to read as follows:

1379.23. Physician Supervision Requirement.

(a) The requirement for physician supervision contained in Section 2507 of the Code is deemed to have been met if the licensed midwife has established an informal, collaborative relationship with at least one physician who meets the requirements of section 1379.22 and who agrees to provide guidance and instructions regarding the care of women and/or newborns and to provide emergency advice should complications develop.

(b) A physician and surgeon shall not be deemed to have established a business relationship or relationship of agency, employment, partnership, or joint venture with the licensed midwife solely by providing consultation to or accepting a referral from the licensed midwife.

NOTE; Authority cited: Sections 2018 and 2507(f), Business and Professions Code. Reference: Section 2507, Business and Professions Code.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: January 13, 2012
ATTENTION: Medical Board of California
SUBJECT: Midwifery Regulations
STAFF CONTACT: Curtis J. Worden, Chief of Licensing

REQUESTED ACTION:

Direct staff to schedule a public hearing at the May 3-4, 2012 Board meeting to review the adoption of proposed regulation Section 1379.24 in Chapter 24 of Division 13, Title 16 California Code of Regulations authorizing licensed midwives to obtain and administer drugs, immunizing agents, diagnostic tests and devices, and to order laboratory tests, consistent with their educational requirements.

STAFF RECOMMENDATION:

Staff recommends that the Board set for regulatory hearing the adoption of Section 1379.24 in Chapter 24 of Division 13, Title 16 California Code of Regulations, along with any edits or additional provisions that the Board may suggest for inclusion in the regulation.

BACKGROUND:

Current regulations address the educational requirements for midwifery education programs (16 CCR §1379.30). The education program must prepare the midwife for the management of the normal pregnancy, labor, and delivery, including the administration of intravenous fluids, analgesics, postpartum oxytocics, RhoGAM, amniotomy during labor, local anesthesia, paracervical blocks, pudendal blocks, local infiltration, episiotomies, repair of episiotomies and lacerations, administration of vitamin K and eye prophylaxis, and management of routine gynecological care including barrier methods of contraception such as diaphragms and cervical caps. However, current regulations do not specifically authorize a licensed midwife to incorporate these requirements into her practice. As such, midwives often face difficulty in securing supplies such as oxygen, anesthetics, and oxytocics in order to practice safely and effectively.

At the Board's May 6, 2011 meeting, the Midwifery Advisory Council proposed that staff move forward to develop regulations to ensure that midwifery practice and educational requirements are consistent, specifically authorizing licensed midwives to obtain and use the resources they have been educated for. The Board directed staff to work on regulations to ensure consistency.

At the December 13, 2011 Midwifery Advisory Council (MAC) meeting, legal counsel presented language for the proposed regulation. The MAC approved the proposed language with minor edits (attached).

ANALYSIS:

The attached proposed regulation will clarify that licensed midwives have the authority to obtain, order, and administer the drugs, devices, and tests that they have been educated to use in the management of the normal pregnancy, labor, and delivery. In essence, this regulation rectifies

an inconsistency in existing regulations: while midwives are educated to obtain, order, and administer these items, they often cannot acquire them without enormous difficulty.

FISCAL CONSIDERATIONS

No fiscal impact.

MEDICAL BOARD OF CALIFORNIA
Midwifery Program
Specific Language of Proposed Changes
Draft – 12/14/11

Adopt new section 1379.24 in Chapter 4 of Division 13, Title 16 Cal. Code Regs. To read as follows:

1379.24 Practice of Midwifery

A licensed midwife shall have the authority, limited to the practice of midwifery, to obtain and administer drugs, immunizing agents, diagnostic tests and devices, and to order laboratory tests. This authority includes, but is not limited to, obtaining and administering intravenous fluids, analgesics, postpartum oxytocics, RhoGAM, local anesthesia, oxygen, local infiltration, vitamin K, eye prophylaxis, diaphragms and cervical caps.

NOTE: Authority cited: Section 2018, Business and Professions Code.
Reference: Section 2507, Business and Professions Code.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: January 13, 2012
ATTENTION: Medical Board of California
SUBJECT: Composition of the Midwifery Advisory Council
STAFF CONTACT: Curtis J. Worden, Chief of Licensing

BACKGROUND:

Business and Professions Code §2509 (B&P § 2509) directs the Board to create and appoint a Midwifery Advisory Council, consisting of licensees of the Board in good standing and members of the public who have an interest in midwifery practice. At least one half of the Council members are to be licensed midwives. At the February 2007 Board meeting, based on staff's recommendations, the Board appointed obstetrician/gynecologists (licensed physicians) to two of the public member spots and a member of the Board to the other public member spot. The remaining three spots are filled by currently licensed midwives.

It is important to note how the MAC members are actually seated. To fill a vacancy, the MAC calls for applications and then reviews those applications. The MAC, at one of its meetings, then selects an applicant(s) and makes a recommendation to the Board that the applicant be appointed by the Board to the MAC. The Board then considers the recommendation at one of its quarterly meetings. To summarize, the MAC selects and recommends MAC applicants; the Board appoints them.

At the May 6, 2011 Quarterly Board meeting, Karen Ehrlich, LM, former Chair of the Midwifery Advisory Council (MAC) requested that the Board consider modifying the composition of the Council by adding two members (one public member and one licensee, as required by B&P §2509) in order to allow representation by a member of the public who has been the recipient of midwifery services. Ms. Ehrlich reported at the meeting that the midwifery community fells that the voice of parents who have received midwifery care has been missing in discussions and decisions of importance to midwives. The Board authorized the MAC to study the issue of adding members and to return with a recommendation.

In November 2011, two of the public members on the MAC (Ruth Haskins, M.D. and William Frumovitz, M.D.) resigned from their positions, leaving two public member vacancies on the Council. These resignations also leave the MAC without a physician member. Dr. Haskins' term was set to expire in January 2013; Dr. Frumovitz's term was set to expire in July 2012. In addition, one of the licensed midwife member positions will expire in May 2012.

At the December 13, 2011 MAC meeting, the MAC, stated concerns about the need to restore its membership. Rather than requesting that the Board add two additional members to the MAC, Council members voted to recommend the following items to the Board:

1) That one of the vacant public member spots be filled by a non-licensee of the Board and the other vacant public member spot be filled by an obstetrician/gynecologist;
2) That staff expedite a call for applications to the MAC once the Board has approved how to fill the vacancies, so submitted applications could be reviewed at the MAC's March 29, 2012 meeting; and,
3) That the Board delegate its appointing authority in this instance to the MAC to seat the public members at its March 29, 2012 meeting to serve out the remainder of the two vacant terms.

ANALYSIS:

As stated above, the MAC has two public member vacancies and quorum concerns may begin to arise. Additionally, the MAC has traditionally had a least one physician member (usually an obstetrician/gynecologist) and now it has none. There has also been some discussion that perhaps two physicians were too many and that perhaps a parent or other interested party who was not a licensee of the Board in any capacity would bring a different perspective to the MAC.

In order to fill these vacancies, MAC is asking that the Board, delegate its authority to the MAC so that the recommended applicants need not go before the Board to be formally appointed. Rather, at the March 2012 meeting of the MAC, an applicant selected by the MAC would be seated on the MAC.

The issues presented by the MAC's action are twofold: First, does the Board wish to constitute the MAC in the manner suggested (three LMs, one public member who is on the Board, one public member who is not a licensee of the Board, and one obstetrician/gynecologist) versus expanding the overall membership to eight? Second, does the Board wish to delegate its authority to appoint MAC members?

FISCAL CONSIDERATIONS

No fiscal impact.

REQUESTED ACTION:

That the Board take the following actions:

1) Approve the request that the two vacant public member spots be filled by a non-licensee of the Board and the other vacant public member spot be filled by an obstetrician/gynecologist;
2) Direct MBC staff to expedite a call for applications to the MAC so submitted applications could be reviewed at the MAC's March 29, 2012 meeting; and,
3) Delegate its appointing authority in this instance only to the MAC to seat the two public members at its March 29, 2012 meeting to serve out the remainder of the two terms.

STAFF RECOMMENDATION:

An alternative for the Board to consider for item 3 above is that the Board authorize the MAC to appoint members for one meeting only and then consider the MAC recommendations for full appointment at the May 3-4, 2012 Board meeting.

The Board could elect to fill the vacant position that expires in July 2012 to a full three year term, in addition to the remaining time in the current term.

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
Calendar Year 2011

SPECIALTY	Number of cases reviewed/sent to Experts	Number of Experts used and how often utilized	Active List Experts Y-T-D: 1,172↓
ADDICTION	10	**6 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	16
ALLERGY & IMMUNOLOGY (A&I)			6
ANESTHESIOLOGY (Anes)	20	**14 EXPERTS** 8 LIST EXPERTS REVIEWED 1 CASE 5 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 7 CASES* **involved companion cases**	88 ↓
COLON & RECTAL SURGERY (CRS)	2	**1 EXPERT** 1 LIST EXPERT REVIEWED 2 CASES	4
COMPLEMENTARY/ALTERNATIVE MEDICINE	9	**3 EXPERTS** 2 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 5 CASES	29
CORRECTIONAL MEDICINE	3	**3 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE	42 ↓
DERMATOLOGY (D)	27	**5 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 6 CASES* 1 LIST EXPERT REVIEWED 9 CASES* 1 LIST EXPERT REVIEWED 11 CASES* **involved companion cases**	15 ↓
EMERGENCY (EM)	22	**17 EXPERTS** 12 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 3 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES	61
ETHICS	1	**1 EXPERT** 1 LIST EXPERT REVIEWED 1 CASE	9
FAMILY (FM)	110	**56 EXPERTS** 31 LIST EXPERTS REVIEWED 1 CASE 9 LIST EXPERTS REVIEWED 2 CASES 5 LIST EXPERTS REVIEWED 3 CASES 4 LIST EXPERTS REVIEWED 4 CASES 6 LIST EXPERTS REVIEWED 5 CASES 1 LIST EXPERT REVIEWED 9 CASES* **involved 5 case reviews and 4 physical evaluations**	102 ↓
HOSPICE & PALLIATIVE MEDICINE	1	**1 EXPERT** 1 EXPERT REVIEWED 1 CASE	12

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
Calendar Year 2011

SPECIALTY	Number of cases reviewed/sent to Experts	Number of Experts used and how often utilized	Active List Experts Y-T-D: 1,172↓
INTERNAL (General Internal Med)	103	**61 EXPERTS** 37 LIST EXPERTS REVIEWED 1 CASE 12 LIST EXPERTS REVIEWED 2 CASES 3 LIST EXPERTS REVIEWED 3 CASES 5 LIST EXPERTS REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES 3 LIST EXPERTS REVIEWED 6 CASES* **involved prep for hearing, supplemental work, and physical evaluations**	229 ↓
Cardiovascular Disease (Cv)	25	**17 EXPERTS** 11 LIST EXPERTS REVIEWED 1 CASE 4 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES	35
[Interventional Cardiology]	[7]		[27]
[Non-Interventional Cardiology]	[18]		[22]
Gastroenterology (Ge)	5	**4 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	21 ↓
MIDWIFE REVIEWER	6	**4 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	10
NEUROLOGICAL SURGERY (NS)	9	**4 EXPERTS** 3 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 4 CASES	9
NEUROLOGY (N)	10	**10 EXPERTS** 7 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES	29
NEUROLOGY with Special Qualifications in Child Neurology (N/ChiN)			5
NUCLEAR MEDICINE (NuM)			6

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
Calendar Year 2011

SPECIALTY	Number of cases reviewed/sent to Experts	Number of Experts used and how often utilized	Active List Experts Y-T-D: 1,172↓
OBSTETRICS & GYNECOLOGY (ObG)	102	**43 EXPERTS** 24 LIST EXPERTS REVIEWED 1 CASE 7 LIST EXPERTS REVIEWED 2 CASES 3 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES 2 LIST EXPERT REVIEWED 5 CASES 1 LIST EXPERT REVIEWED 6 CASES* 1 LIST EXPERT REVIEWED 7 CASES* 1 LIST EXPERT REVIEWED 9 CASES* 2 LIST EXPERTS REVIEWED 10 CASES* 1 LIST EXPERT REVIEWED 12 CASES*	95 ↓
	**involved case reviews of companion cases, supplemental work and prep for hearing* (also a specialty where it's difficult to find an actively practicing expert available to perform peer reviews for MBC)*		
OCCUPATIONAL MEDICINE	2	**2 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE	10
OPHTHALMOLOGY (Oph)	25	**15 EXPERTS** 3 OFF LIST EXPERTS REVIEWED 1 CASE 7 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 2 LIST EXPERTS REVIEWED 5 CASES	37
ORTHOPAEDIC SURGERY (OrS)	33	**17 EXPERTS** 10 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED2 CASES 1 LIST EXPERT REVIEWED 3 CASES 2 LIST EXPERTS REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 6 CASES* **involved companion cases**	35 ↓
OTOLARYNGOLOGY (Oto)	12	**10 EXPERTS** 9 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 5 CASES	27 ↓
PAIN MEDICINE (PM)	63	**18 EXPERTS** 7 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 5 CASES 1 LIST EXPERT REVIEWED 6 CASES* 2 LIST EXPERTS REVIEWED 7 CASES* 2 LIST EXPERTS REVIEWED 8 CASES* 1 LIST EXPERT REVIEWED 10 CASES*	26
	**involved case reviews of companion cases, supplemental work, prep and testimony* (also a specialty where it's difficult to find an actively practicing expert available to perform peer reviews for MBC)*		

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
Calendar Year 2011

SPECIALTY	Number of cases reviewed/sent to Experts	Number of Experts used and how often utilized	Active List Experts Y-T-D: 1,172↓
PATHOLOGY (Path)	5	**3 EXPERTS** 1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED3 CASES	12
PEDIATRICS (Ped)	7	**6 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES	57
Neonatal-Perinatal Medicine (NP)	3	**1 EXPERT** 1 LIST EXPERT REVIEWED 3 CASES	6
Pediatric Cardiology (Cd)	1	**1 EXPERT** 1 LIST EXPERT REVIEWED 1 CASE	7
PHYSICAL MEDICINE & REHABILITATION (PMR)	1	**1 EXPERT** 1 LIST EXPERT REVIEWED 1 CASE	11
PLASTIC SURGERY (PIS)	42	**23 EXPERTS** 12 LIST EXPERTS REVIEWED 1 CASE 7 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 4 CASES 2 LIST EXPERTS REVIEWED 5 CASES 1 LIST EXPERT REVIEWED 6 CASES	58 ↑
PREVENTIVE MEDICINE (PrM) General	1	**1 EXPERT** 1 LIST EXPERT REVIEWED 1 CASE	5
PSYCHIATRY (Psyc)	124	**52 EXPERTS** 21 LIST EXPERTS REVIEWED 1 CASE 1 OFF LIST EXPERT PERFORMED 1 EVAL. 7 LIST EXPERTS REVIEWED 2 CASES 8 LIST EXPERTS REVIEWED 3 CASES 6 LIST EXPERTS REVIEWED 4 CASES 4 LIST EXPERTS REVIEWED 5 CASES 2 LIST EXPERTS REVIEWED 6 CASES* 1 LIST EXPERT REVIEWED 7 CASES* 1 LIST EXPERT REVIEWED 8 CASES* 1 LIST EXPERT REVIEWED 12 CASES*	110 ↓
	involved- combination- case reviews, psych evaluations, supplemental reports, prepared for hearing and testified at hearing		
RADIOLOGY (Rad)	11	**8 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	40
Radiation Oncology (Rad RO)	2	**2 EXPERTS** 1 LIST EXPERT REVIEWED 1 CASE 1 OFF LIST EXPERT REVIEWED 1 CASE	5

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
Calendar Year 2011

SPECIALTY	Number of cases reviewed/sent to Experts	Number of Experts used and how often utilized	Active List Experts Y-T-D: 1,172↓
SLEEP MEDICINE (S)	2	**3 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE	10
SURGERY (S)	24	**17 EXPERTS** 11 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 2 LIST EXPERTS REVIEWED 4 CASES	58 ↑
Pediatric Surgery (PdS)	2	**2 EXPERTS** 1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	3
Vascular Surgery (VascS)	8	**5 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	14 ↑
THORACIC SURGERY (TS)	2	**2 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE	20 ↑
(MEDICAL) TOXICOLOGY	1	**1 EXPERT** 1 LIST EXPERT REVIEWED 1 CASE	3
UROLOGY (U)	25	**11 EXPERTS** 4 LIST EXPERTS REVEWED 1 CASE 4 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 2 LIST EXPERTS REVIEWED 5CASES	19

TOTAL EXPERTS USED – 2011	**450**
TOTAL CASES SENT TO EXPERTS - 2011	**786**
TOTAL ACTIVE LIST EXPERTS (as of 1/3/2012)	**1,172**

/susan (1/3/12)

Medical Board of California
Investigation Prosecution Timeframes*

	2005	2006		2007		2008		2009		2010		2011
	Prior to VE	All	VE	All	VE	All	VE	All	VE	All	VE	All
Calendar Day Age from Case Assigned to Case Closed Not Resulting in Prosecution												
Average	271	299	138	330	268	374	358	383	381	333	333	296
Median	252	285	134	304	269	335	324	346	346	298	297	273
Record Count	827	703	192	648	539	609	588	673	672	664	663	857
Calendar Day Age from Request to Suspension Order Granted												
Average	51	44	4	34	38	19	19	52	39	40	40	43
Median	17	3	2	22	23	10	10	23	23	1	1	17
Record Count	24	21	11	17	13	21	17	17	16	27	27	31
Calendar Day Age from Request to Receipt of Medical Records												
Average	58	53	37	59	57	63	58	73	73	64	64	67
Median	32	31	26	31	31	28	28	32	32	29	29	30
Record Count	475	376	228	264	259	256	252	243	243	257	257	246
Calendar Day Age from Request to Physician Interview Completed												
Average	48	51	43	52	50	63	63	52	52	46	46	52
Median	36	42	38	37	36	41	42	37	37	34	34	38
Record Count	597	453	172	406	371	473	466	696	696	582	582	729
Calendar Day Age from Request to Receipt of Expert Opinion												
Average	51	47	35	51	43	50	50	48	48	47	47	58
Median	41	35	31	36	35	39	38	36	35	37	37	39
Record Count	519	424	82	344	270	374	359	426	424	415	415	599
Calendar Day Age from Case Assigned to Completed Investigation and Accusation Filed												
Average	556	554	140	543	340	565	493	584	578	589	588	552
Median	525	504	120	523	339	541	486	575	569	616	616	533
Record Count	187	149	17	198	95	157	131	189	186	200	199	239
Calendar Day Age from Accusation Filed to Disciplinary Outcome**												
Average	608	602	85	576	188	561	243	473	339	426	340	425
Median	526	466	99	426	182	384	238	351	309	326	304	391
Record Count	212	195	3	226	29	203	80	198	145	171	156	190

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

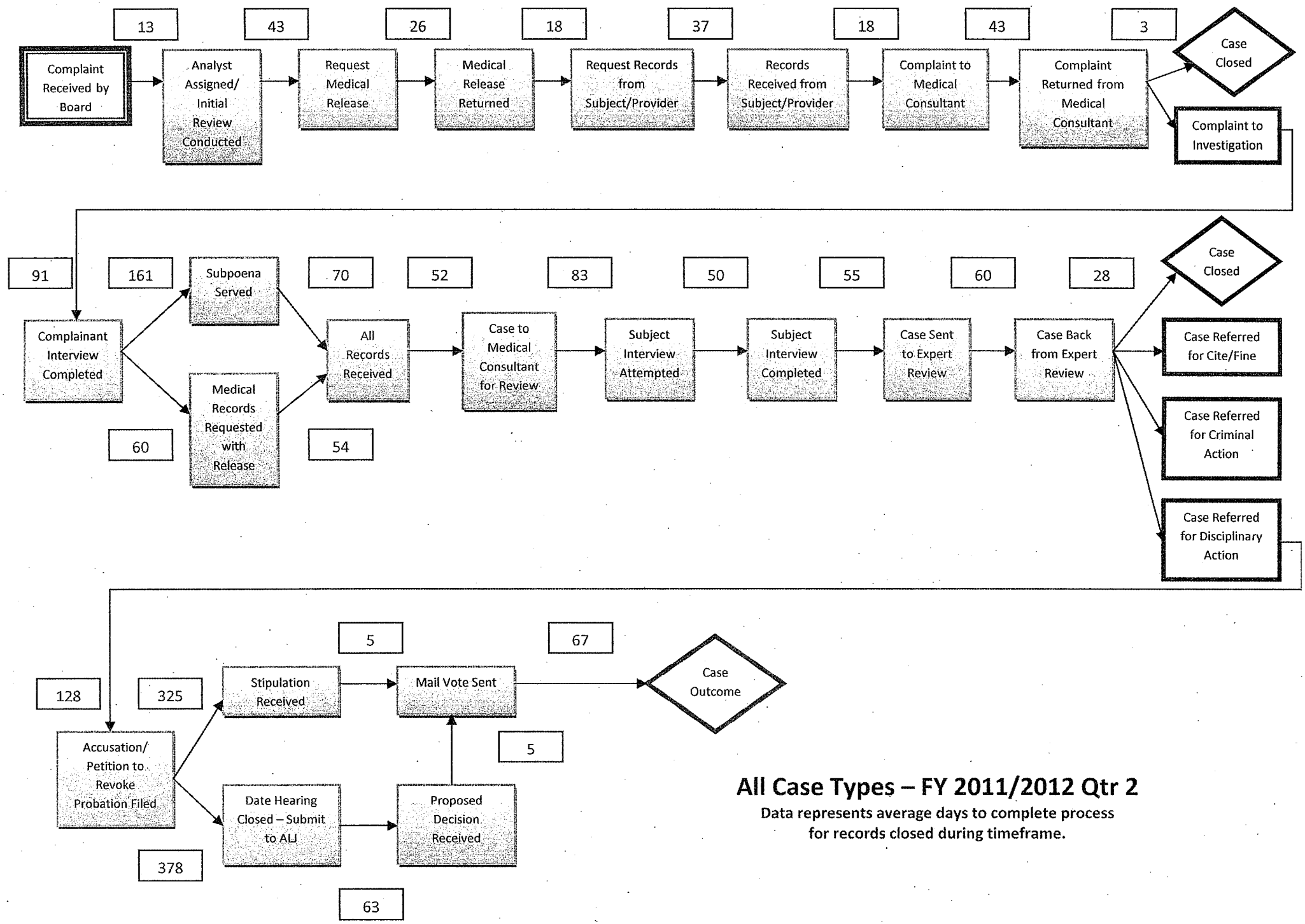
Enforcement Data Markers
All Case Types

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		FY 2011/2012 Qtr 2	
	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records
Complaint Processes										
Complaint Received by Board → Analyst Assigned/Initial Review Conducted	10	6761	11	6869	9	7513	10	1995	13	1721
Analyst Assigned/Initial Review Conducted → Request Medical Release	25	1216	24	1360	28	1567	30	328	43	411
Request Medical Release → Medical Release Returned	29	1044	26	1166	25	1321	28	270	26	321
Medical Release Returned → Request Records from Subject/Provider	7	687	7	802	11	888	15	175	18	204
Request Records from Subject/Provider → Records Received from Subject/Provider	39	1759	38	1879	35	1906	37	428	37	474
Records Received from Subject/Provider → Complaint to Medical Consultant	15	1617	16	1865	17	1768	22	411	18	434
Complaint to Medical Consultant → Complaint Returned from Medical Consultant	54	1934	54	2120	52	2129	43	506	43	525
Complaint Returned from Medical Consultant → Case Closed/Complaint to Investigation	7	1932	4	2114	5	2126	4	503	3	524
Investigative Processes										
Complaint to Investigation → Complainant Interview Completed	103	349	102	424	110	490	88	70	91	144
Complainant Interview Completed → Subpoena Served	173	42	237	43	172	44	220	8	161	11
Complainant Interview Completed → Medical Records Requested with Release	76	141	88	170	59	194	130	48	60	56
Subpoena Served → All Records Received	124	120	100	178	88	166	85	34	70	40
Medical Records Requested with Release → All Records Received	95	372	92	406	85	420	79	98	54	110
All Records Received → Case to Medical Consultant for Review	78	227	84	318	70	369	69	78	52	95
Case to Medical Consultant for Review → Subject Interview Attempted	110	374	109	488	77	558	79	135	83	148
Subject Interview Attempted → Subject Interview Completed	66	712	53	880	53	961	53	256	50	288
Subject Interview Completed → Case Sent to Expert Review	97	412	81	511	72	580	61	157	55	185
Case Sent to Expert Review → Case Back from Expert Review	79	510	72	601	63	658	63	182	60	209
Case Back from Expert Review → Case Closed or Referred for Action	39	495	31	585	30	656	24	186	28	215

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		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	Average Days	Number of Records
Case Referred for Action → Accusation/Petition to Revoke Probation Filed	121	239	113	237	103	219	115	70	128	75
Accusation/Petition to Revoke Probation Filed → Stipulation Received	330	159	291	173	318	142	341	53	325	47
Stipulation Received → Mail Vote Sent	6	136	6	132	4	124	5	40	5	32
Accusation/Petition to Revoke Probation Filed → Date Hearing Closed - Submit to ALJ	416	25	370	30	393	44	276	12	378	14
Date Hearing Closed - Submit to ALJ → Proposed Decision Received	28	35	98	43	39	58	25	16	63	17
Proposed Decision Received → Mail Vote Sent	5	54	5	53	6	60	9	17	5	20
Mail Vote Sent → Case Outcome	131	206	87	208	111	205	82	69	67	60

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		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	Average Days	Number of Records
Complaint Received → Closure in Complaint Unit	84	5278	84	5247	80	5755	84	1466	97	1202
Complaint Received → Closure at Field/Referred for Administrative or Criminal Action/Citation Issued	467	1585	464	1747	453	1861	416	553	440	539



All Case Types – FY 2011/2012 Qtr 2

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

LEGISLATIVE PACKET

MEDICAL BOARD MEETING

FEBRUARY 3, 2012
SAN FRANCISCO, CA

MEDICAL BOARD OF CALIFORNIA
TRACKER – LEGISLATIVE BILL FILE
January 25, 2012

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 589	Perea	Medical School Scholarships	Sen. Approps.	Support	08/17/11
AB 783	Hayashi	Professional Corporations: Licensed PTs	Sen. B&P	Support	04/07/11
AB 1533	Mitchell	UCLA IMG Pilot Program	Assembly	Sponsor	
SB 352	Huff	Chiropractors	Sen. Floor	Reco: Support if Amended	01/04/12

Pink – Sponsored Bill, Blue – For Discussion

2012 TENTATIVE LEGISLATIVE CALENDAR

COMPILED BY THE OFFICE OF THE SECRETARY OF THE SENATE & THE OFFICE OF THE ASSEMBLY CHIEF CLERK

Revised 10-4-11

JANUARY						
S	M	T	W	TH	F	S
1	2	3	4	5	6	7
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15	16	17	18	19	20	21
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29	30	31				

FEBRUARY						
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MARCH						
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APRIL						
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MAY						
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27	28	29	30	31		

DEADLINES

Jan. 1 Statutes take effect (Art. IV, Sec. 8(c)).

