State of California

State and Consumer Services Agency

MEDICAL BOARD OF CALIFORNIA

May 3-4, 2012

Panel A	**May 3**	**9:00 a.m.-12:00 p.m.**
Panel B	**May 3**	**9:00 a.m.-12:00 p.m.**
Enforcement Committee	**May 3**	**1:00 p.m.- 2:00 p.m.**
Licensing Committee	**May 3**	**2:00 p.m.- 3:00 p.m.**
Executive Committee	**May 3**	**3:00 p.m.- 3:30 p.m.**
Full Board	**May 3**	**3:30 p.m.- 5:30 p.m.**
Full Board	**May 4**	**9:00 a.m.- 3:00 pm**

MEDICAL BOARD OF CALIFORNIA
BOARD MEETING SCHEDULE

Doubletree by Hilton Hotel Torrance- South Bay
21333 Hawthorne Blvd.
Torrance, CA 90503
310-540-0500 (directions only)

May 3-4, 2012

Thursday, May 3

- **9:00 a.m. – 12:00 p.m.** — **Panel A – Salon A & B**
  (Members: Duruisseau (Chair), Bishop, Carreon, Diego, Salomonson, Yaroslavsky)

- **9:00 a.m. – 12:00 p.m.** — **Panel B – Salon C**
  (Members: Chang (Chair),GnanaDev, Levine, Low, Schipske)

- **12:00 p.m. – 1:00 p.m.** — ***Lunch Break***

- **1:00 p.m. – 2:00 p.m.** — **Enforcement Committee – Salon A & B**
  (Members: Low (Chair), GnanaDev, Levine, Schipske)

- **2:00 p.m. – 3:00 p.m.** — **Licensing Committee – Salon A & B**
  (Members: Salomonson (Chair), Bishop, Carreon, Chang, Diego, Duruisseau, Schipske)

- **3:00 p.m. – 3:30 p.m.** — **Executive Committee– Salon A & B**
  (Members: Yaroslavsky (President), Salomonson (Vice President), Schipske (Secretary), Chang, Duruisseau, Levine)

- **3:30 p.m. – 5:30 p.m.** — **Full Board – Salon A & B**
  (All Members)

Friday, May 4

- **9:00 a.m. – 3:00 p.m.** — **Full Board Meeting – Salon A & B**
  (All Members)

MEDICAL BOARD OF CALIFORNIA

Executive Office

****Agenda Amended to Revise Title of Agenda Item 22****

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.
Jorge Carreon, M.D.
Hedy Chang
Silvia Diego, M.D.
Shelton Duruisseau, Ph.D.
Dev GnanaDev, M.D.
Sharon Levine, M.D.
Reginald Low, M.D.

QUARTERLY BOARD MEETING

May 3-4, 2012

Doubletree by Hilton Hotel Torrance- South Bay
Salon A & B
21333 Hawthorne Blvd.
Torrance, CA 90503
310-540-0500 (directions only)

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

AGENDA

Thursday, May 3
3:30 p.m. – 5:30 p.m.

Friday, May 4
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, May 3

1. 3:30 p.m. Call to Order / Roll Call

2. Introduction of New DCA Attorney - Ms. Yaroslavsky

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 February 2-3, 2012 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. Update of Pharmacy Board Actions – Ms. Herold

6. Update on Pain Management Summit – Ms. Whitney and Ms. Herold

7. Physician Assistant Committee Update – Dr. Low

8. Consideration of Regulatory Proposal to Revise Physician Assistant Scope of Practice (Section 1399.541-Medical Services Performable) – Mr. Sachs and Mr. Heppler

9. Consideration of Revised Regulatory Proposal Regarding Sponsored Healthcare Events – Mr. Heppler and Ms. Scuri

10. Update of Strategic Plan Implementation – Ms. Kirchmeyer

11. Physician Responsibility in Supervision Committee Update - Ms. Schipske

12. Enforcement Committee Update – Dr. Low

13. Licensing Committee Update – Dr. Salomonson

14. Executive Committee Update – Ms. Yaroslavsky

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

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

17. Licensing Outreach/Education Report – Mr. Schunke

18. NPDB Feasibility

Recess

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Friday, May 4

19. 9:00 a.m. Call to Order / Roll Call

20. 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)]

21. Presentation on Use of Hospitalists – Dr. Bruce Gipe

22. 9:00 a.m. REGULATIONS – PUBLIC HEARING – Mr. Heppler
Physician Incarceration and Inactive License; Notice to Medical Board: (CCR, Title 16, Division 13, Chapter 2, Article 1, Section 1355.45). This proposal establishes the license information that will be displayed when a physician is incarcerated following the conviction of a misdemeanor and the type of notice to be provided to the Board when he or she is released.

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

24. President's Report – Ms. Yaroslavsky

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

26. Department of Consumer Affairs Update – Ms. Everhart

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

28. Midwifery Advisory Council Update
    A. Discussion and Consideration of Appointments to the Council
    B. Interested Parties Meeting Regarding Regulatory Proposals Update – Mr. Worden
    C. Council Update – Ms. Sparrevohn

11:45 Lunch Break (Move to Horizon Room)

29. 12:00 (Noon) Presentation: FSMB Centennial Meeting and Projects of the Board – Dr. Chaudhry

30. 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

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

32. Legislation/ Regulation – Ms. Simoes
    A. 2012 Legislation
    B. Status of Regulatory Action

33. Agenda Items for July 19-20, 2012 