Jan. 4 Legislature **reconvenes** (J.R. 51(a)(4)).

Jan. 10 Budget must be submitted by Governor (Art. IV, Sec. 12 (a)).

Jan. 13 Last day for **policy committees** to hear and report to Fiscal Committees fiscal bills introduced in their house in 2011 (J.R. 61(b)(1)).

Jan. 16 Martin Luther King, Jr. Day.

Jan. 20 Last day for any committee to hear and report to the **Floor** bills introduced in their house in 2011 (J.R. 61(b)(2)).

Jan. 27 Last day to submit **bill requests** to the Office of Legislative Counsel.

Jan. 31 Last day for each house to pass **bills introduced in 2011** in their house (Art. IV, Sec. 10(c)), (J.R. 61(b)(3)).

Feb. 20 President's Birthday.

Feb. 24 Last day for bills to be **introduced** (J.R. 61(b)(4)), (J.R. 54(a)).

Mar. 29 **Spring Recess** begins at end of this day's session (J.R. 51(b)(1)).

Mar. 30 **Cesar Chavez Day observed**

Apr. 9 Legislature reconvenes from **Spring Recess** (J.R. 51(b)(1)).

Apr. 27 Last day for **policy committees** to hear and report to Fiscal Committees **fiscal bills** introduced in their house (J.R. 61(b)(5)).

May 11 Last day for **policy committees** to hear and report to the Floor **non-fiscal** bills introduced in their house (J.R. 61(b)(6)).

May 18 Last day for **policy committees** to meet prior to June 4 (J.R. 61(b)(7)).

May 25 Last day for **fiscal committees** to hear and report to the Floor bills introduced in their house (J.R. 61 (b)(8)). Last day for **fiscal committees** to meet prior to June 4 (J.R. 61 (b)(9)).

May 28 Memorial Day.

May 29 - June 1 **Floor Session only**. No committee may meet for any purpose (J.R. 61(b)(10)).

*Holiday schedule subject to final approval by the Rules Committee

2012 TENTATIVE LEGISLATIVE CALENDAR

COMPILED BY THE OFFICE OF THE SECRETARY OF THE SENATE & THE OFFICE OF THE ASSEMBLY CHIEF CLERK

Revised 10-4-11

JUNE

S	M	T	W	TH	F	S
					1	2
3	4	5	6	7	8	9
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JULY

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AUGUST

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June 1 Last day for bills to be **passed out of the house of origin** (J.R. 61(b)(11)).

June 4 Committee meetings may resume (J.R. 61(b)(12)).

June 15 Budget must be passed by **midnight** (Art. IV, Sec. 12 (c)(3)).

June 28 Last day for a legislative measure to qualify for the Nov. 6 general election ballot (Elec. Code Sec. 9040).

July 4 Independence Day.

July 6 Last day for **policy committees** to meet and report bills (J.R. 61(b)(13)). **Summer Recess** begins at the end of this day's session if Budget Bill has been passed (J.R. 51(b)(2)).

Aug. 6 Legislature reconvenes from **Summer Recess** (J.R. 51(b)(2)).

Aug. 17 Last day for **fiscal committees** to meet and report bills to the Floor (J.R. 61(b)(14)).

Aug. 20 - 31 Floor Session only. No committees, other than conference committees and Rules Committee, may meet for any purpose (J.R. 61(b)(15)).

Aug. 24 Last day to **amend** bills on the Floor (J.R. 61(b)(16)).

Aug. 31 Last day for **each house to pass bills** (Art. IV, Sec. 10(c)), (J.R. 61(b)(17)). **Final Recess** begins at end of this day's session (J.R. 51(b)(3)).

IMPORTANT DATES OCCURRING DURING FINAL RECESS

2012

Sept. 30 — Last day for Governor to sign or veto bills passed by the Legislature before Sept. 1 and in the Governor's possession on or after Sept. 1 (Art. IV, Sec. 10(b)(2)).

Nov. 6 — General Election.

Nov. 30 — Adjournment Sine Die at midnight (Art. IV, Sec. 3(a)).

Dec. 3 — 12 m. convening of the 2013-14 Regular Session (Art. IV, Sec. 3(a)).

2013

Jan. 1 — Statutes take effect (Art. IV, Sec. 8(c)).

SPONSORED BILLS

AB 1533

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1533
Author: Mitchell
Bill Date: January 23, 2012, introduced
Subject: UCLA IMG Pilot Program
Sponsor: Medical Board of California and University of California
Position: Sponsor/Support

STATUS OF BILL:

This bill is in the Assembly.

DESCRIPTION OF CURRENT LEGISLATION:

AB 1533 would authorize a pilot for the University of California at Los Angeles (UCLA) international medical graduate (IMG) program. The pilot would allow program participants to engage in supervised patient care activities (i.e., similar to participation at the level of a UC medical student on a health care team) for a typical assignment lasting 16 weeks (but not to exceed 24 weeks), as part of an approved and supervised clinical clerkship/rotation at UCLA health care facilities, or with other approved UCLA affiliates. All such training will occur with supervision provided by licensed physicians.

This bill would also request the UC to prepare a report for the Board and Legislature after the pilot program has been operative for five years, which would include the number of participants in the pilot program; the number of participants issued a license by the Board; and the potential for retention or expansion of the pilot program. This bill would sunset the pilot program on January 1, 2019.

ANALYSIS:

In 2006, the UCLA Department of Family Medicine developed an innovative program to prepare bilingual (English-Spanish speaking), bi-cultural IMGs to enter accredited family medicine programs in California and to pursue licensure and board-certification as family physicians. This program functions as a pre-residency training program. The program recruits proficient bilingual IMGs from international medical schools with curricula that meet the educational requirements set forth by the Medical Board of California (the Board) for purposes of physician licensure. To be eligible for the UCLA IMG program, participants must have U.S. citizenship or Permanent Resident or Refugee Status.

UCLA IMG graduates commit to 24-36 months of post-residency employment in a California health care facility located in a designated medically underserved area. As of June 2011, the UCLA IMG program has placed a total of 42 graduates in 15 urban and rural family medicine residencies in California. An additional 10-12 graduates are expected to enter accredited family medicine training programs in July 2012.

Since its inception, the UCLA IMG program has had an extraordinary record of success in preparing participants for entry to residency training in California. As part of the program, all participants complete a Clinical Observership program. Typically, this assignment lasts 16 weeks (but not to exceed 24 weeks). In no instance do UCLA IMGs hold themselves out to be licensed in California for purposes of patient care or any other program activities. Because these trainees are neither "medical students" enrolled in the School of Medicine (since they have already graduated from medical school in their country), nor "medical residents" enrolled in residency training, these individuals are not currently authorized by state law to engage in "hands on" clinical training as part of their course of study. The result is that UCLA IMGs are required to function as "observers," even when supervised by licensed physicians who are teaching in accredited California training programs.

AB 1533 would authorize a pilot for the UCLA IMG program. The pilot would allow program participants to engage in supervised patient care activities for a typical assignment lasting 16 weeks (but not to exceed 24 weeks), as part of an approved and supervised clinical clerkship/rotation at UCLA health care facilities, or with other approved UCLA affiliates (e.g., participating California family medicine programs). All such training will occur with supervision provided by licensed physicians.

This bill also requests the UC to prepare a report for the Board and Legislature after the pilot program has been operative for five years, which would include the number of participants in the pilot program; the number of participants issued a license by the Board; and the potential for retention or expansion of the pilot program. This bill would sunset the pilot program on January 1, 2019.

The Board and the UC believe this pilot program will benefit the UCLA IMG program, its participants, and California family medicine programs seeking to increase the recruitment of bilingual physicians to their programs. Although the UCLA IMG program could continue to operate with no change, residency programs throughout the state continue to express their interest and support for a mechanism through which these trainees could participate in clinical training activities as they work and prepare to enter a residency program. This pilot would improve the preparation and readiness of program participants. Because UCLA IMG graduates commit to 24-36 months of post-residency employment in a California health care facility located in a designated medically underserved area, the continued success of the UCLA program offers longer term benefits for underserved communities throughout the state. The value of this pilot takes on added importance as provisions of health care reform take effect in

2014, and as California prepares to provide health services to substantial numbers of new Spanish-speaking patients

FISCAL: No cost to the Board. The UCLA IMG program is funded by private sources. Funding sponsors include Kaiser Permanente Community Benefit, UniHealth Foundation, The California Endowment, Molina Family Foundation, New America Alliance, Kaplan educational programs and, private individuals.

SUPPORT: MBC (Co-Sponsor)
University of California (Co-Sponsor)

OPPOSITION: None on file

POSITION: Sponsor/Support

January 24, 2012

AB 1533 (Mitchell)
University of California at Los Angeles, David Geffen School of Medicine's International Medical Graduate (IMG) Pilot Program

BACKGROUND

Sponsors: University of California and the Medical Board of California

ISSUE

All states, including California, require physicians to be licensed to practice medicine, including resident physicians who are training and working in California residency or fellowship programs. Specifically, U.S. medical school graduates are eligible to seek licensure in California following completion of one-year of approved residency training, and international medical graduates are eligible to seek licensure in California following completion of two-years of approved residency training. For most UC programs, most residents must seek and obtain a license prior to the completion of their second year of residency training.

California law allows for regularly matriculated medical students (including foreign medical students) to engage in the practice of medicine whenever and wherever prescribed as part of their required/approved course of study (California Business and Professions Code 2064). There is a group of medical trainees, however, that does not fall within the provisions of existing law.

BACKGROUND

In 2006, faculty in the UCLA Department of Family Medicine developed an innovative program to prepare bilingual (English-Spanish speaking), bi-cultural International Medical Graduates (IMGs) to enter accredited family medicine programs in California and to pursue licensure and board-certification as family physicians. This program functions as a pre-residency training program.

The program recruits proficient bilingual IMGs from international medical schools with curricula that meet the educational requirements set forth by the Medical Board of California (MBC) for purposes of physician licensure. To be eligible for the UCLA IMG program, participants MUST have U.S. citizenship or Permanent Resident or Refugee Status.

Since its inception, the UCLA IMG program has had an extraordinary record of success in preparing participants for entry to residency training in California. As part of the program, all participants complete a Clinical Observership program. Trainees are placed in approved clinical teaching environments that provide and ensure supervision by licensed physician faculty. Typically, this assignment lasts 16 weeks (but not to exceed 24 weeks). In no instance do UCLA IMGs hold themselves out to be licensed in California for purposes of patient care or any other program activities.

The "problem": Because these trainees are neither "medical students" enrolled in the School of Medicine (since they have already graduated from medical school in their country), nor "medical residents" enrolled in residency training, these individuals (who are well-prepared graduates of international medical schools) are not currently recognized by state law as trainees who are authorized to engage in "hands on" clinical training (at even the level of a medical student) as part of their course of study.

The result is that UCLA IMGs are required to function as "observers," even when supervised by licensed physicians who are teaching in accredited California training programs.

While California law is intended to protect the public from individuals practicing medicine who do not have a valid license to practice (or who are not in a recognized training program), the absence of recognition of this group of medical trainees creates an unnecessary barrier to entry to accredited California family medicine programs and the path to medical licensure. In recent years, this has increasingly been recognized and experienced as missed opportunities for UCLA IMG program participants who are not able to benefit from the "hands on" training that UCLA medical students and first year residents receive.

BILL SUMMARY

AB 1533 would authorize a five-year pilot for the UCLA IMG program. The pilot would allow program participants to engage in supervised patient care activities (i.e., similar to participation at the level of a UC medical student on a health care team) for a typical assignment lasting 16 weeks (but not to exceed 24 weeks), as part of an approved and supervised clinical clerkship/rotation at UCLA health care facilities, or with other approved UCLA affiliates (e.g., participating California family medicine programs).

All such training will occur with supervision provided by licensed physicians. With this change, UCLA IMGs would receive valuable clinical learning opportunities and not be at risk for disciplinary action by the MBC.

FREQUENTLY ASKED QUESTIONS (FAQs)

Q: *In this challenging fiscal climate, will the IMG pilot require state resources to implement?*

A: No, the pilot will not require funding from the state. The UCLA IMG program is funded by private sources (no state funds are used and no change is anticipated). Funding sponsors include Kaiser Permanente Community Benefit, UniHealth Foundation, The California Endowment, Molina Family Foundation, New America Alliance, Kaplan educational programs and, private individuals.

Q: *Does California need more primary care doctors? How do IMGs 'fit' into the picture?*

A: Yes, California needs more primary care, and particularly Spanish-speaking, doctors. Each year, there are approximately 19,500 graduates of U.S. medical schools who compete in the National Residency Match Program (NRMP) or "Match" process for one of the 25,000 first-year graduate medical education (GME) positions. The U.S. has *more GME positions* than U.S. medical school graduates. As a result, an estimated 5,500 IMGs (or 25% of the total) enter U.S. residency training each year.

According to the NRMP data, in 2011, not all family residency positions were filled, so there is capacity within existing programs to accept more IMG residents in family medicine, provided that these individuals are eligible and well-prepared.

Q: *Are these UCLA IMG program participants in the U.S. legally?*

A: Yes. To be selected as a program participant, the individual MUST have U.S. citizenship, or Permanent Resident or Refugee Status. The program cannot assist the individual in obtaining the required immigration visa.

Q: *How does California benefit from providing training to IMG program participants?*

A: UCLA IMG graduates commit to 24-36 months of post-residency employment in a California health care facility located in a designated medically underserved area. The continued success of the UCLA program offers longer term benefits for underserved communities throughout the state. It offers a much needed resource for increasing the number of bilingual physicians in California at no cost to the State General Fund.

The value of this pilot takes on added importance as provisions of health care reform take effect in 2014, and as California prepares to provide health services to substantial numbers of new Spanish-speaking patients.

Q: *Where can I find more information about the UCLA IMG program?*

A: http://fm.mednet.ucla.edu/IMG/img_program.asp

SUPPORT

Medical Board of California (Sponsor)
University of California (Sponsor)

OPPOSITION

None on file

STATUS

January 23, 2012

FOR MORE INFORMATION

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ASSEMBLY BILL No. 1533

Introduced by Assembly Member Mitchell

January 23, 2012

An act to add and repeal Section 2066.5 of the Business and Professions Code, relating to medicine.

LEGISLATIVE COUNSEL'S DIGEST

AB 1533, as introduced, Mitchell. Medicine: trainees: international medical graduates.

The Medical Practice Act provides for licensing and regulation of physicians and surgeons by the Medical Board of California and imposes various requirements in that regard. Existing law requires an applicant for a license as a physician and surgeon to successfully complete a specified medical curriculum, a clinical instruction program, and a training program. Existing law provides that nothing in the Medical Practice Act shall be construed to prohibit a foreign medical graduate from engaging in the practice of medicine whenever and wherever required as part of a clinical service program, subject to certain conditions.

This bill, until January 1, 2019, would authorize a clinical instruction pilot program for certain bilingual international medical graduates at the Medical School of the University of California at Los Angeles (UCLA) as part of an existing preresidency training program, at the option of UCLA. The bill would provide that nothing in the Medical Practice Act shall be construed to prohibit a foreign medical graduate participating in the pilot program from engaging in the practice of medicine when required as part of the pilot program. The bill would set forth the requirements for international medical graduates to

participate in the pilot program. The bill would require UCLA to provide the board with the names of the participants and other information. The bill would authorize the board to consider participation in the clinical instruction pilot program as remediation for medical education deficiencies in a participant's subsequent application for licensure as a physician and surgeon. The bill would request UCLA to report to the board and the Legislature after the pilot program has been operative for 5 years. The bill would make related legislative findings and declarations.

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

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

1 SECTION 1. The Legislature finds and declares all of the
2 following:
3 (a) California needs more Spanish-speaking health professionals.
4 Although Hispanics represent nearly 39 percent of California's
5 population, only 5.2 percent of the state's physician workforce is
6 Hispanic. According to the 2010 federal census, an estimated 35
7 percent of California's almost 15 million Hispanics reside in
8 medically underserved areas, compared to 20 percent of the total
9 population.
10 (b) California needs more primary care doctors. Each year, there
11 are approximately 19,500 graduates of medical schools in the
12 United States who compete in the National Residency Match
13 Program (NRMP) or "Match" process for one of the 25,000
14 first-year graduate medical education (GME) positions (residency
15 training positions). The United States has more GME positions
16 than United States medical school graduates. As a result, an
17 estimated 5,500 International Medical Graduates (IMGs) or 20
18 percent of the total, enter United States residency training each
19 year. According to the NRMP data for 2011, 94.4 percent of family
20 medicine residency positions were filled. Because not all positions
21 were filled, this indicates that there is capacity within existing
22 programs to accept more IMG residents in family medicine,
23 provided that these individuals are eligible and well prepared.
24 (c) IMGs legally residing in the United States can be part of the
25 solution for California's shortage of Hispanic physicians. Between
26 400 to 1,000 unlicensed Hispanic IMG physicians legally reside

and work in Southern California. Because they do not have a California medical license, they cannot practice medicine in California. Many work in a variety of roles such as ultrasound technicians, health educators, or interpreters, and a few have retrained as nurses.

(d) There is an existing California training resource that is underutilized. Since 2006, the David Geffen School of Medicine at the University of California at Los Angeles (UCLA) has operated an innovative and highly successful program to prepare English-Spanish bilingual, bicultural individuals who have graduated from an accredited medical school outside the United States to enter accredited family medicine programs in California. The UCLA program functions as a preresidency training program. However, because these IMG trainees are neither "medical students" enrolled in the school of medicine (because they have already graduated from medical school in their country), nor "medical residents" enrolled in residency training, these individuals are not currently recognized by state law as trainees who are authorized to engage in "hands on" clinical training, at even the level of a medical student, as part of their course of study. The UCLA IMG program accepts a small number of exceptionally promising bilingual unlicensed Hispanic IMGs who legally reside in California to participate in a program lasting from 4 to 21 months, with total time for completion determined by UCLA based upon assessment of qualifications of each program participant. To be eligible for licensure in California, graduates of both foreign medical schools as well as United States medical schools must successfully pass Steps 1 and 2 of the United States Medical Licensing Exam (USMLE). Upon receiving a passing score on these exams, medical school graduates are then eligible to compete for a residency position in one of California's 30-plus family medicine training programs. Once the three-year family medicine residency training program is completed, these licensed family physicians commit to practice in an underserved community in California for up to three years.

SEC. 2. Section 2066.5 is added to the Business and Professions Code, to read:

2066.5. (a) The pilot program authorized by this section shall be known and may be cited as the University of California at Los

1 Angeles David Geffen School of Medicine's International Medical
2 Graduate Pilot Program.
3 (b) Nothing in this chapter shall be construed to prohibit a
4 foreign medical graduate from engaging in the practice of medicine
5 when required as part of the pilot program authorized by this
6 section.
7 (c) There is currently a preresidency training program at the
8 University of California, Los Angeles David Geffen School of
9 Medicine, Department of Family Medicine, hereafter referred to
10 as UCLA, for selected international medical graduates (IMGs).
11 Participation in the pilot program authorized by this section shall
12 be at the option of UCLA. This section authorizes those IMGs,
13 through the new pilot program authorized by this section, to
14 receive, through the existing program, hands-on clinical instruction
15 in the courses specified in subdivision (c) of Section 2089.5. The
16 pilot program, as administered by UCLA, shall include all of the
17 following elements:
18 (1) Each pilot program participant shall have done all of the
19 following:
20 (A) Graduated from a medical school recognized by the Medical
21 Board of California at the time of selection.
22 (B) Taken and passed the United States Medical Licensing
23 Examination Steps 1 and 2 (Clinical Knowledge and Clinical
24 Science).
25 (C) Submitted an application and materials to the Educational
26 Commission for Foreign Medical Graduates.
27 (2) A pilot program participant shall receive all clinical
28 instruction at health care facilities operated by the University of
29 California, Los Angeles, or other approved UCLA designated
30 teaching sites, which shall be hospitals or clinics with either a
31 signed formal affiliation agreement with UCLA or a signed letter
32 of agreement.
33 (3) Participation of a trainee in clinical instruction offered by
34 the pilot program shall not generally exceed 16 weeks. However,
35 at the discretion of UCLA, an additional eight weeks of clinical
36 instruction may be granted. In no event shall a participant receive
37 more than 24 weeks of clinical instruction under the pilot program.
38 (4) The clinical instruction shall be supervised by licensed
39 physicians on faculty at UCLA or faculty affiliated with UCLA

as specified in an approved affiliation agreement between UCLA and the affiliated entity.

(5) The clinical instruction shall be provided pursuant to written affiliation agreements for clinical instruction of trainees established by UCLA.

(6) The supervising faculty shall evaluate each participant on a regular basis and shall document the completion of each aspect of the clinical instruction portion of the program for each participant.

(d) UCLA shall provide the board with the names of the participants in the pilot program on an annual basis, or more frequently if necessary to maintain accuracy. Upon a reasonable request of the board, UCLA shall provide additional information such as the courses successfully completed by program participants, the dates of instruction, and other relevant information.

(e) Nothing in this section shall be construed to alter the requirements for licensure set forth in Sections 2089 and 2089.5. The board may consider participation in the clinical instruction portion of the pilot program as remediation for medical education deficiencies identified in a participant's application for licensure or authorization for post graduate training should such a deficiency apply to that applicant.

(f) After the pilot program has been operative for five years, UCLA is requested to prepare a report for the board and the Legislature. Topics to be addressed in the report shall include the number of participants in the pilot program, the number of participants in the pilot program who were issued physician's and surgeon's certificates by the board, and the potential for retention or expansion of the pilot program.

(g) This section shall remain in effect only until January 1, 2019, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2019, deletes or extends that date.

O

OMNIBUS

MBC PROPOSED OMNIBUS 2012

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 and application" with the Board for restoration of his or her license. The Board is proposing language 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 statue 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 is proposing to amend existing allow to allow renewal and delinquency notices to be sent via e-mail if the physician opts in to receive notices via e-mail. The Board is also proposing a requirement for the Board to annually confirm the e-mail addresses of applicants and licensees who choose to receive their correspondence via e-mail.

Licensed Midwives – Retired Licensed Status
The Board would like to add 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.

Omnibus Requested Last Year:

Section 2064
In 2005, the Medical Board requested a change in the omnibus bill (SB 1111, Figueroa) to change Section 2064 from "...in an approved medical school or clinical training program...", to "...in an approved medical school ~~or~~ and training program". This amendment was asked for in error and the board should have not asked for this change. We are requesting to go back to the original language, this is a technical amendment.

Section 2184
The purpose of this amendment is to clarify that clinical training should be included as a way an applicant may have spent time in a postgraduate training program, in order to qualify an applicant to have the period of validity for USMLE test scores extended. This is a technical change.

Section 2516
According to the Midwifery Advisory Council, "neonate" is a more appropriate term to use than "infant", as it describes a newborn in the first 4 weeks of life. This is a technical change.

Possible Omnibus being proposed by Senate Business Professions, and Economic Development Committee:

Extend the sunset date of the Vertical Enforcement Program (VEP) to the same dates as the Board's sunset, from 1/1/13, to 1/1/14, and have the full evaluation of VEP as part of the Board's 2013 sunset review process.

2011/2012
LEGISLATION

AB 589

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 589
Author: Perea
Bill Date: August 17, 2011, amended
Subject: Medical School Scholarships
Sponsor: California Medical Association
Position: Support

STATUS OF BILL:

This bill is currently in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would create the Steven M. Thompson Medical School Scholarship Program (STMSSP) within the Health Professions Education Foundation (HPEF). The STMSSP would be funded by private or federal funds and would only be implemented if HPEF determines that sufficient funds are available.

This bill was amended to specify that funds supporting the Steven M. Thompson Loan Repayment Program (STLRP) shall not be used to support the STMSSP. This bill was also amended to specify that STMSSP program participants must agree in writing to the program requirements prior to completing an accredited medical or osteopathic school based in the United States. This bill also specifies that the cost of administering the program shall not exceed ten percent of the total appropriation of the program.

ANALYSIS:

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

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

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

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

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

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

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

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

This amendment was suggested by Senate Health Committee. The Senate Health Committee analysis suggested this amendment to clarify that the STLRP and the STMSSP funds are separate and the STLRP funds should not be used to fund the STMSSP.

The August 17th amendments specify that STMSSP program participants must agree in writing to the program requirements prior to completing an accredited medical or osteopathic school, and require the school to be based in the United States. The amendments also mandate that the costs of administering the STMSSP program shall not exceed ten percent of the total appropriation of the program. The amendments also make other technical and clarifying changes.

These amendments specify program requirements, in order to help ensure that this bill can be easily implemented. These amendments also ensure that the administrative program costs stay within the program's budget.

According to the author's office, this bill will address shortages of physician services that exist in over 200 regions in California identified as medically underserved areas. The purpose of this bill is to make medical school more financially accessible for students who are willing to pursue careers in primary care. According to the author's office, this bill will help to address the geographical disparity of physician supply in California, as well as the increasing cost of medical education, which is a barrier to entry

for students from economically disadvantaged backgrounds. The author's office believes this bill will provide underserved communities with greater access to medical care. This bill is consistent with the mission of the Medical Board of promoting access to care.

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

OPPOSITION: None on file

FISCAL: None

January 23, 2012

AMENDED IN SENATE AUGUST 17, 2011

AMENDED IN SENATE JULY 12, 2011

AMENDED IN ASSEMBLY MAY 27, 2011

AMENDED IN ASSEMBLY APRIL 11, 2011

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 589

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

February 16, 2011

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

LEGISLATIVE COUNSEL'S DIGEST

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

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

This bill would establish within the Health Professions Education Foundation the Steven M. Thompson Medical School Scholarship Program (STMSSP), managed by the foundation and the Office of

Statewide Health Planning and Development to promote the education of medical doctors and doctors of osteopathy, as specified. This bill would provide up to $105,000 in scholarships to selected participants who agree in writing prior to ~~entering~~ *completing* an accredited medical or osteopathic school *based in the United States* to serve in an eligible setting.

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

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

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

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

Medi-Cal residing in a single ZIP Code, or 1,500 LEP individuals eligible for Medi-Cal residing in two contiguous ZIP Codes.

(d) "Medically underserved area" means an area defined as a health professional shortage area in Part 5 (commencing with Sec. 5.1) of Subchapter A of Chapter 1 of Title 42 of the Code of Federal Regulations or an area of the state where unmet priority needs for physicians exist as determined by the California Healthcare Workforce Policy Commission pursuant to Section 128225.

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

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

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

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

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

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

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

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

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

128570. (a) Persons participating in the program shall be persons who agree in writing prior to ~~entering~~ *completing* an accredited medical or osteopathic school *based in the United States*

to serve in an eligible practice setting, pursuant to subdivision (g) of Section 128565, for at least three years. The program shall be used only for the purpose of promoting the education of medical doctors and doctors of osteopathy and related administrative costs.

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

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

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

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

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

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

(1) Provide priority consideration to applicants who are best suited to meet the cultural and linguistic needs and demands of

patients from medically underserved populations and who meet one or more of the following criteria:

(A) Speak a Medi-Cal threshold language.

(B) Come from an economically disadvantaged background.

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

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

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

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

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

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

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

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

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

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

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

(d) The account shall be used to pay for the cost of administering ~~the program, not to exceed 5 percent of the total appropriation for the program.~~ *the program and for any other purpose authorized by this article. The cost of administering the program, including promoting the education of medical doctors and doctors of osteopathy in an accredited school who agree to service in an*

1 *eligible setting and related administrative costs, shall not exceed*
2 *10 percent of the total appropriation for the program.*
3 (e) The office and the foundation shall manage the account
4 established by this section prudently in accordance with other
5 provisions of law.
6 (f) This article shall be implemented only to the extent that the
7 account contains sufficient funds as determined by the foundation.

O

AB 783

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 783
Author:	Hayashi
Bill Date:	April 7, 2011, amended
Subject:	Professional Corporations: Licensed Physical Therapists
Sponsor:	California Medical Association, California Orthopaedic Association, and the Podiatric Medical Association
Position:	Support

STATUS OF BILL:

This bill is in Senate Business, Professions and Economic Development Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would add licensed physical therapists and occupational therapists to the list of healing arts practitioners who may be shareholders, officers, directors, or professional employees of a medical corporation.

ANALYSIS:

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.

Currently, many physical therapists are employed by medical corporations. According to the author's office, this bill was introduced to "prevent the unnecessary loss of employment during this economic recession by allowing medical and podiatric medical corporations to continue to employ physical therapists, as they have done for over 21 years".

The Occupational Therapy Association of California requested that this bill be amended to clarify that occupational therapists are allowed to be employed by medical corporations because they work in numerous health care settings throughout California and should have the choice to be employed by medical corporations; this amendment was taken.

The Medical Board has received complaints regarding physicians who are employing physical therapists. Neither the Medical Board nor the Physical Therapy Board have taken action against licensees as of yet. This bill will codify the practice that has been allowed for over 20 years and allow physicians in medical corporations to employ physical therapists.

SB 543 (Steinberg, Chapter 448, Statutes of 2011) was signed into law and is now effective, as of January 1, 2012. Among other provisions, this bill 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. 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. SB 543 puts 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: CMA (Co-sponsor), California Orthopaedic Association (Co-sponsor); California Podiatric Medical Association (co-sponsor); California Chiropractic Association; California Hospital Association; California Labor Federation; California Society of Anesthesiologists; California Society of Physical Medicine and Rehabilitation; California Teamsters Public Affairs Council; Kaiser Permanente; Occupational Therapy Association of California; Western States Council of the United Food and Commercial Workers; and Individual Physical Therapists

OPPOSITION: California Physical Therapy Association
Individual Physical Therapists

January 23, 2012

AMENDED IN ASSEMBLY APRIL 7, 2011

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 783

Introduced by Assembly Member Hayashi

February 17, 2011

An act to amend Section 2406 of the Business and Professions Code, and to amend Section 13401.5 of the Corporations Code, relating to ~~professional corporations, and declaring the urgency thereof, to take effect immediately.~~ *professional corporations.*

LEGISLATIVE COUNSEL'S DIGEST

AB 783, as amended, Hayashi. Professional corporations: licensed physical *therapists and occupational* therapists.

Existing law regulating professional corporations provides that certain healing arts practitioners may be shareholders, officers, directors, or professional employees of a medical corporation ~~or a~~, podiatric medical corporation, *or a chiropractic corporation,* subject to certain limitations.

This bill would add licensed physical therapists *and licensed occupational therapists* to the list of healing arts practitioners who may be shareholders, officers, directors, or professional employees of those corporations. The bill would also make conforming changes to a related provision.

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

Vote: ~~2/3~~ *majority*. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

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

1 SECTION 1. Section 2406 of the Business and Professions
2 Code is amended to read:
3 2406. A medical corporation or podiatry corporation is a
4 corporation that is authorized to render professional services, as
5 defined in Sections 13401 and 13401.5 of the Corporations Code,
6 so long as that corporation and its shareholders, officers, directors,
7 and employees rendering professional services who are physicians
8 and surgeons, psychologists, registered nurses, optometrists,
9 podiatrists, chiropractors, acupuncturists, naturopathic doctors,
10 physical therapists, or, in the case of a medical corporation only,
11 physician assistants, marriage and family therapists, or clinical
12 social workers are in compliance with the Moscone-Knox
13 Professional Corporation Act, the provisions of this article and all
14 other statutes and regulations now or hereafter enacted or adopted
15 pertaining to the corporation and the conduct of its affairs.
16 With respect to a medical corporation or podiatry corporation,
17 the governmental agency referred to in the Moscone-Knox
18 Professional Corporation Act is the board.
19 SEC. 2. Section 13401.5 of the Corporations Code is amended
20 to read:
21 13401.5. Notwithstanding subdivision (d) of Section 13401
22 and any other provision of law, the following licensed persons
23 may be shareholders, officers, directors, or professional employees
24 of the professional corporations designated in this section so long
25 as the sum of all shares owned by those licensed persons does not
26 exceed 49 percent of the total number of shares of the professional
27 corporation so designated herein, and so long as the number of
28 those licensed persons owning shares in the professional
29 corporation so designated herein does not exceed the number of
30 persons licensed by the governmental agency regulating the
31 designated professional corporation:
32 (a) Medical corporation.
33 (1) Licensed doctors of podiatric medicine.
34 (2) Licensed psychologists.
35 (3) Registered nurses.
36 (4) Licensed optometrists.
37 (5) Licensed marriage and family therapists.
38 (6) Licensed clinical social workers.

1 (7) Licensed physician assistants.
2 (8) Licensed chiropractors.
3 (9) Licensed acupuncturists.
4 (10) Naturopathic doctors.
5 (11) Licensed physical therapists.
6 *(12) Licensed occupational therapists.*
7 (b) Podiatric medical corporation.
8 (1) Licensed physicians and surgeons.
9 (2) Licensed psychologists.
10 (3) Registered nurses.
11 (4) Licensed optometrists.
12 (5) Licensed chiropractors.
13 (6) Licensed acupuncturists.
14 (7) Naturopathic doctors.
15 (8) Licensed physical therapists.
16 *(9) Licensed occupational therapists.*
17 (c) Psychological corporation.
18 (1) Licensed physicians and surgeons.
19 (2) Licensed doctors of podiatric medicine.
20 (3) Registered nurses.
21 (4) Licensed optometrists.
22 (5) Licensed marriage and family therapists.
23 (6) Licensed clinical social workers.
24 (7) Licensed chiropractors.
25 (8) Licensed acupuncturists.
26 (9) Naturopathic doctors.
27 (d) Speech-language pathology corporation.
28 (1) Licensed audiologists.
29 (e) Audiology corporation.
30 (1) Licensed speech-language pathologists.
31 (f) Nursing corporation.
32 (1) Licensed physicians and surgeons.
33 (2) Licensed doctors of podiatric medicine.
34 (3) Licensed psychologists.
35 (4) Licensed optometrists.
36 (5) Licensed marriage and family therapists.
37 (6) Licensed clinical social workers.
38 (7) Licensed physician assistants.
39 (8) Licensed chiropractors.
40 (9) Licensed acupuncturists.

1 (10) Naturopathic doctors.
2 (g) Marriage and family therapy corporation.
3 (1) Licensed physicians and surgeons.
4 (2) Licensed psychologists.
5 (3) Licensed clinical social workers.
6 (4) Registered nurses.
7 (5) Licensed chiropractors.
8 (6) Licensed acupuncturists.
9 (7) Naturopathic doctors.
10 (h) Licensed clinical social worker corporation.
11 (1) Licensed physicians and surgeons.
12 (2) Licensed psychologists.
13 (3) Licensed marriage and family therapists.
14 (4) Registered nurses.
15 (5) Licensed chiropractors.
16 (6) Licensed acupuncturists.
17 (7) Naturopathic doctors.
18 (i) Physician assistants corporation.
19 (1) Licensed physicians and surgeons.
20 (2) Registered nurses.
21 (3) Licensed acupuncturists.
22 (4) Naturopathic doctors.
23 (j) Optometric corporation.
24 (1) Licensed physicians and surgeons.
25 (2) Licensed doctors of podiatric medicine.
26 (3) Licensed psychologists.
27 (4) Registered nurses.
28 (5) Licensed chiropractors.
29 (6) Licensed acupuncturists.
30 (7) Naturopathic doctors.
31 (k) Chiropractic corporation.
32 (1) Licensed physicians and surgeons.
33 (2) Licensed doctors of podiatric medicine.
34 (3) Licensed psychologists.
35 (4) Registered nurses.
36 (5) Licensed optometrists.
37 (6) Licensed marriage and family therapists.
38 (7) Licensed clinical social workers.
39 (8) Licensed acupuncturists.
40 (9) Naturopathic doctors.

(10) Licensed physical therapists.
(11) Licensed occupational therapists.
(*l*) Acupuncture corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Licensed psychologists.
(4) Registered nurses.
(5) Licensed optometrists.
(6) Licensed marriage and family therapists.
(7) Licensed clinical social workers.
(8) Licensed physician assistants.
(9) Licensed chiropractors.
(10) Naturopathic doctors.
(m) Naturopathic doctor corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.
(3) Registered nurses.
(4) Licensed physician assistants.
(5) Licensed chiropractors.
(6) Licensed acupuncturists.
(7) Licensed physical therapists.
(8) Licensed doctors of podiatric medicine.
(9) Licensed marriage, family, and child counselors.
(10) Licensed clinical social workers.
(11) Licensed optometrists.
(n) Dental corporation.
(1) Licensed physicians and surgeons.
(2) Dental assistants.
(3) Registered dental assistants.
(4) Registered dental assistants in extended functions.
(5) Registered dental hygienists.
(6) Registered dental hygienists in extended functions.
(7) Registered dental hygienists in alternative practice.
~~SEC. 3. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:~~
~~In order to authorize licensed physical therapists to be shareholders, officers, directors, or professional employees of~~

1 ~~medical corporations and podiatric medical corporations as soon~~
2 ~~as possible, it is necessary that this act take effect immediately.~~

O

SB 352

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 352
Author: Huff
Bill Date: January 11, 2012, amended
Subject: Chiropractors: Allergies
Sponsor: Author

STATUS OF BILL:

This bill is on the Senate Floor.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would prohibit chiropractors from treating allergies, including hypersensitivity to foods, medications, environmental allergens, or venoms, including the use of laser therapy. This bill would also prohibit chiropractors from advertising to provide the above listed services.

ANALYSIS:

The Board of Chiropractic Examiners (BCE) had drafted regulations relating to the use of cold lasers by chiropractors. Their regulations would only allow chiropractors to use the cold lasers for uses approved by the FDA, and specifically prohibit chiropractors from using lasers for specified reasons, as follows:

"Nothing in this section shall be construed to authorize the use of a laser by a chiropractor outside the chiropractic scope of practice. This includes, but is not limited to, laser ablation, surgical procedures and the laser treatment of allergies in cases where there is a known risk of anaphylactic reaction to the individual being treated".

Medical Board staff has requested that the BCE add cosmetic procedures to this section of the regulation, which would prohibit chiropractors from using lasers for cosmetic procedures, as cosmetic procedures are outside the chiropractic scope of practice.

Senator Huff introduced this bill because he believes as technology has evolved, chiropractic involvement in the treatment of allergies, including the use of lasers, is outside the chiropractic scope of practice, especially for serious allergies that may result in anaphylactic reactions. The author is concerned that the regulations may be bogged down by the bigger issue of the use of cold lasers, and has introduced this bill to keep the measure moving.

Senator Huff has agreed that if the regulations get finalized before the end of the legislative session, he will drop this bill.

The procedures listed in the BCE regulations are agreeably outside the scope of chiropractic practice, and if these procedures and cosmetic procedures could be added to this bill, the Board believes it would help to ensure consumer protection. Board staff recommends that the Board support this bill, if it is amended to specifically list other procedures that chiropractors should not be authorized to perform using laser therapy, including, laser ablation, surgical procedures, and cosmetic procedures.

FISCAL: None to the Board

SUPPORT:
Former Senator Dennis Hollingsworth
California Medical Association (CMA)
James Sublett, M.D. on behalf of the Joint Council of Allergy, Asthma & Immunology
Travis Miller, M.D. on behalf of Capital Allergy & Respiratory Disease Center
Bradley Chipps, M.D. on behalf of Capital Allergy & Respiratory Disease Center
Larry Posner, M.D. on behalf of North Bay Allergy & Asthma Medical Associates
Warner Carr, M.D. on behalf of Allergy & Asthma Associates of Southern California
Christina Schwindt, M.D. on behalf of Allergy & Asthma Associates of Southern California
William Berger, M.D. on behalf of Allergy & Asthma Associates of Southern California
Dena Robertson, Citizen

OPPOSITION:
Board of Chiropractic Examiners
California Chiropractic Association
Southern California University of Health Sciences

POSITION: Recommendation: Support if Amended

January 25, 2012

AMENDED IN SENATE JANUARY 11, 2012

AMENDED IN SENATE JANUARY 4, 2012

SENATE BILL No. 352

Introduced by Senator Huff

February 15, 2011

An act to add Sections 1006 and 1007 to the Business and Professions Code, relating to chiropractors.

LEGISLATIVE COUNSEL'S DIGEST

SB 352, as amended, Huff. Chiropractors.

Existing law, the Chiropractic Act, enacted by initiative act, provides for the licensure and regulation of chiropractors by the State Board of Chiropractic Examiners. Under the act, a license authorizes its holder to practice chiropractic as taught in chiropractic schools or colleges but does not authorize its holder to practice medicine, surgery, osteopathy, dentistry, or optometry.

Existing law prohibits a chiropractor, among other healing arts practitioners, from disseminating any form of public communications containing a false, fraudulent, misleading, or deceptive statement for the purpose of inducing the rendering of professional services, as specified.

This bill would specify that the practice of chiropractic does not include the treatment ~~or diagnosis~~ of hypersensitivity to foods, medications, environmental allergens, or venoms, and would prohibit a chiropractor from advertising that he or she provides or is able to provide those services, as specified. The bill would specify that a violation of these provisions constitutes a cause for discipline by the State Board of Chiropractic Examiners.

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

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

1 SECTION 1. The Legislature hereby finds and declares the
2 following:
3 (a) The law governing practitioners of chiropractic is an
4 initiative statute known as the Chiropractic Act that was originally
5 approved by the electorate on November 7, 1922.
6 (b) The scope of practice authorized by the Chiropractic Act
7 does not extend beyond the scope of the term "chiropractic" as it
8 was understood and defined in 1922. In addition, the Chiropractic
9 Act prohibits a chiropractor from engaging in the practice of
10 medicine.
11 (c) As it was understood in 1922, the term "chiropractic" did
12 not include the treatment ~~or diagnosis~~ of hypersensitivity to foods,
13 medications, environmental allergens, or venoms. Furthermore,
14 those services constitute the practice of medicine. Therefore, the
15 Chiropractic Act does not authorize licensees to provide those
16 services.
17 SEC. 2. Section 1006 is added to the Business and Professions
18 Code, to read:
19 1006. (a) The practice of chiropractic does not include the
20 treatment ~~or diagnosis~~ of hypersensitivity to foods, medications,
21 environmental allergens, or venoms, including, but not limited to,
22 the use of laser therapy for those purposes.
23 (b) A violation of this section shall constitute a cause for
24 discipline by the State Board of Chiropractic Examiners. For
25 purposes of this subdivision, the board shall have the same powers
26 of suspension, revocation, and discipline as authorized by the
27 initiative measure referred to in Section 1000.
28 SEC. 3. Section 1007 is added to the Business and Professions
29 Code, to read:
30 1007. (a) A person licensed by the State Board of Chiropractic
31 Examiners under the Chiropractic Act shall not advertise that he
32 or she provides or is able to provide the services described in
33 Section 1006, unless that person holds another license under this
34 division that authorizes the person to provide those services.

(b) For purposes of this section, "advertise" includes, but is not limited to, the issuance of any card, sign, or device to any person, or the causing, permitting, or allowing of any sign or marking on, or in, any building or structure, or in any newspaper or magazine or in any directory, or any printed matter whatsoever, with or without any limiting qualification. It also includes business solicitations communicated by radio or television broadcasting.

(c) A violation of this section shall constitute a cause for discipline by the State Board of Chiropractic Examiners. For purposes of this subdivision, the board shall have the same powers of suspension, revocation, and discipline as authorized by the initiative measure referred to in Section 1000.

SEC. 4. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

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TRACKER II

MBC TRACKER II BILLS
1/25/2012

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 70	Monning	Public Health: Federal Grant Opportunities	Asm. Floor	01/23/12
AB 137	Portantino	Health Care Coverage: Mammographies	Asm. Floor	01/23/12
AB 174	Monning	Health Information Exchange	Sen. Health	03/21/11
AB 369	Huffman	Health Care Coverage: Prescriptions Drugs: Pain Management	Asm. Floor	
AB 377	Solorio	Pharmacy	Sen. Approps	04/14/11
AB 389	Mitchell	Bleeding Disorders	Sen. Floor	01/17/12
AB 439	Skinner	Health Care Information	Sen. Judiciary	06/28/11
AB 714	Atkins	Health Care Coverage: California Health Benefit Exchange	Sen. Approps	06/30/11
AB 778	Atkins	Health Care Service Plans: Vision Care	Sen. B&P	06/21/11
AB 916	Perez, M.	Promotores: Medically Underserved Communities: Federal Grants	Senate	08/15/11
AB 972	Butler	Substance Abuse: Treatment Facilities	Sen. Approps	08/15/11
AB 1217	Fuentes	Assisted Reproductive Technology: Parentage	Sen. Judiciary	06/20/11
AB 1280	Hill	Ephedrine: Retail Sale	Sen. Approps	08/15/11
AB 1431	Comm. on Acct. & Admin Review	Government Reports	Asm. Floor	01/24/12
AB 1461	Monning	Health Insurance	Asm. Health	
SB 103	Liu	State Government: Meetings	Asm. Approps	07/12/11
SB 173	Simitian	Healing Arts: Mammograms	Asm. Approps	08/15/11
SB 252	Vargas	Public Contracts: Personal Services	Asm. B&P	05/31/11
SB 393	Hernandez	Medical Homes	Asm. Health	05/31/11
SB 411	Price	Home Care Services Act of 2011	Assembly	08/30/11
SB 628	Yee	Acupuncture: Regulation	Sen. B&P	03/22/11
SB 728	Hernandez	Health Care Coverage	Asm. Health	05/31/11
SB 961	Hernandez	Health Care Service Plans	Senate	
SB 975	Wright	Professions & Vocations: Regulatory Authority	Senate	

MEDICAL BOARD OF CALIFORNIA
Status of Pending Regulations

Subject	Current Status	Date Approved by Board	Date Notice Published by OAL	Date of Public Hearing	Date of Final Adoption	Date to DCA (and other control agencies) for Review *	Date to OAL for Review **	Date to Sec. of State***
Polysomno-graphy Program	Pending review at OAL	7/30/10	9/10/10	11/5/10	11/23/11	To DCA 9/8/11; To SCSA 9/27/11; To DOF on 10/6/11	12/6/11	
Disciplinary Guidelines – 2010	Effective 1/11/12	7/30/10	9/17/10	11/5/10	1/24/11	To DCA 6/28/11; to SCSA 10/12/11	11/1/11	12/11/11
Sponsored Free Health Care Events	Pending review at DOF	1/28/11	3/11/11	5/6/11	7/5/11	To DCA 10/26/11; to SCSA 11/14; to DOF 11/16/11		
Non-substantive changes from all units (Section 100 changes)	Next review of MBC regulations – Summer 2012							

Prepared by Kevin A. Schunke
Updated January 17, 2012
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 STAFF REPORT

DATE REPORT ISSUED:	January 25, 2012
ATTENTION:	Members, Medical Board of California
SUBJECT:	Resolution: Delegation to DCA for Review and Registration of Sponsoring Entities
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing

RECOMMENDED ACTION:

Staff recommends that the Medical Board of California (Board) delegate to the Department of Consumer Affairs (Department), by formal resolution, the authority to receive and process forms related to the registration of sponsored health care fairs and other sponsored events.

A suggested resolution is attached.

BACKGROUND:

Assembly Bill 2699 (Bass/2010), which added section 901 to the Business and Professional Code, authorizes health care fairs and other sponsored events at which medical services can be provided by physicians who are not licensed in California but are licensed in other jurisdictions. An entity that wishes to sponsor such an event first must register with the Board. Individual physicians also must register with the Board.

To implement this newly-added section of the law, staff brought proposed regulations before the board, which the Board approved. These regulations now are in the final stages of review. The key section follows:

> "(b) Determination of Completeness of Form. *The board may, by resolution, delegate to the Department of Consumer Affairs* the authority to receive and process Form 901-A (March 2011) on behalf of the board...."(Emphasis added.)

ANALYSIS:

It is important to note that health care fairs and events may involve many health care professionals – dentists, physician assistants, registered nurses, and so on. As the Department has indicated that it is willing to serve as a central point of intake and review of the sponsors' registration forms, staff recommends that the Board delegate this function to the Department.

Please note that the Board is not delegating the registering of individual physicians; this responsibility remains with the Board.

Medical Board of California

Resolution

Delegation to Department of Consumer Affairs for the
Review and Registration of Sponsoring Entities

Whereas, section 901 of the Business and Professions Code (section 901), which relates to sponsored health care events, requires that an entity desiring to sponsor such an event must first register with the appropriate board within the Department of Consumer Affairs (Department); and,

Whereas, the Medical Board of California (Board) is the appropriate board to register sponsored health care events utilizing the services of physicians; and,

Whereas, the Board, to implement the provisions of section 901, has adopted regulations that authorize the Board by resolution to delegate to the Department the authority to receive registration forms and register sponsoring entities; and,

Whereas, a sponsored event may utilize many healthcare license disciplines, including physician assistants, registered nurses, and other professionals; and,

Whereas, the Department would therefore serve as the optimal central point to receive registration forms and to register sponsoring entities;

THEREFORE, BE IT RESOLVED that the Board hereby delegates to the Department the authority to receive sponsored entity registration forms and to register sponsoring entities for sponsored health care events that utilize the services of physicians.

Adopted this ___day of February, 2012

By

Barbara Yaroslavsky

President

Assembly Bill No. 2699

CHAPTER 270

An act to amend Section 900 of, and to add and repeal Section 901 of, the Business and Professions Code, relating to healing arts.

[Approved by Governor September 23, 2010. Filed with Secretary of State September 24, 2010.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2699, Bass. Healing arts: licensure exemption.

Existing law provides for the licensure and regulation of various healing arts practitioners by boards within the Department of Consumer Affairs. Existing law provides an exemption from these requirements for a health care practitioner licensed in another state who offers or provides health care for which he or she is licensed during a state of emergency, as defined, and upon request of the Director of the Emergency Medical Services Authority, as specified.

This bill would also provide, until January 1, 2014, an exemption from the licensure and regulation requirements for a health care practitioner, as defined, licensed or certified in good standing in another state or states, who offers or provides health care services for which he or she is licensed or certified through a sponsored event, as defined, (1) to uninsured or underinsured persons, (2) on a short-term voluntary basis, (3) in association with a sponsoring entity that registers with the applicable healing arts board, as defined, and provides specified information to the county health department of the county in which the health care services will be provided, and (4) without charge to the recipient or a 3rd party on behalf of the recipient, as specified. The bill would also require an exempt health care practitioner to obtain prior authorization to provide these services from the applicable licensing board, as defined, and to satisfy other specified requirements, including payment of a fee as determined by the applicable licensing board. The bill would require the applicable licensing board to notify the sponsoring entity, as defined, of the sponsored event whether the board approves or denies a request for authorization to provide these services within 20 days of receipt of the request. The bill would also prohibit a contract of liability insurance issued, amended, or renewed on or after January 1, 2011, from excluding coverage of these practitioners or a sponsoring entity for providing care under these provisions.

Because this bill would expand the definition of certain crimes, the bill would create 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 900 of the Business and Professions Code is amended to read:

900. (a) Nothing in this division applies to a health care practitioner licensed in another state or territory of the United States who offers or provides health care for which he or she is licensed, if the health care is provided only during a state of emergency as defined in subdivision (b) of Section 8558 of the Government Code, which emergency overwhelms the response capabilities of California health care practitioners and only upon the request of the Director of the Emergency Medical Services Authority.

(b) The director shall be the medical control and shall designate the licensure and specialty health care practitioners required for the specific emergency and shall designate the areas to which they may be deployed.

(c) Health care practitioners shall provide, upon request, a valid copy of a professional license and a photograph identification issued by the state in which the practitioner holds licensure before being deployed by the director.

(d) Health care practitioners deployed pursuant to this chapter shall provide the appropriate California licensing authority with verification of licensure upon request.

(e) Health care practitioners providing health care pursuant to this chapter shall have immunity from liability for services rendered as specified in Section 8659 of the Government Code.

(f) For the purposes of this section, "health care practitioner" means any person who engages in acts which are the subject of licensure or regulation under this division or under any initiative act referred to in this division.

(g) For purposes of this section, "director" means the Director of the Emergency Medical Services Authority who shall have the powers specified in Division 2.5 (commencing with Section 1797) of the Health and Safety Code.

SEC. 2. Section 901 is added to the Business and Professions Code, to read:

901. (a) For purposes of this section, the following provisions apply:

(1) "Board" means the applicable healing arts board, under this division or an initiative act referred to in this division, responsible for the licensure or regulation in this state of the respective health care practitioners.

(2) "Health care practitioner" means any person who engages in acts that are subject to licensure or regulation under this division or under any initiative act referred to in this division.

(3) "Sponsored event" means an event, not to exceed 10 calendar days, administered by either a sponsoring entity or a local government, or both, through which health care is provided to the public without compensation to the health care practitioner.

(4) "Sponsoring entity" means a nonprofit organization organized pursuant to Section 501(c)(3) of the Internal Revenue Code or a community-based organization.

(5) "Uninsured or underinsured person" means a person who does not have health care coverage, including private coverage or coverage through a program funded in whole or in part by a governmental entity, or a person who has health care coverage, but the coverage is not adequate to obtain those health care services offered by the health care practitioner under this section.

(b) A health care practitioner licensed or certified in good standing in another state, district, or territory of the United States who offers or provides health care services for which he or she is licensed or certified is exempt from the requirement for licensure if all of the following requirements are met:

(1) Prior to providing those services, he or she:

(A) Obtains authorization from the board to participate in the sponsored event after submitting to the board a copy of his or her valid license or certificate from each state in which he or she holds licensure or certification and a photographic identification issued by one of the states in which he or she holds licensure or certification. The board shall notify the sponsoring entity, within 20 calendar days of receiving a request for authorization, whether that request is approved or denied, provided that, if the board receives a request for authorization less than 20 days prior to the date of the sponsored event, the board shall make reasonable efforts to notify the sponsoring entity whether that request is approved or denied prior to the date of that sponsored event.

(B) Satisfies the following requirements:

(i) The health care practitioner has not committed any act or been convicted of a crime constituting grounds for denial of licensure or registration under Section 480 and is in good standing in each state in which he or she holds licensure or certification.

(ii) The health care practitioner has the appropriate education and experience to participate in a sponsored event, as determined by the board.

(iii) The health care practitioner shall agree to comply with all applicable practice requirements set forth in this division and the regulations adopted pursuant to this division.

(C) Submits to the board, on a form prescribed by the board, a request for authorization to practice without a license, and pays a fee, in an amount determined by the board by regulation, which shall be available, upon appropriation, to cover the cost of developing the authorization process and processing the request.

(2) The services are provided under all of the following circumstances:

(A) To uninsured or underinsured persons.

(B) On a short-term voluntary basis, not to exceed a 10-calendar-day period per sponsored event.

(C) In association with a sponsoring entity that complies with subdivision (c).

(D) Without charge to the recipient or to a third party on behalf of the recipient.

(c) The board may deny a health care practitioner authorization to practice without a license if the health care practitioner fails to comply with the requirements of this section or for any act that would be grounds for denial of an application for licensure.

(d) A sponsoring entity seeking to provide, or arrange for the provision of, health care services under this section shall do both of the following:

(1) Register with each applicable board under this division for which an out-of-state health care practitioner is participating in the sponsored event by completing a registration form that shall include all of the following:

(A) The name of the sponsoring entity.

(B) The name of the principal individual or individuals who are the officers or organizational officials responsible for the operation of the sponsoring entity.

(C) The address, including street, city, ZIP Code, and county, of the sponsoring entity's principal office and each individual listed pursuant to subparagraph (B).

(D) The telephone number for the principal office of the sponsoring entity and each individual listed pursuant to subparagraph (B).

(E) Any additional information required by the board.

(2) Provide the information listed in paragraph (1) to the county health department of the county in which the health care services will be provided, along with any additional information that may be required by that department.

(e) The sponsoring entity shall notify the board and the county health department described in paragraph (2) of subdivision (d) in writing of any change to the information required under subdivision (d) within 30 calendar days of the change.

(f) Within 15 calendar days of the provision of health care services pursuant to this section, the sponsoring entity shall file a report with the board and the county health department of the county in which the health care services were provided. This report shall contain the date, place, type, and general description of the care provided, along with a listing of the health care practitioners who participated in providing that care.

(g) The sponsoring entity shall maintain a list of health care practitioners associated with the provision of health care services under this section. The sponsoring entity shall maintain a copy of each health care practitioner's current license or certification and shall require each health care practitioner to attest in writing that his or her license or certificate is not suspended or revoked pursuant to disciplinary proceedings in any jurisdiction. The sponsoring entity shall maintain these records for a period of at least five years following the provision of health care services under this section and shall, upon request, furnish those records to the board or any county health department.

(h) A contract of liability insurance issued, amended, or renewed in this state on or after January 1, 2011, shall not exclude coverage of a health care

practitioner or a sponsoring entity that provides, or arranges for the provision of, health care services under this section, provided that the practitioner or entity complies with this section.

(i) Subdivision (b) shall not be construed to authorize a health care practitioner to render care outside the scope of practice authorized by his or her license or certificate or this division.

(j) (1) The board may terminate authorization for a health care practitioner to provide health care services pursuant to this section for failure to comply with this section, any applicable practice requirement set forth in this division, any regulations adopted pursuant to this division, or for any act that would be grounds for discipline if done by a licensee of that board.

(2) The board shall provide both the sponsoring entity and the health care practitioner with a written notice of termination including the basis for that termination. The health care practitioner may, within 30 days after the date of the receipt of notice of termination, file a written appeal to the board. The appeal shall include any documentation the health care practitioner wishes to present to the board.

(3) A health care practitioner whose authorization to provide health care services pursuant to this section has been terminated shall not provide health care services pursuant to this section unless and until a subsequent request for authorization has been approved by the board. A health care practitioner who provides health care services in violation of this paragraph shall be deemed to be practicing health care in violation of the applicable provisions of this division, and be subject to any applicable administrative, civil, or criminal fines, penalties, and other sanctions provided in this division.

(k) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

(*l*) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • GOVERNOR EDMUND G. BROWN JR.
DIVISION OF LEGAL AFFAIRS
1625 N. Market Blvd., Suite S 309, Sacramento, CA 95834
P (916) 574-8220 F (916) 574-8623

MEMORANDUM

DATE	January 17, 2012
TO	Members, Medical Board of California
FROM	Kurt Heppler, Senior Staff Counsel Division of Legal Affairs
SUBJECT	**Implementing Regulations for AB 1267**

This memorandum addresses the regulatory language necessary to implement the provisions of Assembly Bill (AB) 1267 [attached], a bill sponsored by the Medical Board of California (Board). AB 1267 requires the Board designated a physician and surgeon's certificate (his or her medical license) as inactive when that physician is incarcerated following the conviction of a misdemeanor. The inactive status means that the physician cannot practice medicine, and it is important to note that existing law already requires that the license of a physician incarcerated after conviction of a felony is automatically suspended.

AB 1267 also requires that the Board return the physician's license to its prior status within five days after receiving notice that the physician is no longer incarcerated. The Board is obligated to define the notice requirement in regulation and the attached contains the proposed regulatory language.

The proposed language specifies that proper notice to the Board means that a certified copy of the release issued by a local jurisdiction is either mailed or served upon the Board. The proposed regulation also specifies the license status that will be displayed on the Board's Internet site. Please note that existing regulations specify disclosure for other license statuses.

Legal Counsel recommends that the proposed regulation be set for public hearing at the next Board meeting. This action will then require staff to prepare and distribute a notice of the proposed rulemaking, an initial statement of reasons, and other related documents.

STAFF RECOMMENDATION:

Direct staff to set this regulation for hearing at the May 2012 Board Meeting.

Proposed Regulation

"Section 1355.45. (a) For purposes of subdivision (b) of section 2236.2 of the Code, "notice" means a certified copy of a release issued by the applicable local jurisdiction where the licensee was incarcerated which is provided by the licensee either by regular mail or by personal service, at the option of the licensee."

(b) Whenever a license is placed on inactive status pursuant to section 2236.2 of the Code, the Board shall display the status of the license as follows:

'Inactive License - Misdemeanor Conviction. Licensee was convicted of a misdemeanor and is currently incarcerated. No practice is permitted.'"

AGENDA ITEM 27

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	January 25, 2012
ATTENTION:	Medical Board of California
SUBJECT:	Discussion and Consideration of Co-Sponsoring Pain Management Summit with Pharmacy Board
STAFF CONTACT:	Linda Whitney, Executive Director

STAFF RECOMMENDATION:

Direct staff to work with the Pharmacy Board staff to develop the content for and convene a Pain Management Summit jointly sponsored with the California State Board of Pharmacy for California health care providers.

BACKGROUND & ANALYSIS:

Over 10 years ago California State Board of Pharmacy (BOP) joined with the Medical Board and the Department of Consumer Affairs (DCA) to convene a pain management summit. The current president of the BOP is interested in, jointly with the Medical Board, updating information and work product from that summit and making it current. This would entail working on a project to discuss the appropriate pain treatment and how pharmacists and prescribers can work together to provide better patient care.

The members of the BOP are discussing this concept at its January 31 – February 1 board meeting. See the attached agenda item from that board meeting and the outcomes of the 1994 summit as provided in the attached *Pain Management Health Notes.*

If approved the summit would likely take place in the fall of 2012 and all interested parties would be invited to participate.

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STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GOVERNOR EDMUND G. BROWN JR.

Date: January 22, 2012

To: Board Members

Subject: Agenda Item XI: Proposal to Develop and Convene a Pain Management Summit Jointly with the Medical Board of California for California Health Care Providers

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ATTACHMENT XI

FOR DISCUSSION AND POSSIBLE ACTION:

Over 10 years ago, the Board of Pharmacy joined with the Medical Board of California and the DCA to convene a pain management summit. One of the outcomes of this conference was a *Pain Management Health Notes* that was developed and published by this board. A copy is provided as **Attachment XI**.

In the last few years, as you are aware, the board has been struggling to deal with an enormous volume of drug diversion from pharmacies and wholesalers. During the board's enforcement discussions and when taking formal discipline, the board has witnessed that huge quantities of prescription medication are being lost. Today prescription drug abuse kills more people than automobile accidents. The DEA has hosted four national drug take back days for the public to dispose of unwanted medication in consumers' homes as one solution. Meanwhile consumers purchase medication from internet websites, without medical supervision. And until a few years ago with enactment of the federal Ryan Haight Act, many of these websites sold controlled pain medications.

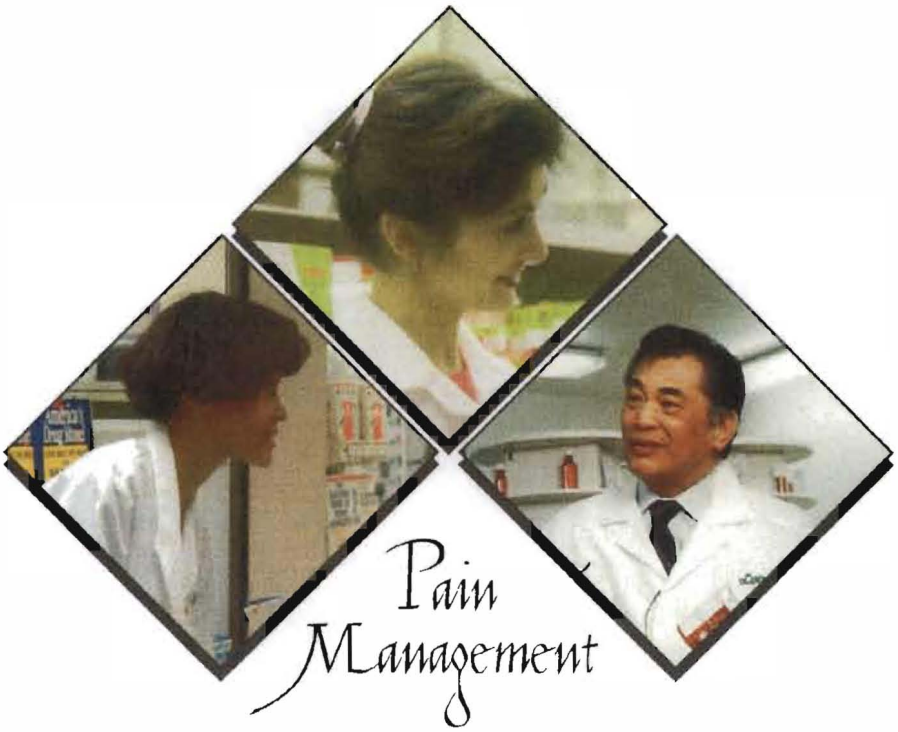
And yet simultaneously last year, AB 507 (Hayashi) was introduced and sponsored by the American Cancer Society. The rationale behind this bill was that existing laws prevent patients from getting adequate pain management and relief. An early version of this bill was opposed by this board for provisions it contained that would have eliminated provisions that are referenced in case law involving excessive dispensing and a pharmacist's corresponding responsibility. Assembly

Member Hayashi agreed to remove this provision once our opposition was expressed and the board's executive officer agreed to work with the American Cancer Society on pain management issues.

In the last few months, the executive officers of this board and the Medical Board of California have discussed hosting another pain summit to discuss appropriate pain treatment and how pharmacists and prescribers can work together to provide better patient care.

President Weisser is interested in working on such a project. At this meeting, the board will have the opportunity to discuss developing such a conference. Following our meeting later in the week, the Medical Board will also discuss joining with this board in hosting such a conference later in the year.

HEALTH NOTES



Pain Management

Consumer Education, Information and Communication Committee

Dedicated to building bridges of communication with those Californians whose health depends on proper drug therapy, compliance with a treatment regimen and a healthier lifestyle.

MEMBERS

M. Standifer Shreve, *Chair*

Sandra Bauer

Hope Lamraz, *Staff*

California State Board of Pharmacy

MEMBERS

Darlene Fujimoto, *President*

Holly Strom, *Vice President*

Caleb Zia, *Treasurer*

Sandra Bauer

Gary Dreyfus

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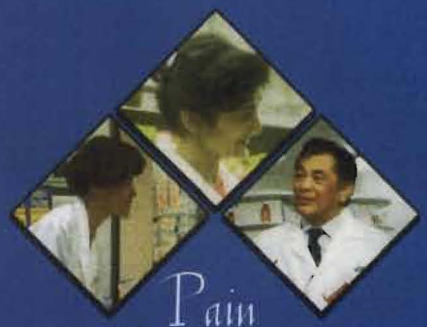
M. Standifer Shreve

Michael Tilles

Patricia Harris, *Executive Officer*

HEALTH NOTES

VOLUME I, NUMBER I



Pain Management

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Introduction

HEALTH NOTES is a series of monographs published by the California State Board of Pharmacy's Consumer Education, Information and Communication Committee to help California pharmacists and other healthcare providers become better informed on subjects of importance to their patients.

Today, more than ever in the history of medicine, healthcare professionals are addressing the goals of integrated healthcare. They are providing patient care that focuses on physical wellness, service-satisfaction, and cost effectiveness.

Pharmacists, by virtue of their close relationship with patients, can quickly respond to a patient's medication needs and can satisfy a patient's desire to be informed about their treatment and the medications they are taking.

Access to information is an important component in attaining wellness. Pharmacists who develop programs that assist patients to better manage their medications and to meet their treatment objectives will help Californians reach higher levels of wellness.

As healthcare evolves into a system focused on integrated patient care, one fact becomes very clear: healthcare professionals who provide disease management programs and prescription information that increases medication compliance will help reduce hospital admissions and the need for follow-up care.

HEALTH NOTES is designed to be a reference source for pharmacists and other health care providers to use in helping patients better understand their illness, comply with prescribed treatment regimens and take greater responsibility for their health.

This first HEALTH NOTES monograph addresses the area of pain management. We hope it will be a valuable tool to help health professionals communicate information about the treatment of pain.

M. Standifer Shreve
Editor, HEALTH NOTES
Chair, Consumer Education, Information and Communication Committee
CALIFORNIA STATE BOARD OF PHARMACY

DISPENSING CONTR SUBSTANCES FOR

A STATEMENT OF THE CALIFORNIA STATE BOARD

INTRODUCTION

Healthcare leaders and patient advocates from throughout California met at the *Summit on Effective Pain Management: Removing Impediments to Appropriate Prescribing* in Los Angeles in 1994 to discuss the effective management of pain. Summit participants concurred that effective pain management, including the use of controlled substance medications, is essential to the health and welfare of Californians experiencing pain. It was also concluded that inappropriate or undertreatment of pain is serious and wide spread.

In response to these findings, the California State Board of Pharmacy is taking a leadership role in promoting the effective management of pain for the state's citizens. The Board's objectives include educating pharmacists on advances in appropriate pain management and taking active roles in providing this therapy. The Board is working to computerize the triplicate prescription program; is encouraging the timely availability of opioids in different healthcare settings such as hospitals, patient's homes and pharmacies; and is encouraging better knowledge and attitudes of patients, the public and other licensed healthcare professionals in the use of pain medications-all with the goal of positively influencing the care of patients in pain.

The Board of Pharmacy must ensure that laws, regulations, policies, and practices promote the availability and use of controlled substance drugs to patients for legitimate pain management. The Board encourages programs to help educate patients, the public, and licensed healthcare professionals about the effective use of medications in the treatment of various types of pain. The Board also recognizes that, with proper assessment, therapeutic planning, and follow up, medications should be available and used when needed.

The pharmacist's role (as educator and manager) in providing drug therapy for patients in pain is extensive. If pharmacists are to provide complete pain management services, they must fulfill their responsibilities to:

1. Facilitate the dispensing of legitimate prescriptions;

2. Understand and learn about the effective uses of all pain medications, especially opioids and other controlled substances, in the management of pain;

3. Carefully explain dosage regimens, and discuss potential side effects of pain medications;

4. Monitor and assess the patient for effective pain therapy outcomes, evaluate compliance, assess for tolerance to opioids, and ensure subsequent dosage adjustments as needed;

5. Obtain, retain, and update appropriate information documenting the course of, and need for, on-going opioid therapy;

6. Encourage patients to talk with their pharmacist about their medications, the benefits and problems;

7. Discuss and allay patients' possible fear of addiction with the use of narcotics where this is a factor;

8. Watch for patients who misuse their prescriptions and be especially aware of a patient or family history of substance abuse that might complicate pain management and act accordingly;

9. Assess the patient for adverse drug reactions from the pain therapy regimen and take action to minimize or eliminate them;

10. Be aware of and recommend non-medication treatments for pain or refer patients for such when appropriate;

11. Evaluate OTC, prescription drugs, and alcohol taken with pain medications for potential drug interactions;

12. Recognize that patients and caregivers are important sources of information in assessing the patient's pain therapy;

13. Act as a liaison between patients and other healthcare providers, ensuring that there is open communication and understanding about the drugs patients are taking to reduce pain; and

14. Optimize pain management so patients can reach their highest level of functioning and quality of life.

ROLE OF OPIOIDS IN PAIN MANAGEMENT

Many patients with cancer or chronic medical conditions experience moderate to severe pain that is often inappropriately treated or undermedicated. Pain can have a negative effect on the patient's health and quality of life resulting in needless suffering, emotional distress, loss of productivity and possibly slower recovery from illness, injury, and disease.

Although there have been significant advances in knowledge about pain and the use of opioids and other medications in pain management, many licensed healthcare professionals prescribe, dispense, or administer these medications suboptimally. There is a misconception by patients, the public, and some licensed healthcare providers that opioids are "bad" drugs because opioids are often associated with drug abuse, addiction, and criminal activity. Studies have shown that opioids used appropriately for pain management have an extremely low potential for abuse.

OLLED PAIN

OF PHARMACY

The Board understands that the ongoing use of opioids for cancer, post-surgical, and chronic pain is not what causes addiction or a patient's desire for higher doses of pain medication. Patients suffering from extreme pain or progression of disease may require increased doses of medication; the appropriate dose is that which is required to adequately treat the pain, even if the dose is higher than usually expected. In addition, with long-term treatment of pain with opioids, patients may develop a tolerance to the drug or a dependence on the drug. These occurrences are considered "normal" and "to be expected"—they should not be confused by the licensed healthcare professional with drug addiction or be mislabeled as "drug seeking."

The Board understands that an important part of effective pain management is ensuring that patients do not have difficulty obtaining adequate medication for pain relief. The Board recognizes that it is the professional responsibility of the pharmacist to recommend that patients in pain receive appropriate, timely, and adequate drug therapy to reduce their pain.

CONCLUSION

Recognition of the utility of opioids and other controlled substance drugs for the treatment of pain resulting from a variety of conditions is well established. The need for regulators and practitioners to understand this use, and to adopt laws, policies, and practices is self-evident if patients are to receive relief from pain which is now medically possible. In addition, pharmacists must understand their role in the on-going monitoring and assessment of patients' pain management. Working cooperatively, the Board of Pharmacy and the profession can ensure that opioids and other controlled substance drugs are used appropriately and effectively. ❑

Patient's BILL OF RIGHTS

Introduction

Effective health care requires collaboration between patients, pharmacists, and other health care professionals. Open and honest communication, respect for personal and professional values, and sensitivity to differences are integral to providing patient care. Pharmacists must ensure a health care ethic that respects the role of patients in decision making about treatment choices and other aspects of their care.

The California Board of Pharmacy encourages health care providers to tailor this bill of rights to their patient community by translating and/or simplifying the language of this document as may be necessary to ensure that patients and their families understand their rights and responsibilities.

Bill of Rights

1. *The patient has the right to considerate and respectful care.*
2. *The patient has the right to and is encouraged to obtain from pharmacists and other direct caregivers relevant, current, and understandable information concerning their medication therapy and treatment.*
3. *The patient is entitled to the opportunity to discuss and request information related to their specific drug therapy, the possible adverse side effects and drug interactions.*
4. *The patient has the right to make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment or plan of care.*
5. *The patient has the right to expect that all communication, discussion, and patient counseling will be conducted so as to protect each patient's privacy.*
6. *The patient has the right to expect that all records and discussion pertaining to his/her drug therapy will be treated as confidential by the pharmacist, and the patient has the right to expect that the pharmacist will emphasize the confidentiality of patient information to any other parties entitled to review the patient's information and records.*
7. *Patients have a right to competent counseling from the pharmacist to help them understand their medications and use them correctly.*

Conclusion

The collaborative nature of health care requires that patients, or their families, participate in their care. The effectiveness of patient care and patient satisfaction with the course of drug therapy will depend, in part, on the patient fulfilling certain responsibilities. Patients are responsible for providing information about their medications as well as a history of their drug and food allergies.

To participate effectively in decision making, patients must be encouraged to take responsibility for requesting information or clarification about the drugs they are taking when they do not fully understand information and instructions.

Concerns and Facts About Pain Management

By Peter J.S. Koo, Pharm.D.

Associate Professor, Pharmacist Specialist in Pain Management, Department of Clinical Pharmacy, University of California San Francisco, School of Pharmacy

If your patient is being treated for chronic pain, you may have concerns about your patient's use of analgesics. The following are some common concerns pharmacists have and the facts regarding them.

Concern: My patient always gets refills of analgesics right on time. The patient must be getting "hooked" or addicted.

Fact: A conclusion a patient is addicted should not be based solely on how frequently a patient is refilling his or her prescriptions. You must first evaluate the patient in light of the overall clinical picture. While the possibility of addiction is a proper concern, it is equally important to determine what the patient is being treated for and whether the current regimen is the best one for the patient's needs.

Too often, patients with pain are given inadequate pain drug therapy. Studies have shown that 20% - 30% of patients with pain are undertreated. Good communication between the prescriber and the pharmacist can significantly improve the patient's pain management outcome. Pharmacists often do not have all the diagnostic or therapeutic information available to them unless they are actively participating in the pharmaceutical care of the patient. Pharmacists who are providing chronic analgesics should at least have a recorded indication for their use in order to provide appropriate pharmaceutical care.

Concern: Patients should take analgesics only when they can no longer tolerate the pain.

Fact: Pain is easier to treat before it becomes severe. Patients should take their pain medication when they first start to feel the pain and on a regularly scheduled basis thereafter.

Frequent clinical assessment of the painful condition is an essential part of chronic pain management, and dosing adjustments must be based on those assessments.

Concern: My patient is taking several medications for pain. Is this polypharmacy necessary?

Fact: Pain has many causes. It can result from direct injury to the bone, muscles, skin, nerves, or other body organs. Pain can sometimes persist even after the initial injury has healed. This pain can be caused by scarring of the nerve or injured tissue, and it is often maintained by local tissue or sympathetic irritation. Treatment of such pain often requires analgesics that are active locally as well as in the central nervous system. Unfortunately, there is no one drug that is active in all the sites that are responsible for pain sensation and response.

Recent studies have indicated the need for multiple sites of intervention for control of many forms of chronic pain. Therefore, patients with chronic pain often require compound drug therapy. However, multiple fixed dose analgesic combinations should be avoided because of the potential for inadvertent toxicity with acetaminophen or aspirin.

Concern: My patient always requests one particular medication and refuses to change to another analgesic even at equivalent analgesic doses. Does this indicate addiction?

Fact: Rather than addiction, the patient's refusal to change medication may be an indication that an equivalent analgesic does not achieve the same clinical response. Not all patients respond to a particular drug in the same way. All analgesic equivalency studies are based on population statistics or animal studies, but are not absolute, and should only be used as a guide for switching from one analgesic to another. Your patient's drug and dose must be based on his or her clinical response. Therefore, it is to the patient's advantage to stay with one pharmacy and get to know the pharmacist, who functions as the patient's pain management advocate. If the patient is getting an inadequate response from the therapeutic regimen, the pharmacist must then communicate that information to the treating clinician(s).

Concern: Is my patient addicted to opiate analgesics?

Fact: One must not confuse addictive behavior, dependence or tolerance with therapeutic failure. Use of opiates chronically can lead to tolerance and dependence.

Tolerance occurs when the same dose of an analgesic becomes less effective over time and may result in therapeutic failure. The first sign of tolerance is when the given dose of an analgesic is not lasting as long as when it was first introduced. Tolerance can be managed with appropriate dose adjustments or with a change in analgesic.

CONTINUED ON PAGE 9

PAIN TREATMENT GUIDELINES

BY DARLENE FUJIMOTO, PHARM. D., HOLLY STROM, PHARM. D., & PETER J.S. KOO, PHARM. D.

Recent surveys indicate that approximately 34 million adult Americans go to their physicians at least once a year for treatment of pain—pain that is serious enough to have a detrimental effect on their lives. Undertreated pain impedes recovery from surgery, injury or illness. Pain also interferes with physical activity and productivity; increases the use and cost of healthcare services; and decreases the quality of life.

Counseling, educating and discussing pain management with patients, their caregivers and their families, provides pharmacists with a unique opportunity to assist patients in the treatment of pain.

The following PAIN TREATMENT GUIDELINES were developed with the Board of Pharmacy to aid California pharmacists in assessing and evaluating a patient's pain therapy. These Guidelines can help pharmacists—working in cooperation with other healthcare professionals—to provide optimal pain management and minimize the adverse effects associated with many of the drugs used to treat pain.

I EVALUATION OF A PATIENT IN PAIN

When filling prescriptions for chronic pain control medications, pharmacists should assess the following:

1. ASSESSMENT/EVALUATION OF PATIENT'S PAIN CONTROL, e.g., use a pain scale, such as:

0	5	10
No Pain	Moderate Pain	Severe Pain

The pharmacist should ask the patient what is his or her acceptable pain level.

2. ASSESSMENT OF PAIN CONTROL MEDICATIONS. Is the medication being taken in accordance with the indicated directions? If not, the pharmacist should contact the prescriber to update the medication's directions and to evaluate the medication's appropriate use.

3. ASSESSMENT OF SIDE EFFECTS:

a. Constipation—Is the patient experiencing constipation from opioid analgesics? If so, the pharmacist should assess the patient and provide recommendations to prevent it. Stimulant laxatives are needed to prevent and treat opioid induced constipation.

b. Nausea and vomiting—Is the patient about to receive a new opioid analgesic or presently experiencing nausea or vomiting with opioid analgesics? If so, the prescriber should anticipate nausea and prescribe as needed (PRN) anti-nausea medications. The patient should obtain these medications so that they are available for use. The pharmacist may also suggest to the prescriber alternative opioid analgesics that might be better tolerated.

c. Central nervous system (CNS) side effects—Is the patient experiencing sedation, confusion, stupor, delirium, or hallucinations? These side effects might be anticipated with medications used for pain control. Each patient may react to these medications differently, therefore the pharmacist should ask the patient early and often about these side effects. Frequently, these side effects will resolve with a change in prescribed pain control medications.

d. Respiratory depression—Is the patient taking multiple medications that can affect respiration? Patients seldom experience respiratory depression when opioids are taken alone for pain. Most often respiratory depression occurs when opioids are used in combination with other CNS depressants such as benzodiazepines or phenothiazines. Be sure to assess and discuss this complication with the patient so that he or she is aware of this possible side effect.

II RED FLAG SITUATIONS

1: A patient is taking a combination of opioid analgesics (i.e., acetaminophen with codeine and acetaminophen with hydrocodone)

ACTION: The pharmacist should contact the prescriber and suggest a stronger opioid analgesic such as morphine or hydromorphone to be taken at appropriately scheduled dosing intervals. The main reason for using a stronger opioid analgesic alone is to avoid an excessive acetaminophen dose. Alternatively, a longer acting opioid analgesic such as sustained action morphine, levorphanol, or methadone can be used on a schedule in combination with a short acting opioid analgesic as needed (PRN) for breakthrough pain.

2: A patient is taking a sustained release (SR) narcotic product on a PRN schedule.

ACTION: The pharmacist should contact the prescriber to recommend changing the product to an immediate acting narcotic (i.e., morphine) that is appropriately dosed if the patient is taking the SR product in shorter than eight hour intervals. The SR product will not work immediately because the onset is delayed.

3: A patient is given a prescription for SR opioid analgesics (i.e., SR morphine, or fentanyl patches), and the patient is not on any other short acting analgesics.

ACTION: The pharmacist should ask the patient if he or she is taking any other medications and

having pain between the SR scheduled doses. If the patient is having pain between scheduled SR doses, the pharmacist should educate the patient to talk with the prescriber about getting an immediate acting analgesic for the breakthrough pain. The pharmacist can also talk to the prescriber to discuss the patient's needs.

4: A patient is requesting refills much earlier than scheduled.
ACTION: The pharmacist should consult with the patient because this might be a sign that the patient's pain is not being adequately controlled. After determining the cause, the pharmacist should discuss with the prescriber the patient's uncontrolled pain and the possibility of changing the patient to a better analgesic regimen. If the pain is of a chronic nature, longer acting or sustained action opioids should be preferred for the patient's convenience and comfort. If there are other reasons that the patient is seeking refills, the pharmacist should document the reasons and the amount given per the pharmacist's professional judgment, and notify the prescriber about any loss of medications.

5: A patient is taking more than 4-6 grams per day of acetaminophen from combination analgesic products.
ACTION: The pharmacist should alert the prescriber to the amount of acetaminophen the patient is taking. The pharmacist should also recommend changing the patient to a product that will reduce the total daily amount of acetaminophen intake.

6: A patient is converted from one opioid analgesic to another (i.e., morphine to hydromorphine).
ACTION: The pharmacist should consult with the patient to determine the reason for the change in medication. The pharmacist should estimate the "equianalgesic" dose and verify that the conversion is appropriate to maintain pain control. If the change in medication has decreased the pain coverage or the dose is unreasonably increased, the prescriber should be contacted to recommend an appropriate change in the dosage.

III VERIFICATION AND DOCUMENTATION OF PRESCRIPTIONS

Prescriptions are to be used for legitimate purposes. The pharmacist's responsibility is to make sure that prescribed medications are dispensed to patients in a timely manner and that the pain medication dispensed is the most appropriate one for the patient. Pharmacists also have a responsibility to use professional judgment and their knowledge of medications to ensure all medications are dispensed for a legitimate medical purpose.

The pharmacist should be sure that assessment information and medication documentation are readily retrievable on the prescription hard copy, on the patient's computer medical record profile or in a separate file.

Adequate documentation and verification will allow a pharmacist to answer these questions.

1. Are the directions correct for the medication prescribed; do the directions correspond to the amounts of medication the patient is receiving; and, do the intervals between refills and/or new prescriptions correspond to directions?

2. Is there documentation of the diagnosis?

   a. What is the disease state being treated?

   b. Is the duration of treatment for:
      - Acute pain?
      - Chronic pain associated with malignant disease?
      - Chronic pain not associated with malignant disease?

3. For chronic pain, does the medication have a long enough half-life for adequate pain control? Is the patient on routine (around-the-clock) doses? What provision is there for breakthrough pain? Is the patient on medication(s) to prevent constipation?

4. Refer to the directions: are refills requested too soon? (If so, the pharmacist needs to contact the prescriber to recommend alternatives/adjustments to the medication regimen or to update current directions.)

5. Are adjuvant/adjuncts to opioid use needed (e.g., acetaminophen, nonsteroidal anti-inflammatory agents, antidepressants for neurogenic or neuropathic pain or depression, anticonvulsants, antinauseants, and medications for constipation)?

6. If a patient has been on chronic pain medications and the medications are to be discontinued, has the patient had the opportunity to be tapered off the medications to prevent symptoms of withdrawal?

IV. REGULATORY AND LEGAL ISSUES

1. All prescriptions should conform to all legal requirements detailed in the Health and Safety Code §11164 and summarized below:

a. SCHEDULE II prescriptions, among other requirements, must be:

(1) written wholly in ink or indelible pencil in the handwriting of the prescriber;

(2) submitted on a clear and complete triplicate prescription form;

(3) signed and dated by the prescriber; and

(4) filled within 7 days of the date of issuance, with the denoted copy forwarded to the Department of Justice within 30 days after filling.

b. Schedule III-V prescriptions, among other requirements, must:

(1) if written, be signed and dated by the prescriber;

(2) if written, be presented on a prescription document that is not mutilated, forged or altered; and

(3) not be refilled more than 5 times or refilled 6 months after the issuance date of the prescription.

2. Prescriptions are to be used only for legitimate medical purposes [21 USC §841.21; 21 CFR §1306.04 (a), Health and Safety Code §11153(a)]

3. Like the prescriber, the pharmacist has a corresponding responsibility to ensure the proper prescribing and dispensing of controlled substances to prevent clearly excessive furnishing of controlled substances or the furnishing of controlled substances for other than a legitimate medical purpose. [Business and Professions Code §4350.5 [4301(d) as of 1/1/1997]; 21C.F.R. section 1306.04(a)]

4. For any controlled substance prescription, the pharmacist's knowledge or lack of knowledge about the prescriber and patient may require additional information before dispensing medications. Factors to consider in evaluating prescription legitimacy include:

a. PATIENT FACTORS—Can the patient be identified? What is the distance between the patient's residence and normal trading area of the pharmacy or the distance between patient's residence and office of the prescriber? What is the drug use history of the patient, does the patient submit prescriptions from multiple prescribers for controlled substances?

b. PRESCRIBER FACTORS—What is the nature of the prescriber's practice and specialty, prescribing pattern including types of drugs, appropriate frequency and volume, ratio of controlled substance prescriptions written by the physician as compared to the total number of prescriptions filled by the pharmacy?

5. Pursuant to Business and Professions Code §4362(4301(i) as of 1/1/1997), knowingly selling, furnishing, giving away or administering or offering to sell, furnish, give away or administer any Schedule I or II controlled substances to an addict or habitué constitutes unprofessional conduct. Moreover, except as may be authorized by the Health and Safety Code, a pharmacist may not fill an order for controlled substances for an addict or habitual user of controlled substances (unless in the course of medical treatment) for the purpose of keeping the user comfortable by maintaining customary use. [Health and Safety Code 11153(a)]

Although the legal requirements, verification, and documentation of a prescription are important, a pharmacist's primary responsibility is to make adequate and appropriate pain control medications and adjunctive therapy available in a timely manner.

It is also important to work closely with other healthcare providers to assess medication efficacy, to evaluate and treat side effects, educate patients and their caregivers, and to be an active participant in helping patients receive optimal pain management. ◻

CONCERNS AND FACTS ABOUT PAIN MANAGEMENT - Continued from Page 6

Dependency is the physiological need for a drug, and without it the body undergoes withdrawal symptoms. Dependencies occur not only with analgesics but with many other medications as well. For example, chronic glucocorticoid use can lead to withdrawal symptoms upon abrupt discontinuation, and this is also true with opiate analgesics. In both cases, the body develops a physiological dependence for the drug.

Addiction is the culmination of drug dependence and drug seeking behavior. A patient is said to be addicted when the drug seeking behavior becomes all-consuming in one's life, and when the patient takes the medication for other than the intended indication(s) or is attempting to achieve euphoria or intoxication.

Criteria for Addiction

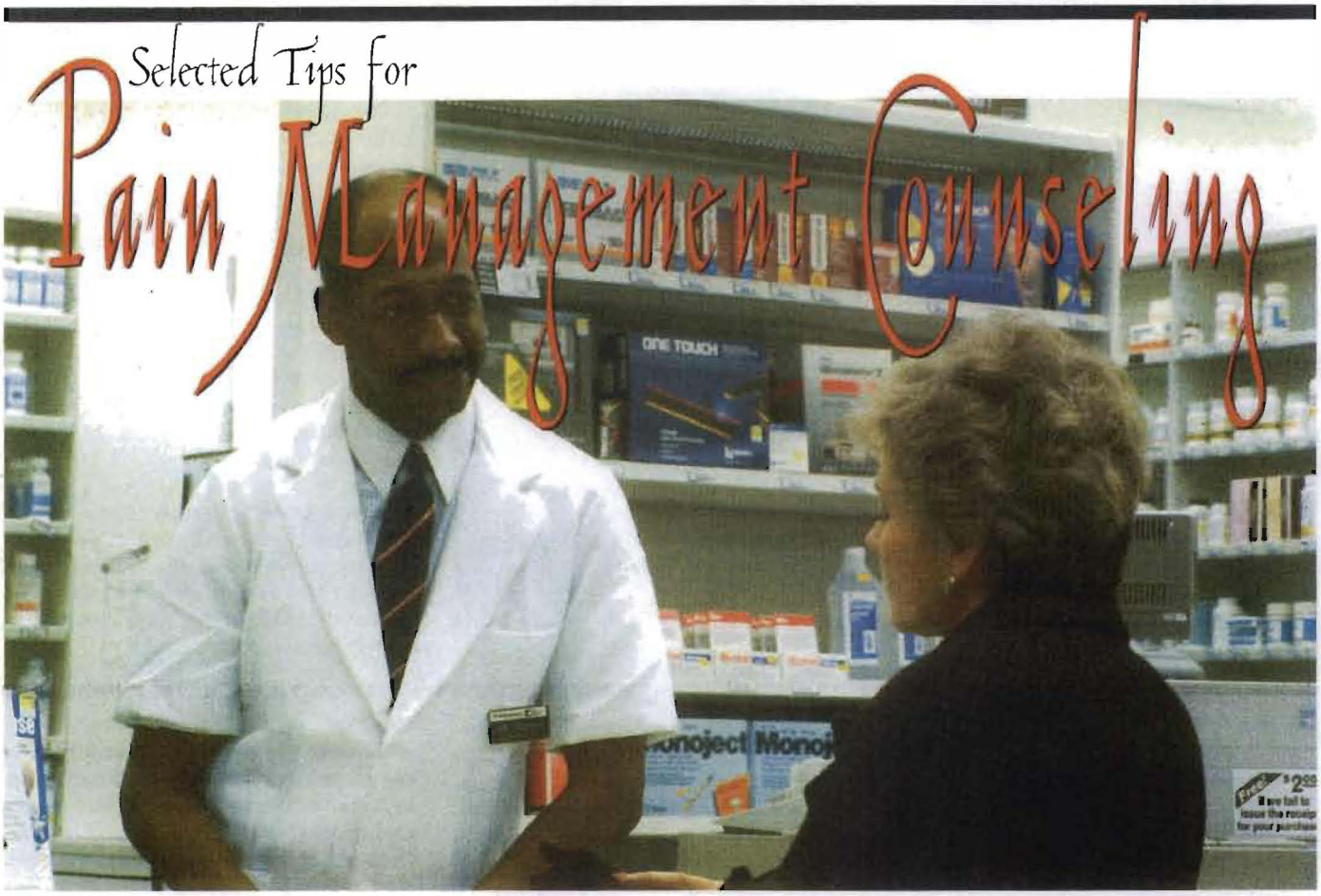
1. Taking the drug more often or in larger amounts than intended.
2. Alternates between intake binges and withdrawals.
3. Unsuccessful attempts to quit, persistent desire or craving.
4. Excessive time spent in drug seeking.
5. Feeling intoxicated or withdrawals at inappropriate times.
6. Giving up other things that one enjoys for the drug.
7. Continued use, despite knowledge of harm to oneself and others.
8. Marked tolerance in which the amount needed to achieve the desired effect increases to the point of toxicity.
9. Characteristic withdrawal symptoms for particular drug.
10. Taking the drug to relieve or avoid withdrawal.

These symptoms must have persisted for at least a month or have occurred repeatedly over a longer period. Mild addiction to a drug is determined by meeting four of the ten criteria. Experiencing five of the criteria would indicate moderate addiction and seven would indicate severe addiction.

Concern: What can I do to help my patient who is suffering from pain and is not getting adequate pain relief from the medications?

Fact: Most recent studies indicate that there remains a discrepancy between the patient's report of pain and the clinician's perception of the patient's pain. As healthcare providers who have seen the patient's progress with each medication received, it is our duty to provide the patient with the best information we can about pain management. If the pain is not controlled, recommend that the patient communicate with his or her healthcare provider(s). As an advocate for better pain management, every pharmacist should be part of a team of healthcare providers that is working to improve the quality of life for patients. There are pharmacists now practicing in partnership with other healthcare providers to provide pharmaceutical care in pain management. The pharmacists can serve as a resource and pharmaceutical care liaison for both patients and clinicians. Often, simply understanding your patient's therapeutic goals and providing feedback to other care provider team members can significantly improve your patient's quality of life. ◻

Selected Tips for Pain Management Counseling in Community Practice



BY MARIE BELSHE

Third year student at University of California, San Francisco School of Pharmacy; Winner of the National Patient Counseling Competition, United States Pharmacopeial Convention of 1996.

Pain is one of the most common reasons patients seek medical attention, yet it is frequently undertreated, leaving patients to suffer needlessly and their families with a sense of helplessness. Misperceptions and fears about pain medications, including their respiratory depressive effects, tolerance to the medication, and their addictive potential are common causes of undertreatment and reasons for patient noncompliance. As pharmacists and interns, we must help alleviate these fears by taking active roles in counseling patients about their pain medications so they can receive optimal benefits from the therapy. Counseling is an important component of that therapy, as it improves patient compliance and, consequently, outcomes.

Over-the-counter (OTC) analgesics, including acetaminophen, aspirin, and nonsteroidal anti-inflammatory drugs (NSAIDs), are available in many forms and are often used as first-line therapy for mild to moderate pain. All of these agents are effective analgesics and potential antipyretics; however, acetaminophen and low dose NSAIDs (OTC doses) do not have any significant anti-inflammatory activity. It is important to realize, and inform patients, that even though many medications for pain are available over-the-counter, they are not benign. Patient counseling provides the information that may well prevent drug misadventures.

Narcotics such as codeine, morphine, and oxycodone are usually reserved for severe pain. Although drugs in this class are considered the most effective in relieving nociceptive pain, many patients, unfortunately, are concerned about becoming addicted to this type of medication. The distinctions between tolerance (where more medication is needed to provide the same relief), dependence (the physical need for the drug to control pain), and addiction (the psychological craving and compulsive "seeking" of the drug) should be explained to the patient. This will help patients understand how they may become tolerant and even dependent, yet not addicted to their pain medications.

Narcotics can also be used in combination with NSAIDs, antidepressants, and anxiety agents very effectively for the relief of severe pain.

Counseling Tips for OTC and Prescription Analgesics:

ACETAMINOPHEN

- should be used with caution in patients who are alcoholics or who have liver disease.
- should be used with caution in patients who are fasting.

- should not be taken with alcohol.

- can be found in several OTC agents (e.g., decongestant preparations and cough and cold remedies) which, to minimize the likelihood of liver toxicity, should be avoided when taking acetaminophen for pain.

ASPIRIN

- with concurrent alcohol consumption may worsen gastrointestinal distress and should be avoided.

- may increase bleeding time and should not be used by patients on warfarin.

- should be dosed with caution in patients with diabetes, gout, or poor renal function.

- overdose is indicated by tinnitus (ringing in the ears). This condition is reversible by discontinuing the drug.

- will produce a vinegar-like smell when it has begun to degrade and should not be used. Patients can slow down this process by keeping aspirin in a dry place (i.e., not in the bathroom).

NSAIDS

- can be taken with antacids to decrease gastric irritation, but the liquid form should not be mixed with liquid antacids.

- may be effective in lower doses for the elderly.

- may cause drowsiness.

- have a ceiling effect. When pain relief has been attained, more drug will not provide more analgesia, but analgesia may last slightly longer.

OPIOIDS

- may cause constipation. This can be relieved by an OTC bowel stimulant, not a bulk-forming laxative.

- will cause sedation, and alcohol will intensify this effect.

- may cause dry mouth which can be relieved by sucking on sugarless hard candy or chewing sugarless gum.

- will provide more consistent analgesia for chronic pain patients, if taken around-the-clock rather than as needed.

- are not recommended for long-term use in pregnant women.

Several disease states or medical conditions require pain management with the previously mentioned analgesics. A select few are discussed here with specific patient counseling tips to help these patients receive better therapy for their pain.

CANCER PAIN

Pain experienced by cancer patients may be caused by either the cancer or the cancer treatment. Often, cancer pain therapy is initiated with NSAIDs, aspirin, or acetaminophen, and may progress to include narcotics or a combination of medications. Many cancer therapy regimens can cause nausea. For these patients, pain medications are available in rectal or transdermal forms.

Counseling Tips

- Patients will get better pain relief if they take the medication as scheduled, rather than as needed.

- Injectable and oral opioids are equally effective. The only difference is that oral opioids take a bit longer to demonstrate their analgesic effect.

- Even though some NSAIDs are OTC, they are effective at higher doses in relieving bone pain associated with cancer.

DENTAL PAIN

Pain due to dental procedures is usually self-limiting, but treatment improves patient comfort and productivity. Short-term, around-the-clock dosing is recommended to prevent the pain rather than trying to stop it. Often, treatment is initiated prior to the dental procedure for this reason. NSAIDs are commonly prescribed for dental pain to provide strong anti-inflammatory relief. Higher than OTC doses of NSAIDs will be required for anti-inflammatory activity.

Counseling Tips

- Patients should expect pain to decrease in three to five days.

- Aspirin should not be used because it may increase the likelihood of bleeding.

- Aspirin should never be applied directly to the gums or oral cavity, as it may cause a burn to these sensitive tissues.

DYSMENORRHEA

Dysmenorrhea may be a primary or secondary syndrome. The primary syndrome is more common and involves menstrual cramping. Though the pain may vary from woman to woman, OTC doses of ibuprofen or naproxen sodium are often successful in improving patient comfort and alleviating the pain.

Counseling Tips

- NSAIDs should be initiated at the onset of menstruation and continued for two to three days.

- Patients on birth control pills may experience a decrease in pain associated with menstruation cramping.

Secondary dysmenorrhea is due to endometriosis, pelvic inflammatory disease (PID), or an intrauterine device. These conditions need to be evaluated by a physician to determine the underlying cause of pain.

SPORTS INJURY PAIN

Sports injuries are generally separated into two types: acute (sprain, dislocation, concussion) and chronic/overuse (joint inflammation). For acute or chronic minor injuries, OTC analgesics or counterirritants are often effective in relieving pain.

Counseling Tips

- Acute sports injuries are best treated promptly with a combination of nondrug and drug therapy to help decrease inflammation.

- The R.I.C.E technique (rest, ice, compression, elevation) is recommended.

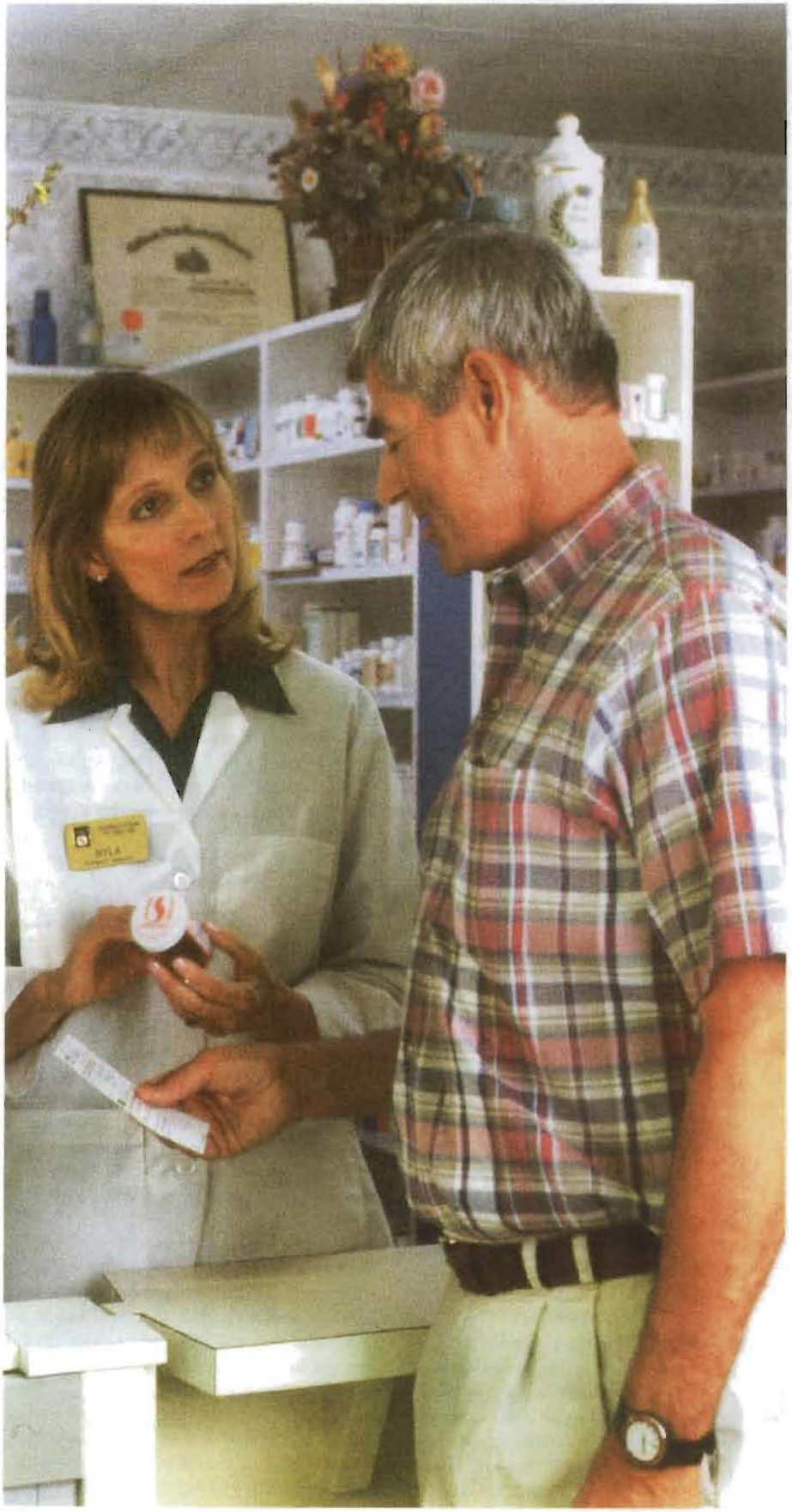
- An internal analgesic such as ibuprofen may help prevent inflammation due to injury.

Rest and OTC analgesics will often be enough to alleviate the pain of chronic sports injuries.

POST-SURGICAL PAIN

Pain from surgery is often associated with the site of incision and can be treated with nondrug therapy. This may include any combination of massage, hot/cold therapy, rest, relaxation, or transcutaneous electrical stimulation (TENS). Surgical pain may also be alleviated with NSAIDs or opioids, depending on the severity. See "Counseling Tips for OTC and Prescription Analgesics."

Pain is most often treated with OTC analgesics, prescription NSAIDs, or prescription opioids. These medications are effective and fairly well tolerated, but it is important that the patients on these medications be fully informed so that they can be enfranchised as active partners in their care plans. These tips are not meant to be complete, but only a sample of information which should be shared with the patient to improve patient comfort and care. ◻



The Impact of Pain on Patients & Families

BY CORINNE MANETTO, PH.D.

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Co-Director, Pain Management Services
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Cancer patients and their families must contend with significant changes in many aspects of their lives. These include social, employment, and financial status changes, and alterations in their physical and psychological functioning. Compounding these life changes is the unfortunate reality that as many as 90% of cancer patients with advanced disease experience pain and related symptoms while also facing issues of loss and death. These factors can produce profound distress and despair in patients and their families. In the presence of unmanaged pain, it is quite clear that suffering and psychological disturbances increase significantly both for patients and their caretakers.

The inadequate management of pain may occur in as many as 42% of cancer patients (Cleeland, 1994). This is particularly alarming in light of increasing evidence indicating that unmanaged pain can lead to profound adverse changes in the patients' physiological, psychological, and immunological functionings. While the

factors leading to inappropriately treated pain are many, patient and family barriers can be of particular consequence (Ward, 1993). A careful assessment of patient and family variables is required to fully understand why effective pain relief has not been achieved. Individual reactions to illness and pain include learned responses from their families of origin. If for example, stoicism is a valued family trait, it may make it more likely that a cancer patient will not complain of pain. Additionally, family fears of addiction, tolerance, and side effects of medications can contribute to inadequate analgesia as the family may discourage opioid use.

> The experience of pain is colored by an individual's unique physiology, psychology, sociocultural, and family background.

Although it is recognized that pain is a complex perceptual experience involving the patient and his or her support system, the assessment and management of pain often focuses exclusively on the physiological aspects of pain (Craig, 1994). This occurs despite of the extensive literature suggesting the lack of relationship between the sensory aspects of pain and the ultimate experience of pain (Fordyce, 1988; Romano et al, 1989). The experience of pain is colored by an individual's unique physiology, psychology, sociocultural, and family background. Several studies have suggested that psychosocial factors are better predictors of pain than the extent of pathophysiological damage. For example, Spiegel (1985) has found that fear and meaning of pain tended to be better predictors of the pain experience in cancer patients than the extent or site of metastases. Flor and Turk (1993) have shown that a patient's assessment of hopelessness/helplessness was a better predictor of pain ratings, while physical factors were not predictive of pain severity. Given the likelihood that cancer pain patients will experience changes in cognitive status, motivational, behavioral, and affective capacities, a comprehensive assessment of their pain and related symptoms is required. The inability to manage symptoms that affect pain and its treatment (e.g., sleep disturbance) will severely limit success.

The prevailing current model of pain emphasizes the motivational-emotional, conceptual-judgmental, and sociocultural aspects of pain (Chapman, 1977; 1985). Consideration of these factors is extremely important to the experience of pain. Recent studies have shown that psychological distress and environmental factors are associated with pain and related symptoms (Bradley, et al, 1992). Moreover, Fordyce (1988) underscores the fact that pain and suffering are often confused. Suffering is defined as the emotional or affective response of the nervous system to noxious stimulation or other aversive events such as threat, fear, and anticipation. In order to conceptualize the pain experience, distinctions between nociception, pain, suffering and pain behavior must be made (Loeser, 1980). In this model, nociception and pain are the inputs into the system. Suffering and pain behaviors are the culmination of responses of inputs into the nervous system.

Pain behavior is the behavioral manifestation of aversive stimulation and suffering. As such, prior experiences, expectancies, vulnerability factors, and perceived or anticipated losses should be taken into account. Taken together, these underscore the fact that an evaluation of pain is incomplete without an evaluation that assesses the complex interactions between the patient, their caretakers, and all of the factors that contribute to the pain experience including the idiosyncratic expression of pain and suffering.

Inherent to this model is the notion that in order to adequately manage pain, suffering of the patient and caregivers must also be assessed and treated. Given the frequency and complexity of pain and related symptoms in cancer patients in the face of challenging psychological variables, suffering can be quite severe. Factors such as fear, anxiety, depression, and distress, in addition to contributing to pain, are also predictors of the response to a treatment regimen (Romano et al., 1989). Pain and depression have been shown to be interrelated: Being depressed may cause a person to report higher levels of pain, while higher levels of pain may cause a person to be depressed (Williams & Schultz, 1992). Distress, despair, and hopelessness can result in suicide preoccupation and requests for physician assisted death especially in the presence of unmanaged pain.

In summary, pain is a multidetermined phenomena that affects patients and their families. The consequences of unmanaged pain are significant to the overall psychological, physical, and immunologic status of affected individuals and their loved ones. In addition, the witnessing of a loved one suffering in pain will result in acute and long-term sequelae for caregivers, the effects of which may determine their lifelong reactions to pain and illness. Given today's trend of caring for the terminally ill patient in the home environment, we must more closely attend to relieving unmanaged symptoms in the family unit. By providing patients and families with the necessary resources, education, and support, we can significantly enhance the quality of their lives while going through such a devastating experience. ◻

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"You put yourself in neutral. You don't think. You don't plan...(you) just suffer. You live and count to ten often enough (and) hope the pain pill takes effect."

(Ferrell, Grant, Padilla, Vemuri, & Rhiner, 1991)

What Can Health Professionals and Pharmacists Do to Effect Change in Pain Management in an Institutional Setting?

BY LYNNE M. RIVERA, RN, MS.N.

Research Specialist, City of Hope National Medical Center
Department of Nursing Research and Education at Duarte, California
Chair, Public Education Committee, Southern California Cancer Pain Initiative

Pain has been described as an overwhelming experience that consumes all aspects of an individual's life. Unrelieved pain causes unnecessary suffering and burden for the patient. The table below explains the relationship between pain and quality of life (QOL) and demonstrates the enormous impact that pain has on quality of life.

The Impact of Pain on Quality of Life[1]

Physical Well Being & Symptoms	Social Well Being	Spiritual Well Being	Psychological Well Being
Fatigue / Strength	Family Distress	Religiosity	Anxiety
Appetite	Family Support	Uncertainty	Depression
Sleep	Sexuality / Affection	Positive Changes	Coping
Constipation	Employment	Sense of Purpose	Control
Nausea	Isolation	Hopefulness	Concentration
Function	Financial Burden	Suffering	Sense of Usefulness
	Appearance	Meaning of Pain	Fear
	Roles & Relationships	Transcendence	Enjoyment / Happiness

Over the past two decades, there has been an increased awareness about the impact of pain on a person's QOL. Several professional organizations, (e.g., the American Cancer Society, National Institutes of Health, Joint Commission on Accreditation of Health Care Organizations, and World Health Organization), have identified pain management as a priority in the provision of care. Despite growing awareness of the problem, all types of pain (e.g., acute pain related to injury, disease, procedures, or surgery; and chronic pain related to cancer and other nonmalignant medical conditions such as arthritis or back pain) continue to be undertreated.

Inadequate pain management can lead to costly and unscheduled hospital admissions, and increased length of stay for the patient with pain[2]. Unrelieved acute pain can also cause prolonged postoperative recovery that may lead to other costly sequelae including lost wages and increased length of stay.

BARRIERS TO ADEQUATE PAIN MANAGEMENT

Many barriers to adequate pain management have been identified. Generally, these barriers are attributable to society's viewpoint, both in the health care community and in society at large, that pain relief is not a priority in the delivery of care.

SOLVING THE PROBLEM

Effective pain management can be achieved through institutional commitment— achieving change by means of a top-down approach. Pain management should be an institutional priority that is reflected in the institution's goals, its mission statement, and through strategic planning to develop pain management policies and promote appropriate clinical practice. Several strategies have been identified to achieve institutional commitment to pain management.[3,4,5,6] Ferrell has identified eight strategies for improving pain management that are discussed below.

DOCUMENTING THE STATUS OF PAIN MANAGEMENT

Strategies for documenting the status of pain management include assessing the knowledge and attitudes of health professionals.[4,7] These activities are most successful when organized and conducted by a multidisciplinary team.

Chart audits provide information about pain assessment and about documentation and pharmacologic management of pain, inconsistencies between practice and the clinical standards developed by professional organizations. Objective data obtained through audits often identify (a) inadequate assessment practices, (b) inappropriate prescribing practices, (c) inadequate administration of analgesic doses, (d) use of PRN medication schedules, (e) underuse of pain consultants, and (f) minimal or no use of nonpharmacologic pain relief methods.

Patient interviews supplement the audits. Interviews should include (a) assessment of the patient's current pain intensity, (b) range of pain intensity over the past 24 hours, (c) worst pain, (d) side effects, (e) pain relief, and (f) perceived patient barriers to pain management.[7] While many institutions are interested in identifying patient satisfaction, this information must be evaluated with caution. Patients often report satisfaction with treatment of their pain, despite being in moderate to severe pain.[8] Commonly, this occurs because patients have low expectations for receiving pain relief and even minimal pain relief is better than no pain relief at all.

Generally, health professionals perceive themselves as knowledgeable clinicians who provide good pain relief. Thus, it is helpful to obtain objective information related to their pain management knowledge and attitudes. The information is used to identify topics for staff education. These surveys can be simple and easily administered in staff meetings.

ESTABLISHING A STANDARD OF CARE

Standards for the provision of appropriate pain management have been developed by organizations such as the American Pain Society, Committee on Quality Assurance Standards (1991); American Society of Clinical Oncology, Ad Hoc Committee on Cancer Pain (1992); Agency for Health Care Policy and Research (AHCPR), Acute Pain Management Guideline Panel (1992); and AHCPR, Management of Cancer Pain Guideline Panel (1994). However, individual institutions rarely have written policies that reflect these standards. Pain guidelines can serve as a resource and foundation for institutions to develop an institutional standard of care that promotes the institution's commitment to providing appropriate pain relief. An institutional standard of care should include (a) an expectation that pain can be relieved; (b) a uniform standard for the assessment and documentation of pain and its management; (c) and require professional accountability.

EDUCATING THE PATIENTS

Generally, patients have little knowledge about pain related information, have low expectations for receiving effective pain relief, and are unaware of their rights or options. Thus, patient education is a vital step to achieving effective pain relief. The aims of patient education should be to (a) increase knowledge

about the pain control regimen; (b) identify the rationale for the prescribed pain relief regimen; (c) increase the patient's ability to recognize and manage side effects; (d) clarify patient misconceptions related to addiction and tolerance; (e) improve adherence to the pain control regimen; (f) identify the patient's role in managing the pain; and (g) promote effective communication with health professionals. Education provides patients with the knowledge and skills needed to self-advocate for effective pain relief.

While pain information can be provided using one-to-one verbal contact between health professionals and patients, written materials, and audio and video tapes should also be used to reinforce the content and promote retention. Institutions can develop their own patient education materials or use existing materials. The AHCPR has patient education materials on acute pain management and cancer pain management that can be ordered through the National Cancer Institute's toll free number at 1-800-4-CANCER or by writing to the AHCPR Clearinghouse, Cancer Pain Guideline, P.O. Box 8547, Silver Spring, MD 20907. The American Cancer Society has a patient education book that can be ordered through their district offices. Other patient education materials can be ordered through the Mayday Pain Resource Center, located at the City of Hope Medical Center, Duarte, CA, (818) 359-8111, extension 3829.

EDUCATING THE PUBLIC

The general public also lacks accurate and current information about pain management. Therefore, community outreach is an important component to providing effective pain relief. Public education about the problem of pain and its treatment is critical for several reasons including (a) society's unwarranted preoccupation with the risk of drug abuse that is promoted by the media; (b) increased use of home care in which family members are responsible for providing pain management; and (c) the changing health care system.

RECOGNIZING THE COST OF FAILURE TO TREAT PAIN

The current health care system requires health professionals and health care institutions to provide care with fewer resources. While pain relief measures do cost the system, failure to provide effective pain relief is not cost effective. Unscheduled readmissions for uncontrolled pain and increased length of stay are costly.[2] It is imperative that health care institutions compare cost effectiveness and cost benefits associated with inadequate pain relief and effective pain relief.

SUMMARY

Pain can be effectively relieved for most patients. Health professionals and health care organizations are challenged to accept responsibility for providing effective pain relief for their patients in pain. This challenge can be achieved through an organizational commitment that supports acquisition of current pain management knowledge, ongoing pain assessment, patient and public education, and development of an institutional standard of care for the relief of pain. Through these efforts, health care organizations and health professionals will ensure that effective pain relief is provided for all patients and that continuity of care for pain management activities is provided between inpatient units, outpatient units, physicians' offices, hospice, and the home care setting. ◻

> Patients often report satisfaction with treatment of their pain, despite being in moderate to severe pain. Commonly, this occurs because patients have low expectations for receiving pain relief and even minimal pain relief is better than no pain relief at all.

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Training Programs and Regulatory Changes are Essential for Better Pain Management

By William L. Marcus,
Deputy Attorney General, Department of Justice
Liaison Counsel, California State Board of Pharmacy
Sandra K. Bauer,
Public Member,
California State Board of Pharmacy

One very important aspect of improving pain management involves the education and training of those concerned with or affecting the quality of pain treatment. This includes not only prescribers, pharmacists, and other healthcare professionals, but patients, caregivers, the public, and—of course—those engaged in setting and carrying out regulatory policies.

REFORMING THE TRIPLICATE PROGRAM

Changes in regulatory policy gained impetus when state Senator Robert Presley gained passage of Senate Current Resolution 74 in 1992. Subsequently, a ten member Council was formed to review the state's triplicate prescription process (which is mandated when Schedule II drugs are prescribed). California's Triplicate Prescription Program has often been cited as a major impediment to patients receiving adequate medication for pain. The Council, chaired by Sandra Bauer, studied the issue, recognized that there was a serious problem of under treatment of pain on the part of the state's medical practitioners, and called for the computerization of the triplicate program in order to facilitate appropriate prescribing.

Reform of the triplicate process continued in 1994 with the Board of Pharmacy funding a computer feasibility study. The Board also supported legislation (AB 3042, Takasugi) in 1996 which makes available over $1 million to establish an electronic triplicate program as a three year pilot project. The project will be a unique partnership of the Board and the state's Bureau of Narcotic Enforcement.

When implemented, the new Controlled Substances Utilization Review and Evaluation System (CURES) will computerize Schedule II prescription data and revolutionize the current cumbersome triplicate system. It will also for the first time make data available for educational, peer review, statistical, and research purposes. The data could become a very important tool for developing medical policies based on demographic research.

DEVELOPMENT OF EDUCATIONAL PROGRAMS

Regarding training programs, the Department of Consumer Affairs and Board of Pharmacy member Raffi Simonian have developed proactive consumer education programs on pain management and patient rights.

Another equally important facet of pain management training is the presentation of programs for those involved in the investigation and prosecution of pain management disciplinary cases. A half-day program on the nature of pain, methods of pain management, laws and regulations governing pain management, and case examples has been presented by Laura Audell, M.D., the director of the Pain Center at Cedars-Sinai Comprehensive Cancer Center in Los Angeles, John Berger, Pharm.D., J.D., and William Marcus of the Attorney General's Office. The program has been presented for the deputy attorneys general and administrative law judges who handle or hear disciplinary cases for the medical, pharmacy, nursing, dental, and other health profession boards. A similar program, coordinated by Joan Jerzak of the Medical Board of California, was presented at a training conference of state and federal investigators. At least twice separate presentations on pain management have been presented by Board supervising inspector Dora Gonzalez and Mr. Marcus, at Board inspector workshops.

BETTER ENFORCEMENT ACTIVITIES

In addition to providing training, both the Board of Pharmacy and the medical board have aggressively sought out experts in pain management to evaluate potential disciplinary cases and completed investigations. Such evaluations minimize the likelihood of expending time and money on future investigations of legitimate medical practices, while at the same time strengthening cases against those who should have action taken against their licenses.

The effect of training those involved in investigating and prosecuting (and deciding) pain management disciplinary cases, combined with law changes, the boards' statements and guidelines, and some of the other changes cited in this publication, should result in less actual intrusion into appropriate, legitimate medical and pharmaceutical practice. This in turn should lead to lessened fear and tension in professional communities, and more effective (more successful; more cost efficient) investigation and prosecution of the practitioners who should be disciplined and even criminally prosecuted.

Training and education in pain management must be an ongoing process. The state of knowledge about the nature and different kinds of pain and the available and appropriate modalities of treatment is steadily improving. What was accepted 10-15 years ago is often recognized as being in error today. What is believed today may be superseded in another decade or so. The Board understands this and is committed to ensuring it applies appropriate standards to its disciplinary cases and in the development of its laws, regulations, and policies. The Board is helping to communicate current knowledge and standards to its licensees and to the public.

OTHER SIGNIFICANT REGULATORY CHANGES

In 1990, California became the second state to enact an intractable pain treatment act (Business and Professions Code section 2241.5). The act recognized the legitimacy of chronic use of controlled substances to treat pain in appropriate cases.

In 1994, the Governor sponsored the Summit on Effective Pain Management: Removing Impediments to Appropriate Prescribing. Over 120 regulators, legislators, practitioners, and others met to identify, discuss, and recommend solutions for problems affecting delivery of adequate care of pain patients in California. The Board of Pharmacy co-sponsored the summit. ◻

Continuing Education

By The California Society of Health System Pharmacists

To receive 3 hours of continuing education credit (0.3 CEUs) for successful completion of this program, you must return the completed answer sheet to the California Board of Pharmacy No later than April 1, 1997.

Please type or print clearly.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Mail your completed answer sheet to:
Continuing Education Desk
California State Board of Pharmacy
400 R Street
Suite 4070
Sacramento, CA 95814

Please circle one answer for each question.

1.	a	b	c	d	**10.**	a	b		
2.	a	b	c	d	**11.**	a	b	c	d
3.	a	b	c	d	**12.**	a	b	c	d
4.	a	b	c	d	**13.**	a	b	c	d
5.	a	b	c	d	**14.**	a	b		
6.	a	b			**15.**	a	b		
7.	a	b	c	d	**16.**	a	b	c	d
8.	a	b			**17.**	a	b	c	
9.	a	b							

1) Which of the following are considered barriers to effective pain management?
- a) lack of knowledge among consumers about pain management
- b) exaggerated fears of opioid side effects and addiction
- c) fear of legal consequences when controlled substances are used
- d) all of the above

2) When filling prescriptions for chronic pain control medications, the pharmacist should assess whether the patient has:
- a) constipation
- b) nausea and vomiting
- c) central nervous system side effects
- d) all of the above

3) Which of the following statements is not true? If a patient is requesting refills much earlier than scheduled, the pharmacist should:
- a) consult with the patient to determine whether their pain is being adequately controlled
- b) discuss with the prescriber the patient's uncontrolled pain and the possibility of changing the patient to a better analgesic regimen
- c) immediately refuse to fill the prescription and notify the authorities
- d) document the reasons the patient is seeking refills on a more frequent basis and notify the prescriber about any loss of medications

4) Which of the following questions are important for a pharmacist to answer related to the management of a patient's pain?
- a) Are the directions correct for the medication prescribed?
- b) Is there documentation of the diagnosis?
- c) For chronic pain, does the medication have a long enough half-life for adequate pain control?
- d) all of the above

5) Which of the following statements is not true? Schedule III-V prescriptions, among other requirements must :
- a) be signed and dated by the prescriber
- b) be presented on a prescriprion document that is not mutilated, forged, or altered
- c) be submitted on a clear and complete triplicate prescription form
- d) not be refilled more than 5 times or refilled 6 months after the issuance date of the prescription.

6) According to Cleeland (1994), the inadequate management of pain may occur in as many as % of cancer patients.
- a) 90%
- b) 56%
- c) 42%
- d) 27%

7) With the long term treatment of pain with opioids, patients may develop a tolerance or dependence on the drug. These occurrences are considered "normal" and "to be expected"– they should not be confused by the licensed healthcare professional with drug addiction or be mislabeled as "drug seeking". This statement is:
- a) True
- b) False

8) Several studies have suggested that psychosocial factors are better predictors of pain than the extent of pathophysiological damage. This statement is:
- a) True
- b) False

9) Patients should take analgesics only when they can no longer tolerate the pain. This statement is:
- a) True
- b) False

10) The fact that a patient always requests one particular medication is a sure sign that the patient is addicted to that particular drug. This statement is:
- a) True
- b) False

11) Dependence:
- a) occurs when the same dose of an analgesic becomes less effective over time and may result in therapeutic failure.
- b) is the physiological need for a drug and without which the body undergoes withdrawal symptoms.
- c) is the culmination of drug dependence and drug seeking behavior
- d) none of the above

12) Strategies for documenting the status of pain management include which of the following?
- a) Chart audits
- b) Patient interviews
- c) (a) and (b)
- d) none of the above

13) Patient interviews related to the management of pain should include which of the following?
- a) assessment of the patient's current pain intensity, worst pain, and range of pain intensity over the past 24 hours
- b) side effects
- c) perceived patient barriers to pain management
- d) all of the above

14) The only standards which exist for the provision of appropriate pain management were developed by the AHCPR, Management of Cancer Pain Guideline Panel (1994). This statement is:
- a) True
- b) False

15) Generally, patients are well informed about pain related information, have high expectations for receiving effective pain relief, and are aware of their rights and options. This statement is:
- a) True
- b) False

16) Which of the following statements is not true?
- a) Over-the-counter (OTC) analgesics including acetaminophen, aspirin, and non-steroidal anti-inflammatory drugs (NSAIDs) are often used as first-line therapy for mild to moderate pain.
- b) Narcotics such as codeine, morphine, and oxycodone are usually reserved for severe pain.
- c) Narcotics should not be used in combination with NSAIDs, antidepressants, and anxiety agents for the relief of severe pain.
- d) All of the above

17) Which of the following statements is false regarding the management of cancer pain?
- a) Cancer patients will get better pain relief if they take their medication as scheduled, rather than as needed.
- b) Injectable opioids are more effective than oral opioids, since they act faster.
- c) Even though some NSAIDs are OTC, they are effective at higher doses in relieving bone pain associated with cancer.

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Longs Drug Stores
Safeway Inc.
National Council on Patient Information and Education (NCPIE)
Walgreen Company

Design: Tim Davis

Making A Difference

Knoll Pharmaceutical Company

Demonstrating the value of communication, Knoll Pharmaceutical Company provided an educational grant to help fund The Board of Pharmacy's Pain Management Issue of Health Notes.

California Society of Health System Pharmacists

Advocating that pharmacists provide quality patient care, The California Society of Health System Pharmacists assisted the Board of Pharmacy by facilitating the printing and developing the continuing education section of the first issue of Health Notes.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	January 19, 2012
ATTENTION:	Members, Medical Board of California
SUBJECT:	Strategic Plan Discussion Items
STAFF CONTACT:	Kimberly Kirchmeyer, Deputy Director

RECOMMENDED ACTION:

Review the discussion items/issues listed below in order to deliberate and make any necessary edits to the final draft Strategic Plan at the February 3, 2012 meeting.

BACKGROUND AND ANALYSIS:

At the October 28th Board Meeting, the Board voted to approve the draft Strategic Plan with the edits that had been put forward by the Executive Committee Members from their meeting on October 27, 2011. Staff revised the Strategic Plan document and submitted it for final review by the Strategic Plan Subcommittee. The Subcommittee had some minor edits which are identified in the attached Strategic Plan. In addition, the Subcommittee had some comments that need further deliberation by the full Board. The discussion items/issues and the Goal or Objective that the issue is associated with are listed below. Please review these items to determine if any edits need to be made to the Board's Strategic Plan.

Please note that some of the initial activities on the Strategic Plan may have already been completed and the dates of completion are in 2011. Upon approval of the complete Strategic Plan at the February 2012 Board meeting, staff will begin making presentations on the Plan at the Board meetings starting in May 2012. These presentations will indicate the status of each activity, including those that are completed.

DISCUSSION ITEMS FROM THE SUBCOMMITTEE:

Objective 1.1 – This objective is scheduled to take approximately 18 months for completion. Does the priority of this objective necessitate an earlier completion date? If so, does the Board have the resources to complete this earlier than identified?

Objective 1.2 – This objective seems to be a prerequisite of Objective 1.1. Should Objective 1.1 and 1.2 be reversed?

Objective 1.4 – This objective states to establish a committee and task force; however, should this be under the purview of the Licensing Committee or maybe a subcommittee of it?

Objective 1.6 and Objective 2.5 – Should these be a higher priority?

Objective 2.8 – Add a new activity: Communicate to all interested parties the scope of the Medical Board's authority and what is outside of the Board's authority in order to avoid confusion.

Objective 3.6 – Add another activity or more to the first activity to explain how the Board is going to evaluate how the Newsletter is being utilized, e.g. survey, focus groups, etc.

Objective 5.4 – This objective asks for a yearly review of all Board Committees. Should this be changed to every two years?

Objective 6.2 – Should the first activity be changed to "Identify the role the Medical Board and its licensees can and should play in promoting public health and addressing the upstream social and environmental causes of illness and disease, and refocusing the healthcare system on prevention and health promotion"?

If you have any questions concerning this memorandum, please telephone me at (916) 263-2389.

Medical Board of California
Strategic Plan, 2012

(Draft incorporating edits from Board meeting held on October 28, 2011)

Mission:

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

Goals:

1. **Professional Qualifications:** Promote the professional qualifications of medical practitioners by setting requirements for education, experience, and examination
2. **Regulations and Enforcement:** Protect the public by effectively enforcing laws and standards.
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.

Objectives:

Goal 1: Professional Qualifications: Promote the professional qualifications of medical practitioners by setting requirements for education, experience, and examination.

Objective 1.1: Examine and identify methods available to the Medical Board to ensure physicians remain current in knowledge and skills.

Activity	Date	Staff	Priority
• Educate the Board members and staff: Establish a workgroup, consisting of licensing and enforcement staff, to identify problems caused by physicians not remaining current.	Spring 2013	Licensing	+ B
• Gather information about other states and other professions in their approach to this issue.	Summer 2013	Licensing	B
• Analyze the information: Identify the most feasible methods for the Board to promote licensees remaining current, and identify the board's authority in taking action.	Spring 2014	Licensing	B
• Draft an issue paper for the Board.	Summer 2014	Licensing	B
• Take action: Depending upon the Board's authority, establish policies or programs, promulgate regulations, develop and seek legislation, or a combination.	Fall 2014	Licensing	B

+ Key to priority categories:

A. Mission critical

B. Secondary to mission critical activities

C. Tertiary to mission critical activities

D. Non-mission critical, but important to consumer protection.

E. Non-mission critical, but deemed by members as important to public protection or physician practice

Objective 1.2: Examine current CME structure, its effectiveness, the current California requirements, and opportunities for improvement.

Activity	Date	Staff	Priority
• Provide annual CME audit statistics to the Medical Board members.	Winter 2012	Licensing	A
• Examine and verify the current CME Audit effectiveness.	Winter 2013	Licensing	A
• Educate the Board and staff on current CME structure. Invite organizations that accredit CME (such as the ACCME, IMQ, or ABMS Boards and their member societies) to educate the members on how requirements have changed, what is required for course accreditation, what is done to ensure compliance. Reissue the white paper written in 2009, and revise if outdated.	Spring 2012	Licensing	A
• Examine current CME environment and delivery and California's requirements to determine if they are relevant to keeping physicians current, including elements of the training that promote education in cultural issues that affect medical practice.	Summer 2012	Licensing	A
• Examine how CME requirements may relate to FSMB MOL initiative. (See objective 1.4)	Winter 2012-13	Licensing	B
• Under the Board's current regulatory authority, determine if the CME regulations are sufficient, or need to be amended.	Winter 2013	Licensing	A
• Develop and promulgate regulations, or develop and seek legislation, as appropriate.	Fall 2014	Licensing	A

Objective 1.3: Define what is necessary to promote safe re-entry into medical practice after extended absences.

Activity	Date	Staff	Priority
• Conduct a review of current data, including the ongoing work of the ~~working with~~ FSMB, to determine ~~if~~ what physicians re-entering practice after long absences need/require ~~additional requirements~~ prior to ~~re-admittance~~resuming clinical practice.	Spring 2012	Licensing	B
• Determine ~~if there is something more~~what the Board's role should ~~do, if anything~~be, and how it should be involved in determining the safety of those reentering practice for the purpose of public protection.	Winter 2013	Licensing	B
• As necessary and appropriate, develop and promulgate regulations or develop and seek legislation.	Spring 2013	Licensing	B

Objective 1.4: Establish a committee to examine the FSMB Maintenance of Licensure and ABMS Maintenance of Certification initiatives to study what should be adopted in California, and how it can collaborate with the FSMB and ABMS certifying boards.

Activity	Date*	Staff	Priority
• Appoint a Task Force to evaluate the FSMB Maintenance of Licensure Initiative and determine what is feasible in California.	Fall 2012	Licensing	B
• Invite a participant in the FSMB Working Group to make a presentation to the Full Board/Committee.	Winter 2013	Licensing	B
• Conduct a study of other states' actions relating to the FSMB MOL Initiative, and examine the experience of states participating in the FSMB pilot program.	Winter 2013-Winter 2014	Licensing	B
• Identify what should be adopted in California, and examine what is needed for implementation.	Fall 2014	Licensing	B
• Depending on what is determined to be needed, develop and promulgate regulations or develop and seek legislation.	Winter 2015	Licensing	B
***The dates of these objectives may need to be reconsidered, as they are dependent upon when the FSMB has concluded and has compiled and published sufficient data from their MOL pilot programs.**			

Objective 1.5 Conduct a comprehensive review of international schools.

Activity	Date*	Staff	Priority
• Establish a working task force, including Chief of Licensing and an experienced Medical Consultant.	Winter 2012	Licensing	A
• An experienced medical consultant should present a history of the issue to the Board so that they may understand the law and history of off-shore medical school evaluation.	Spring 2012	Licensing	A
• Staff to present a complete overview of the CCR Codes, and educate the Board on the extent and limits of its legal authority.	Fall 2011	Licensing	A
• Identify those schools that may need site visits or additional information.	Summer 2012-Winter 2014	Licensing	A
• Research all international medical schools to create a comprehensive database.	Summer 2012 - Summer 2014, ongoing	Licensing	A
• Update school names and locations on the Board's database in instances where schools have moved or changed their names.	Summer 2013	Licensing	A
• Update the schools' application process, including the surveys and evaluations, and identify ways to expedite the approval process, as well as determine if application fees cover the Board's cost.	Winter 2012-Summer 2012	Licensing	A

***The dates of these objectives may need to be reconsidered, as they are dependent upon the hiring and training of AGPA staff in Licensing. Tasks to be conducted in approximate 6 month intervals.**

Objective 1.6: Conduct a literature review and internal study of the performance of physicians in training and how it may predict later performance in practice. (See objective 2.5)

Activity	Date	Staff	Priority
• Re-review the report of Dr. Maxine Papadakis on performance and behavior in medical school as a predictor of future practice problems.	Winter 2014	TBD	C
• Review disciplinary files in conjunction with licensing applications to determine if a link can be established between performance problems in medical school and future practice problems.	Winter 2014 - Spring 2015	TBD	C
• Evaluate whether such a study should be expanded, or whether there is an opportunity with a medical school to do a retrospective study on the correlation between medical practice and behavior in medical school.	Spring 2015	TBD	C
• If there is significant data obtained, determine how the information may be communicated to those who may find it useful (Goal 3).	Fall 2015	TBD	C

Goal 2: Regulations and enforcement: Protect the public by effectively enforcing laws and standards.

Objective 2.1: Develop a plan to conduct a complete review of all laws and regulations relating to licensing to identify those no longer relevant, and what needs to be added or eliminated. Identify requirements that are not necessary to the safety of practice but may be serving as barriers for qualified applicants, as well as simply updating requirements to be congruent with current educational environments. (To be done in conjunction with Objective 2.2)

Activity	Date	Staff	Priority
• Staff to develop an outline of priorities and a calendar/timeline for the evaluation of statutes and regulations, taking into account the timing for Sunset Review. (Including the development of an interested parties contact list for inclusion in discussions.)	Spring 2012 – Fall 2012	Legal/ Licensing	A
• Schedule interested parties meetings by legal topic and statute/regulation under analysis.	Summer 2012 - Winter 2015	Legal/ Licensing	A
• Work is delegated to the Licensing Committee; updates provided to full Board as actions are needed. As each section of the evaluation concludes, as appropriate to the legislative and regulatory calendar, proposals will be taken to the full Board for regulations to be promulgated and legislation sought.	Summer 2012 - Winter 2015	Legal/ Licensing	A
• As appropriate, development and promulgation of regulation, and develop and seek legislation.	Various 2013-15	Legal/ Licensing/ Legislative	B

Objective 2.2: Develop a plan to conduct a complete review of all laws and regulations relating to enforcement to identify those that are no longer useful, and augment those that are needed for public protection. Identify the Board's regulatory authority for promulgating new regulations and also identify those issues that require legislation. (To be done in conjunction with Objective 2.1)

Activity	Date	Staff	Priority
• Staff to develop an outline of priorities and a calendar/timeline for the evaluation of statutes and regulations, taking into account the timing for Sunset Review. (Including the development of an interested parties contact list for inclusion in discussions.)	Spring 2012 – Fall 2012	Legal/ Enforcement	A
• Schedule interested parties meetings by legal topic and statute/regulation under analysis.	Summer 2012 - Winter 2015	Legal/ Enforcement	A
• Work is delegated to the Enforcement Committee; updates provided to full Board as actions are needed. As each section of the evaluation concludes, as appropriate to the legislative and regulatory calendar, proposals will be taken to the full Board for regulations to be promulgated and legislation sought.	Summer 2012 - Winter 2015	Legal/ Enforcement	A
• As appropriate, development and promulgation of regulation, and develop and seek legislation.	Various 2012- 15	Legal/ Enforcement Legislative	B

Objective 2.3: Conduct a review of the Vertical Enforcement model to assure uniform implementation in all offices and identify any aspects of the model that are increasing cost without producing benefits.

Activity	Date	Staff	Priority
• Begin to c~~C~~onduct a review of the VE performance data.	Summer 2011	TBD	A
• Begin to c~~C~~onduct a statistical analysis of performance in the various geographic areas on number of cases, number of personnel hours, and results, including the time taken in various steps of the process. Identify similar and inconsistent data in various regions.	Summer 2011 - Fall 2012~~1~~	TBD	A
• Begin to c~~C~~onduct a statistical analysis of the enforcement timelines to indentify which steps may be delaying the process.	Summer 2011	TBD	A
• Compare the California process to other states' and other California licensing boards, including those handled by the AG's licensing section rather than HQES. (As an example, how default decisions are handled)	Summer 2011- Fall 2012~~1~~	TBD	A
• Draft a report to the Board on the analysis of statistical data, including recommendations for actions by the Board to reduce the timeline, increase efficiency, and obtain better outcomes for public protection.	~~Winter~~ Fall 2012	TBDt	A
• Depending upon findings of evaluation, and within budgetary restraints, amend policies and procedures, promulgate regulations, or seek legislation.	~~Winter~~ Fall 2012	TBD	A

Objective 2.4 Examine complaint handling priorities. Educate members on how complaints are prioritized, as well as the legislatively mandated priorities. Determine if there is a need to change the priorities.

Activity	Date	Staff	Priority
• Educate the members on the current policy and legislative priorities in complaint handling.	Winter 2012	Enforcement	A
• Review and evaluate the complaints and their relation to physician disciplinary action.	Winter - Summer 2012	Enforcement	A
• Present a report on review of complaint handling, including whether current priorities are congruent with public safety, or that other priorities might better serve public protection.	Summer 2012	Enforcement	A
• Depending upon the Board's authority and resources, amend policies, develop and promulgate regulations, or develop and seek legislation.	Summer 2012-Spring 2013	Enforcement Legal/ Legislative	A

Objective 2.5: Study disciplinary cases to identify trends or issues that may signal dangerous practices or risks. (Done in conjunction with Objective 1.6)

Activity	Date	Staff	Priority
• Staff to perform a study to identify risk factors for patient harm and physician discipline. Study should look at disciplinary cases causing serious harm and determine if there are trends and "red flags" that could be used for the purpose of identifying troubling patterns before serious harm occurs.	Winter 2014 - Spring 2015	Enforcement	C
• Report of study to be presented to the Board, including recommendations for establishing priorities, wellness initiatives, remedial actions, greater record review authority, further study, or other initiatives, if identified.	Spring 2015	Enforcement	C
• Dependent upon findings and opinion of the board, and in keeping with the Board's authority and resources, establish or amend policies and procedures, develop and promulgate regulations, or develop and seek legislation.	Fall 2015	Enforcement Legal/ Chief of Legislation	C

Objective 2.6 Examine the Expert Reviewer Program and policies to determine how it may be improved, including recruitment, evaluation of experts, opportunities for education, and policies governing the Board's use of experts.

Activity	Date*	Staff	Priority
• Evaluate, revise, and update the training program and materials for experts.	Fall 2011	Enforcement	A
• Educate the Board as to the current policies, laws, and regulations governing the Expert Reviewer program.	Winter 2012	Enforcement	A
• Study the training and evaluation measures, as well as policies to identify problem areas and those that should be amended.	Spring 2012	Enforcement	A
• Study the use of experts by other states and by other California boards and commissions.	Spring – Fall 2012	Enforcement	A
• Examine which policies and regulations (under the Board's authority) should be amended to further the program's efficiency.	Fall 2012	Enforcement	A
• Based on the study and review of the current program, as appropriate to the Board's authority and resources, revise policies and procedures, promulgate regulations, or seek legislation.	Fall 2012	Enforcement Legal/ AGHQES/ Chief of Legislation	A

Objective 2.7: Identify opportunities to better educate judges/hearing officers.

Activity	Date	Staff	Priority
• Evaluate the current training and information furnished to the OAH judges/hearing officers.	* Winter 2012	Enforcement HQES	B
• Conduct OAH training semiannually.	Spring 2012-Ongoing	Enforcement HQES	B
• Examine disciplinary decisions to determine if they meet the mission to protect the public.	Winter 2012-Spring 2012	Enforcement HQES	B
• Identify if there may be inconsistent outcome in disciplinary cases. Present findings to the Board.	Spring 2012	Enforcement HQES	B
• Examine the decision to determine if the disciplinary guidelines are being utilized consistently, or, if the guidelines need amending to create greater consistency in decisions.	Spring 2012 - Fall 2012	Enforcement HQES/ Legal/ Chief of Legislation	B

***The dates of implementation and completion of these tasks may need to be reconsidered, as they are dependent upon the hiring of the Supervisor I in the Standards & Training Unit in the Enforcement Program.**

Objective 2.8 Work to clarify the Board's responsibility to regulate outpatient surgery centers, and obtain the resources to be effective.

Activity	Date *	Staff	Priority
• Evaluate the impact of SB 100, and begin develop goals and timelines for implementation. .	Fall 2011	Licensing/ Enforcement	A
• Examine the current Board responsibility and authority to regulate outpatient surgery facilities. Identify what can be done under current authority. Begin implementation of SB 100.	Fall 2011- Fall 2012	Licensing/ Enforcement	A
• Identify the resources needed to implement an effective program	Spring 2012	Licensing/ Enforcement	A
• Work with the Legislature to enact legislation or gain resources, or obtain what is necessary for California to have an effective program to ensure a minimum standard of safety in outpatient settings. Develop and seek legislation.	Fall 2012	Licensing/ Enforcement Legal/ Legislative	A
***Dates for these tasks are pending the hiring of staff for the outpatient surgery regulation program.**			

Objective 2.9: ~~In light of reduced membership and funding, e~~Examine Board responsibilities that could be eliminated or moved to a more appropriate board, bureau, or program. (Midwives, Registered Dispensing Opticians, Spectacle Lens Dispensers, Research Psychoanalysts, approval of non-ABMS specialty boards, etc.)

Activity	Date	Staff	Priority
• Educate the membership about the Board's responsibility over allied health professions. Staff should prepare a paper and make a presentation at a Board meeting.	Summer 2012	TBD	B
• Identify those areas where the Board may not have sufficient expertise or resources to adequately provide consumer protection.	Fall 2012 through Spring 2013	TBD	B
• Depending upon areas identified by the membership, seek legislation to move or eliminate responsibilities of the Board that appear to be inappropriate. (To be completed to coincide with Sunset Review)	Summer 2013	TBD	B

Objective 2.10 Examine the decline of the number of reports received ~~required by~~pursuant to Business & Professions Code Section 805.

Activity	Date	Staff	Priority
• Review the history of 805 reports; history of the law, statistical data, and how they relate to the Board's disciplinary actions.	Spring 2012	Enforcement	C
• Obtain information from those required to file 805 reports and the reasons they have declined over the years. (Individual hospitals, medical groups, societies and associations.)	Spring – Fall 2012	Enforcement	C
• Evaluate Peer review: what it does, how it impacts what the Board does, what institutions file 805 reports.	Fall 2012	Enforcement	C
• Study practices not subject to peer review to determine if quality of care can be monitored.	Fall 2012	Enforcement	C
• Invite the CDPH to share information on how they determine violations and how they may relate to compliance with B&P 805.	Summer 2013	Enforcement	C
• Review how other states handle peer review and mandatory reporting, and how or if they correlate with disciplinary action.	Summer 2013	Enforcement	C
• Determine if, as it has been stated, the system is broken. Is there anything that could and should be done by the Board to improve patient protection by legislation, regulation, greater enforcement, greater investigatory authority, etc. Seek legislation, if needed.	Winter 2013	Enforcement Legal/ Chief of Legislation	C

Goal 3: Consumer and Licensee Education: Increase Public and Licensee awareness of the Board, its mission, activities and services.

Objective 3.1 Improve and expand professional educational outreach, including outreach to students and new graduates, about the laws and regulations that govern medical practice.

Activity	Date*	Staff	Priority
• Re-examine the Website to determine what can be improved.	Winter 2012	PIO	B
• Utilize the website and newsletters to inform licensees of issues relating to legal responsibilities, changes in law and regulations, practice patterns and tools (telemedicine, translation methods and opportunities, etc.), issues of public health and cultural and linguistic literacy.	Fall 2012	Public Infor-mation Officer (PIO)	B
• Work with state, county and federal agencies to inform licensees.	Fall 2012	PIO	B
• Educate physicians about complying with the law. Initiate programs to promote the Board's information and programs to its licensees. If resources permit, send every physician a new handbook with license renewals.	Fall 2012	PIO	B
• Re-establish a speakers' bureau, and reinstitute the "teams of 2" consisting of one staff person and one board member to talk to professional meetings. (This can only begin after hire, resources, and travel restrictions are lifted.)	Winter 2012	PIO	B
• Conduct outreach to various organizations such as hospitals and group practices through providing speakers or articles for their publications.	Spring – Fall 2012	PIO	B

*** The start and completion dates of this objective are dependent upon the hiring and training of a new Information Officer.**

Objective 3.2 Improve public education by expanding current outreach efforts and initiating more outreach programs to educate the public on the board's programs, the rights of patients, and how to file complaints.

Activity	Date*	Staff	Priority
• Re-examine the Website to determine what can be improved.	Winter 2012	PIO	C
• Identify consumer education groups and publications to distribute MBC material.	Various 2012-13	PIO	C
• Schedule meetings with editorial boards of major media at least once a year; more, when necessary.	Various 2012-13	PIO	C
• Update the content of brochures to reflect the current insurance and practice environment.	Various 2012-13	PIO	C
• Work with other state agencies to provide Board materials to consumers	Various 2012-13	PIO	C
• Work with DCA and State and Consumer Services Agency to develop an integrated communications plan that would promote the Board and its services.	Various 2012-15	PIO	C
• Explore the use of social media in outreach to the public.	Summer 2012	PIO	C
• Add Board information to the California Healthcare Insurance Exchange Web site, with timing to be established after discussion with HBEX Executive Director and the Board.	~~Winter~~ Fall 2013	PIO	C
*** The start and completion dates of this objective are dependent upon the hiring and training of a new Information Officer.**			

Objective 3.3 Identify more effective methods to promote the Expert Review Program to recruit qualified physicians.

Activity	Date	Staff	Priority
• Establish a committee to work with staff and professional associations to promote the Expert Reviewer program through various methods, including articles in Board newsletters and other professional publications, speakers at facilities and professional societies, etc. (See Objective 3.1)	Fall 2011 Ongoing	Enforcement PIO	A

Objective 3.4 Evaluate the appropriateness and effectiveness of the Physician Recognition Award, and the methods used to promote nominations.

Activity	Date	Staff	Priority
• The Committee should review its program to determine if it is appropriate in its current form.	Fall 2011	TBD	A/E
• If a decision is made to continue the work of this Committee, c~~C~~onduct a review of outreach methods to determine if more nominations could be recruited, including from and for student initiatives.	Spring 2012	TBD	A/E

Objective 3.5 Establish a more ~~assertive~~ proactive approach in communicating with the media to educate consumers and publicize disciplinary cases and criminal investigations, including those done in cooperation with other agencies.

Activity	Date*	Staff	Priority
• Build relationships with major media so that all disciplinary cases are provided to the appropriate outlets.	Winter 2012	PIO	C
• Work with DCA and the DA's office to establish a joint press release procedure, if necessary, to use on joint investigations or actions.	Winter 2012	PIO	C
• When the budget allows, provide press kits about the Board to all media outlets.	Winter 2013	PIO	C
• Participate in professional/public outreach programs (see Objective 3.2)	Various 2012-15	PIO	C
*** The start and completion dates of this objective are dependent upon the hiring and training of a new Information Officer.**			

Objective 3.6 Expand the newsletter to better inform physicians and medical students.

Activity	Date*	Staff	Priority
• Evaluate how the current newsletter is being utilized by licensees, what is useful and what is not.	Spring 2012	PIO	C
• Allow applicants to receive the newsletter by e-mail or social media, as well as licensees.	Various 2011-13	PIO	C
• Establish some kind of feedback for the newsletters' content to determine who is reading it, and for what information.	Various 2012-13	PIO	C
• Examine ways of promoting the newsletter to encourage more readership.	Winter 2012	PIO	C
• Reach out to other agencies and foundations to contribute to the newsletter.	Various 2012-13	PIO	C
• Incorporate into the newsletter more information about Board activities, including encouraging attendance of Board meetings, topics discussed at meetings, and so forth.	Various 2011-15	PIO	C
• Encourage professional associations and societies to include a link to the Newsletter	Various 2011-13	PIO	C
*** The start and completion dates of this objective are dependent upon the hiring and training of a new Information Officer.**			

Objective 3.7 Expand the website capabilities to create a portal to provide intuitive and searchable web experience. Develop more online services and surveys to help improve Board's program (see Objective 3.2)

Activity	Date*	Staff	Priority
• ISB to work with the Web Working Group to determine how and what can be done to improve the Website and its searchability.	Various 2012-13	PIO	B
• ISB to work with new Information Officer to determine if the current site is user friendly and how it might be improved.	Various 2012-13	PIO	B
• Establish a program to periodically update FAQs on the various subjects.	Various 2012-13	PIO	B
• Identify what areas of the website are utilized, and if users are finding what they are looking for. Provide a survey to users to provide feedback.	Winter 2013	PIO	B
*** The start and completion dates of this objective are dependent upon the hiring and training of a new Information Officer.**			

Objective 3.8 Examine how the Board might provide training to the profession via the Internet, including hosting webinars on subjects of importance to public protection and public health.

Activity	Date*	Staff	Priority
• Determine the feasibility of providing courses and the priority of this venture.	Winter 2013	PIO	D
• Work with DCA's current Information Officer and Public Affairs, to expand interactive webcasting. (As part of the Board's pro-rata funding)	Winter 2013	PIO	D
*** The start and completion dates of this objective are dependent upon the hiring and training of a new Information Officer.**			

Objective 3.9 Establish a method of holding public briefings taught by legal or enforcement personnel on disciplinary cases, the laws violated, and other issues of importance to the profession and public.

Activity	Date*	Staff	Priority
• Establish a method or procedure to identify issues that could benefit from holding a public briefing.	2014	PIO	C
• Identify AGs, legal counsels, investigators, that should be called upon to develop and deliver briefings.	2014	PIO	C
• Work with DCA's current Information Officer and Public Affairs, to expand interactive webcasting. (As part of the Board's pro-rata funding)	2014	PIO	C
• Publicize the briefings to foster viewership.	2014	PIO	C

Objective 3.10 Conduct outreach to ethnic and other language publications and groups.

Activity	Date*	Staff	Priority
• Identify the ethnic and cultural groups to be targeted.	Summer 2012	PIO	C
• Identify the media outlets for various ethnic groups and other-than-English publications, including community newspapers, radio, television stations, and web groups.	Summer 2012	PIO	C
• Identify those in staff or on the Board who may be able to communicate with the targeted groups, either through language fluency, or cultural sensitivity.	Summer 2012	PIO	C
• Establish a plan to coincide with the outreach to English language and general audience.	Summer 2012	PIO	C

*** The start and completion dates of these objectives are dependent upon the hiring and training of a new Information Officer.**

<u>Goal 4: Organizational Relationships</u>: Improve effectiveness of relationships with related organizations to further the Board's mission and goals.

Objective 4.1: Improve relationships with elected officials and their staffs. Build and strengthen collaborative relationships to work toward common goals – create partnerships on areas of common interests.

Activity	Date	Staff	Priority
• Chief of Legislation to develop a plan to visit some legislators and their staffs with board members, at the Capitol and field offices.	Fall 2011	Chief of Legislation	B
• Provide training and briefing to the Board members about the Board's legislative initiatives, and who is contacted and why.	Winter 2012	Chief of Legislation	B
• Prepare Members to be effective when communicating with legislators and their staff.	Various 2012-13	Chief of Legislation	B
• Invite legislative field staff to board meetings, and visit field offices.	Winter 2012	Chief of Legislation	B

Objective 4.2 Work with California medical schools and training programs on common needs and goals. Create a better partnership with them on educational issues beyond licensing requirements, such as those relating to professionalism, ethics, unprofessional behavior, etc.

Activity	Date	Staff	Priority
• Appoint a medical consultant(s) to work with staff and schools on developing a program to address ethical questions and emerging issues developing in the new practice environment. (Prescribing practices, enticements from pharmaceutical and medical device industries, boundary issues, social media, working for and in various industries, etc.)	Winter 2013	Licensing/ PIO	B
• Invite comment from all schools on issues they are identifying as troubling trends, or those that will change the practice environment and make old rule obsolete. Survey Directors of postgraduate training programs.	2013	Licensing/ PIO	B
• Develop issue/position papers in coordination with the medical schools, to be shared with medical students and licensees.	Winter 2014 Ongoing	Licensing/ PIO	B

Objective 4.3 Work to establish better relationships with the accreditation agencies, associations representing hospitals and medical groups, professional associations and societies, the Federation of State Medical Boards, Federal government agencies, and other state agencies, including Department of Consumer Affairs and State and Consumer Services Agency.

Activity	Date*	Staff	Priority
• Identify areas of concern that may be of common interest among various organizations.	Fall 2012	PIO/ Chief of Legislation	C
• Schedule meetings with organizations to establish better relationships as needed, and driven by emerging issues of common interest.	Fall 2012	PIO/ Chief of Legislation	C
• Develop a communication plan for California agencies.	2013	PIO	C
• Develop a communication plan for categories of agenda items for various groups.	2013	PIO	C
• Utilize the "Teams of two" or others in speaking to various professional groups.	After lifting of travel restrict-tions.	PIO	C
*** The start and completion dates of this objective are dependent upon the hiring and training of a new Information Officer.**			

Objective 4.4 Improve educational outreach to hospitals, health systems, and similar organizations about the Board and its programs. Educate the profession not only about the Medical Board, but all of the health boards in DCA. Re-establish a speakers' bureau or some other outreach for this purpose.

Activity	Date*	Staff	Priority
• Identify and create a database of those organizations and groups that the Board wants to target.	2012	PIO	C
• Contact all appropriate practice groups, and associations and offer to provide speakers and contribute articles about the board for their newsletters or email broadcasts.	2012	PIO	C
• Utilize the speakers' bureau, or "Teams of two" to speak at lunch meetings, dinners, etc., and to annual meetings or conferences.	2013	PIO	C
• Work with various foundations and groups, such as the Hospital association, to provide information to their membership.	After lifting of travel restrict-tions.	PIO	C
*** The start and completion dates of this objective are dependent upon the hiring and training of a new Information Officer.**			

<u>Goal 5: Organizational Effectiveness</u>: Evaluate and enhance organizational effectiveness and systems to improve service.

Objective 5.1 Licensing applications to be reviewed within 45 days.

Activity	Date	Staff	Priority
• Goal communicated to staff	Fall 2011	Licensing Chief	A
• Monitor reports to be automatically sent to managers, and report when review has not been conducted in a specified amount of days.	2011 Ongoing	Licensing Chief & Managers	A
• Report to the Board at every quarter on the time taken to review licensing applications.	2011 Ongoing	Licensing Chief	A

Objective 5.2 Reduce discipline, complaint processing, and investigation timelines by 10-20%; reduce complaint processing average to under 70 days, with 50-60% under 50 days.

Activity	Date*	Staff	Priority
• Analyze current process, including breaking down types of cases by time taken for each element of the process.	Winter 2012	Enforcement	A
• Identify reasons for delays in the Board's processes from complaint handling through disposition.	Various 2012-13	Enforcement	A
• Research and identify best practices from other states' processing of complaints and disciplinary actions. Identify areas in California's system that may be unnecessary and slowing the process.	Various 2012-13	Enforcement	A
• Research and identify best practices from other California boards' processing of complaints and disciplinary actions. Identify areas in the Board's system that may be unnecessary and slowing the process. (Including the use of the AG's Licensing Section in comparison to HQES)	Various 2012-13	Enforcement	A
• Survey regional deputies and supervising investigators on management tools needed to better monitor investigation handling. (CAS v. new computer system's ability for reports, etc.)	Various 2012	Enforcement	A
• In conjunction with Objective 2.3, identify how VE model may be amended if it is slowing the process.	Various 2012	Enforcement	A
• After analyzing all of the data collected, as appropriate, establish or amend policies and procedures, develop and promulgate regulations, or develop and seek legislation.	Winter 2013	Enforcement	A

Objective 5.3 Conduct a review of all outside agencies' billing (Department of Consumer Affairs, Attorney General, Office of Administrative Hearings, etc.) to identify redundancies, save money, and promote better efficiency.

Activity	Date	Staff	Priority
• Staff to prepare a report on all spending for past 4 years to all regularly used agencies (DCA pro-rata, Attorney General's HQES, and Office of Administrative Hearings)	Summer -Fall 2011	TBD	B
• Conduct an analysis of spending through the years, broken down by function and region, to identify trends, and possible inconsistencies, if any.	Winter 2012	TBD	B
• Identify areas that require discussion and examination by reviewing what areas have improved efficiency and those that have declined. (Incorporate data and analysis on Vertical Enforcement; See Objective 2.3)	Winter - Spring 2012	TBD	B
• Establish a procedure to regularly evaluate the value of spending to outside areas.	Summer 2012	TBD	B
• Establish a reporting method that will keep the Board updated, and also will be helpful in providing information at Sunset evaluation.	Fall 2012	TBD	B

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
• 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.	Every Fall Board Meeting	Deputy Director	A

Objective 5.5 Establish and conduct an annual self evaluation.

Activity	Date	Staff	Priority
• At the Fall Executive Committee or full Board meeting, staff will provide a report on the progress of the Strategic Plan, highlighting successes, failures, and those areas that should be eliminated, expanded, or amended.	Begin 2012	Deputy Director	A

Objective 5. 6 Establish a means of better educating staff about the Board's activities and priorities set by the membership, including encouraging staff to attend meetings.

Activity	Date	Staff	Priority
• Executive Director to provide e-mail updates approximately every two months to inform staff of board activities and positions.	2011 ongoing	Executive Director	C
• At the time of the Agenda mailing, Division Chiefs will contact appropriate staff about the meeting, what will be on the agenda, and encourage attendance, where appropriate.	Begin 2012	Division Chiefs	C

Objective 5. 7 Establish a means of better educating the Board membership about operational activities by providing tours of headquarters, district or regional offices when they are at or near the location for Board meetings.

Activity	Date	Staff	Priority
• A report of these visits will be part of the Executive Directors/Enforcement Chiefs' report at the quarterly Board meetings.	2011 ongoing	Executive Director	C
• At the time of agenda mailing, Division Chiefs will arrange for a tour of facilities where appropriate. (Chiefs to arrange for a tour of district offices in areas outside of Sacramento, and a tour of headquarters when in Sacramento)	Begin 2012	Division Chiefs	C

Objective 5.8 Establish a method of obtaining feedback from our users about services.

Activity	Date*	Staff	Priority
• Continue Complaint survey/ evaluate how it might be improved	Winter 2012 Ongoing	TBD	B
• Establish a survey for newly licensed physicians about the application/licensing process	Spring 2012 Ongoing	TBD	B
• Establish a survey on the website on other areas, including the usefulness of the website	Summer 2012 Ongoing	TBD	B
• Provide an annual report to the Board on the results at the time of the Annual report.	Fall 2012 Ongoing	TBD	B
*** The start and completion dates of this objective are dependent upon the hiring and training of a new Information Officer.**			

Goal 6: Access to Care, Workforce, and Public Health: Understanding the implications of Health Care Reform and evaluating how it may impact access to care and issues surrounding healthcare delivery, as well as promoting public health, as appropriate to the Board's mission in exercising its licensing, disciplinary and regulatory functions.

Objective 6.1 Educate the Board on the new healthcare reform law and how it may impact physicians' practice, workforce (possible shortages), and utilization of allied healthcare professionals.

Activity	Date	Staff	Priority
• Invite appropriate speakers to address the Board about ~~the new healthcare law~~implemenation of the Affordable Care Act in the State, and how it will impact care delivery in California.	2011 Ongoing	TBD	D
• Ask appropriate associations to share their view of the changing practice environment due to healthcare reform (California Medical Association, California Hospital Association, California Association of Physician Groups, etc.)	Summer 2012	TBD	D
• Direct the Access to Care Committee to study the impact of healthcare reform and identify areas in which the Board can help, such as addressing shortages through telemedicine, if appropriate, or publicizing programs to help those in underserved populations, etc.	~~Fall~~ Spring 2013~~2~~	TBD	D
• Take appropriate action based on the remedies identified by the committee.	Winter 2013	TBD	D

Objective 6.2 In general, identify issues and areas in which the Board may assist in promoting better public health.

Activity	Date*	Staff	Priority
• Expand the scope of the Access to Care Committee to include issues relating to promoting public health. The Committee will be available to study and identify issues identified by the Board, congruent to its mission and promoting appropriate medical care from its licensees.	2012 Ongoing	TBD	D
• Educate consumers and licensees on public health issues.			

Key to priority:

A. Mission critical

B. Secondary to mission critical activities

C. Tertiary to mission critical activities

D. Non-mission critical, but important to consumer protection.

E. Non-mission critical, but deemed by members as important to consumer protection or physician practice

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	January 23, 2012
ATTENTION:	Medical Board of California
SUBJECT:	Discussion and Consideration of Proposed Chiropractic Regulations Related to the Use of Lasers and Comments Thereto
STAFF CONTACT:	Kurt Heppler, Staff Counsel

STAFF RECOMMENDATION:

Staff recommends that the Executive Officer of the Board be authorized to comment on the regulations proposed by the Board of Chiropractors Examiners and offer an amendment that would clarify that chiropractors cannot use lasers for cosmetic procedures.

BACKGROUND:

The Board of Chiropractic Examiners (BCE) has recently proposed regulations that relate to the use of lasers by chiropractors. The proposed regulations are attached to this report.

BCE contacted Medical Board staff and asked for a meeting regarding the Board's position on the proposed regulations. BCE and Board staff met and discussed the regulations, and Board staff recommended that the regulations be revised to clarify that chiropractors could not use lasers to perform cosmetic procedures on patients. The comments were memorialized in the attached letter. After the dispatch of the letter, BCE asked for a definition of cosmetic procedures, and those were provided.

At its January 20, 2012, BCE preliminarily considered the regulation and asked the Board for its input. The Board testified that the revision was necessary to promote consumer protection. The Board's suggested revision was not adopted by BCE.

ANALYSIS:

A laser is a device that emits amplified light and may be used for a variety of tasks from removing hair and tattoos as well as skin rejuvenation. The Board has also adopted a precedential decision which provides that the penetration of skin by a laser necessary involves the practice of medicine.

In recent years, the use of lasers and the persons that can appropriately use them has generated considerable controversy, and generally the issue has been the level of physician supervision. The Board has become aware of advertisements from chiropractors offering laser liposuction, skin rejuvenation, and toenail fungus treatment.

The Board is not persuaded that these types of treatments are properly within the scope of practice for a chiropractor. As a laser may promote pain relief and muscle healing, it would not seem in consistent with public policy to allow for a chiropractor to use lasers for those purposes.

Board of Chiropractic Examiners
Proposed Regulatory Language for the Use of Lasers
California Code of Regulations, Title 16, Division 4, Article 1

§ 302.5. Use of Laser

(a) A duly licensed chiropractor and any person under their direct or indirect supervision, as defined in section 312, shall:

(1) Not use any laser in the practice of chiropractic which has not been properly approved or cleared by the United States Food and Drug Administration (FDA).

(2) Not market or advertise the use of a laser or use a laser for purposes other than treatment consistent with section 302 and the product's FDA approval or clearance.

(3) Follow the manufacturer's specified guidelines for the safe use of laser.

(4) Comply with all state and federal laws governing the use of lasers in clinical settings.

(b) Nothing in this section shall be construed to authorize the use of a laser by a chiropractor outside of the chiropractic scope of practice. This includes, but is not limited to, laser ablation or surgical procedures, and laser treatment of allergies in cases where there is a known risk of anaphylactic reaction to the individual being treated.

(c) Any violation of this section may constitute unprofessional conduct and the licensee shall be subject to discipline by the Board.

NOTE: Authority cited: Sections 1000-4(b), 1000-4(e) and 1000-10(a), Business and Professions Code (Chiropractic Initiative Act of California Stats. 1923 p. 1xxxviii). Reference: Sections 1000-4(b) and 1000-10(a), Business and Professions Code (Chiropractic Initiative Act of California Stats. 1923 p. 1xxxviii).

MEDICAL BOARD OF CALIFORNIA
Executive Office

January 18, 2012

Robert Puleo
Board of Chiropractic Examiners
2525 Natomas Park Drive, Suite 260
Sacramento, CA 95833

Re: Proposal to Adopt Section 302.5 of the Chiropractic Regulations

Dear Mr. Puleo:

The Medical Board of California has reviewed the proposed Section 302.5 and recommends that it be modified to clearly prohibit use of lasers to perform cosmetic procedures. Accordingly, we recommend the following modifications to paragraph (b):

"Nothing in this section shall be construed to authorize the use of a laser by a chiropractor outside the chiropractic scope of practice. This includes, but is not limited to, laser ablation, cosmetic procedures, surgical procedures and the laser treatment of allergies in cases where there is a known risk anaphylactic reaction to the individual being treated."

This would give clearer guidance to chiropractors and the Board staff regarding the appropriate use of lasers.

We trust the foregoing is useful. Please contact me if you have any questions.

Sincerely,

Linda K. Whitney
Executive Director, Medical Board of California

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California Medical Association

California Physician's Legal Handbook

CPLH

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or other drug, such that his or her ability to practice medicine compromises the safety of the public and his or her patients. (Business & Professions Code §2280.)

Diversion Program: As noted in Chapter 36, section entitled "Assisting Physicians with Substance Abuse or Mental Health Problems," the Medical Board has decided to shut down its in-house Diversion Program as of June 30, 2008.

Elective Cosmetic Surgery

A physician may not perform elective cosmetic surgery procedure on a patient unless the patient has received, within 30 days prior to the elective cosmetic surgery procedure, and confirmed as up-to-date on the day of the procedure, an appropriate physical examination by, and written clearance for the procedure from, any of the following:

1. The physician and surgeon who will be performing the surgery.
2. Another licensed physician and surgeon.
3. A certified nurse practitioner, in accordance with a certified nurse practitioner's scope of practice, unless limited by protocols or a delegation agreement.
4. A licensed physician assistant, in accordance with a licensed physician assistant's scope of practice, unless limited by protocols or a delegation agreement.

The physical examination must include the taking of an appropriate medical history. An appropriate medical history and physical examination done on the day of the procedure shall be presumed to be in compliance with the law.

"Elective cosmetic surgery" for the purposes of this law means an elective surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance, including, but not limited to, liposuction and elective facial cosmetic surgery.

(Business & Professions Code §2259.8.) For more information, *see* section entitled "Grounds for Medical Board Discipline," in this chapter, and Chapter 35, section entitled "Surgicenters and Other Outpatient Facilities."

Ethical Guidelines

Physicians should generally also comply with the ethical guidelines of the medical profession. A complete copy of AMA's Code of Medical Ethics, including the interpretations of the Code issued by the AMA's Council on Ethical and Judicial Affairs, may be obtained by ordering the booklet entitled *Code of Medical Ethics Current Opinions and Annotations* from: American Medical Association, P.O. Box 930876, Atlanta, GA, 31193-0876; (800) 262-3211 for members, Fax (312) 464-5600, or visit the website at https://catalog.ama-assn.org/Catalog/home.jsp#. Notwithstanding the ethical mandates of the profession, unprofessional conduct that warrants discipline by the Medical Board is defined by the Legislature in statute, not by principles adopted by organized medical associations and societies. *See Thorburn v. California Department of Corrections* (1998) 66 Cal.App.4th 1284, 1290, 78 Cal.Rptr.2d 584 (unprofessional conduct is understood by reference to the qualifications established by the State of California for licensure as a physician, and the types of conduct that Legislature and courts have defined as grounds for discipline or loss of the professional license).

PDR MEDICAL DICTIONARY

SECOND EDITION

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Medical Dictionary

THE INFORMATION STANDARD FOR MEDICAL TERMINOLOGY

Corticoviridae ... DNA (MW 5×10^6), which accounts for about 12% of ... weight.

corticovirus ... Only genus in family of Corticoviridae.

cor·tilymph (kŏr′tē-limf). The fluid in Corti tunnel.

cor·tin (kor′tin). SYN corticosteroid.

cor·ti·sol (kor′ti-sŏl). SYN hydrocortisone.

cor·ti·sol acetate. SYN *hydrocortisone* acetate.

cor·ti·sone (kor′ti-sōn). A glucocorticoid not normally secreted in significant quantities by the human adrenal cortex. Endogenously, it is probably a metabolite of hydrocortisone but exhibits no biologic activity until converted to hydrocortisone (cortisol); it acts upon carbohydrate metabolism and influences the nutrition and growth of connective (collagenous) tissues. It was the first glucocorticoid available for therapy. SYN Wintersteiner compound E.

α-cor·tol (kor′tŏl). The 5β enantiomer of α-allocortol; a reduction product of cortisone, present in the urine, differing from cortisone in that the three keto groups are reduced to hydroxyls.

β-cor·tol. α-Cortol with a 20β-OH group; the 5β enantiomer of β-allocortol, found in urine.

α-cor·to·lone (kor′tō-lōn). The 5β enantiomer of α-allocortolone, a reduction product of cortisone, present in the urine, differing from cortisone in that two of the keto groups (at positions 3 and 20) are reduced to hydroxyls.

β-cor·to·lone. α-Cortolone with a 20β-OH group; the 5β enantiomer of β-allocortolone, found in urine.

co·run·dum (ko-rŭn′dŭm). Native crystalline aluminum oxide. [Hind. *kurand*]

Corvisart des Marets, Baron Jean N., French clinician, 1755–1821. SEE Corvisart *facies*.

cor·ym·bi·form (kŏ-rim′bi-fōrm). Denoting the flowerlike clustering configuration of skin lesions in granulomatous diseases (e.g., syphilis, tuberculosis). [L. *corymbus*, cluster, garland]

cor·y·ne·bac·te·ria (kŏ-rĭ′nē-bak-tēr′ē-ă). Plural of corynebacterium.

cor·y·ne·bac·te·ri·o·phage (kŏ-rĭ′nē-bak-tēr′ē-ō-fāj). Any one of the bacteriophages specific for corynebacteria.

β-C. A DNA-containing bacteriophage that induces toxigenicity in strains of *Corynebacterium diphtheriae* that are lysogenic for its prophage. SYN β phage.

Corynebacterium (kŏ-rĭ′nē-bak-tēr′ē-ŭm). A genus of nonmotile (except for some plant pathogens), aerobic to anaerobic bacteria (family Corynebacteriaceae) containing irregularly staining, Gram-positive, straight to slightly curved, often club-shaped rods which, as a result of snapping division, may show a picket fence arrangement. These organisms are widely distributed in nature. The best known species are parasites and pathogens of humans and domestic animals. The type species is *C. diphtheriae*. [G. *coryne*, a club, + *bacterium*, a small rod]

C. acnes, former name for *Propionibacterium acnes*.

C. amycolatum, a species found as normal skin flora, it causes septicemia, frequently associated with venous access devices, and has also been recovered from urinary tract infections and mixed flora abscesses.

C. diphtheriae, a bacterial species that causes diphtheria and produces a powerful exotoxin causing degeneration of various tissues, notably myocardium, in humans and experimental animals and catalyzes the ADP-ribosylation of elongation factor II; virulent strains of this organism are lysogenic; it is commonly found in membranes in the pharynx, larynx, trachea, and nose in cases of diphtheria; it is also found in apparently healthy pharynx and nose in carriers, and is occasionally found in the conjunctiva and in superficial wounds; it occasionally infects the nasal passages and wounds of horses; it is the type species of the genus *C.* SYN Klebs-Loeffler bacillus, Loeffler bacillus.

C. equi, SYN *Rhodococcus equi*.

C. glucuronolyticum, a species isolated from patients with urinary tract infections.

C. haemolyticum, former name for *Arcanobacterium haemolyticum*.

C. hofmannii, former name for *C. pseudodiphtheriticum*.

C. jeikeium, species associated with septicemia and skin lesions in immunocompromised patients, especially associated with venous access devices.

C. matruchotii, a species recovered in mixed infections from human eye specimens.

C. minutissimum, a bacterial species that is a component of normal skin flora, causes erythrasma in humans.

C. parvum, former name for *Propionibacterium acnes*.

C. pseudodiphtheriticum, a rarely pathogenic species found in normal throats. SYN Hofmann bacillus.

C. striatum, a bacterial species found in nasal mucus and in the throat; also found in udders of cows with mastitis; pathogenic to laboratory animals; a rare cause of infection to immnocompromised patients.

C. xerosis, a bacterial species found in normal and diseased conjunctiva; there is no evidence that this organism is pathogenic.

cor·y·ne·bac·te·ri·um, pl. **cor·y·ne·bac·te·ria** (kŏ-rĭ′nē-bak-tēr′ē-ŭm, -ă). A vernacular term used to refer to any member of the genus *Corynebacterium*.

co·ry·za (kŏ-rī′ză). SYN acute *rhinitis*. [G.]

allergic c., SYN hay *fever*.

Co·ry·za·vi·rus (kŏ-rī′ză-vī′rŭs). Obsolete name for Rhinovirus.

cos·me·sis (koz-mē′sis). A concern in therapeutics for the appearance of the patient; i.e., an operation that improves appearance. [G. *kosmēsis*, an adorning, fr. *kosmeō*, to order, arrange, adorn, fr. *kosmos*, order]

cos·met·ic (koz-met′ik). **1.** Relating to cosmesis. **2.** Relating to the use of cosmetics.

cos·met·ics (koz-met′iks). Composite term for a variety of camouflages applied to the skin, lips, hair, and nails for purposes of beautifying in accordance with cultural dictates.

cos·mid (koz′mid). A recombinantly engineered plasmid, a circular DNA containing, in order: a plasmid origin of replication and a drug-resistance marker, the *cos* (cohesive end) site from bacteriophage λ, and a fragment of eukaryotic DNA to be cloned; c.'s are constructed to permit cloning of fragments of up to about 40,000 base pairs in length, with one or more unique restriction sites being necessary to facilitate cloning.

cos·mo·pol·i·tan (koz-mō-pol′i-tan). In the biologic sciences, a term denoting worldwide distribution. [G. *kosmos*, universe, + *polis*, city-state]

cos·ta, gen. and pl. **cos·tae** (kos′tă, -tē). **1** [TA]. [I–XII]. SYN rib [I–XII]. **2.** A rodlike internal supporting organelle that runs along the base of the undulating membrane of certain flagellate parasites such as *Trichomonas*. SYN basal rod. [L.]

c. cervica′lis [TA], SYN cervical *rib*.

cos′tae fluctuan′tes [XI–XII], SYN floating *ribs* [XI–XII], under *rib [I–XII]*.

cos′tae fluitan′tes, SYN floating *ribs* [XI–XII], under *rib [I–XII]*.

c. lumbalis [TA],

c. prima [I] [TA], SYN first *rib* [I].

cos′tae spu′riae [VII–XII] [TA], SYN false *ribs*, under *rib [I–XII]*.

cos′tae ve′rae [I–VII] [TA], SYN true *ribs* [I–VII], under *rib [I–XII]*.

cos·tal (kos′tăl). Relating to a rib.

cos·tal·gia (kos-tal′jē-ă). SYN pleurodynia. [L. *costa*, rib, + G. *algos*, pain]

cos·tec·to·my (kos-tek′tō-mē). Excision of a rib. [L. *costa*, rib, + G. *ektomē*, excision]

Costen, James B., U.S. otolaryngologist, 1895–1962. SEE C. *syndrome*.

cos·ti·car·ti·lage (kos-ti-kar′ti-lij). SYN costal *cartilage*.

cos·ti·form (kos′ti-fōrm). Rib-shaped. [L. *costa*, rib, + *forma*, form]

cos·tive (kos′tiv). Pertaining to or causing constipation. [contraction from L. *constipo*, to press together]

cos·tive·ness (kos′tiv-ness). SYN constipation.

costo-. The ribs. [L. *costa*, rib]

cos·to·cen·tral (kos-tō-sen′trăl). SYN costovertebral.

Attorneys' Dictionary of Medicine

ILLUSTRATED

SCHMIDT

pressure when standing, cold hands and feet, itching, rash.

Corzide 40/5 (nadolol + bendroflumethiazide), medical conditions or status of patient precluding the use of. Atrioventricular block (which see); heart failure; cardiogenic shock (which see); allergy for sulfonamides; failure of the kidneys to excrete urine; sinus bradycardia (which see); bronchial asthma.

Cosmegen (kos'me-jen). The trademark name of an injectable form of dactinomycin, an antibiotic with cytotoxic effects that is used in the treatment of certain forms of cancer.

Cosmegen, generic name of. Dactinomycin.

cosmesis (koz-mē'sis). In surgery, a consideration or regard for the appearance of the patient as it may be affected by a surgical procedure or by the failure to perform a particular operation; the art of surgery which aims to preserve, increase, or restore physical beauty.

cosmetic dentistry. The branch of dentistry which is concerned mainly with improving the original appearance of teeth, as by covering them with porcelain jackets, etc.

cosmetic dermatitis. A skin irritation caused by the application of a cosmetic.

cosmetic operation. A surgical operation the aim of which is to improve the appearance of a part, as of the nose.

cosmetic plastic surgery. Same as *aesthetic plastic surgery.*

cosmetic surgery. Surgery which aims to improve the appearance rather than the function or usefulness of a structure of the body, as of the nose.

cosmetology (koz"me-tahl'o-jē). The branch of knowledge dealing with the care of the body in regard to beauty and cleanliness.

cosmic rays (koz'mik). Streams of particles coming at high speed from outer space and bombarding the earth's atmosphere. These particles, knowns as primary cosmic rays, consist mainly of protons (units of positive electricity each forming a part of the nucleus of an atom around which electrons revolve) and other nuclei of atoms. These primary rays are absorbed in the upper atmosphere but not before they produce other particles, such as neutrons, mesons, and electrons, from the atoms of the atmosphere. These particles are known as secondary cosmic rays. The energy possessed by the secondary rays is of a much lower magnitude than the energy of the primary rays.

CosmoDerm. The trademark name of a bioengineered preparation of human collagen that is administered by injection as a dermal filler to improve the appearance of facial scars and wrinkles.

CosmoPlast. The trademark name of a bioengineered preparation of human collagen that is administered by injection as a dermal filler to improve the appearance of facial scars and wrinkles.

cosmotron (koz'm ō-tron). Same as *proton-synchrotron,* which see.

cost. A word-making combining form denoting a *rib.* Example: *costectomy,* the operation of excising or removing a rib.

costa (kos'tah), *pl.* **costae** (kos'tē). A rib.

costae (kos'tē). The plural form of *costa,* which see.

costal (kos'tal). Pertaining to a rib or ribs; as, *costal* cartilage.

costal angle. 1. The angle formed between the cartilage which connects the floating ribs on the right side of the chest with the breastbone, and the cartilage which connects the floating ribs on the left side of the chest with the breastbone. The cartilages can be felt at the lower border of the rib cage as they ascend and meet at the lower end of the breastbone. Also called *angulus infrasternalis.* **2.** The place in the back part of a rib where the curvature changes abruptly, forming somewhat of an angle.

costal arch. The arch or vault formed by the lower ribs as they converge and meet at the lower end of the sternum or breastbone. Also called *arcus costalis.* See *costal angle,* definition 1.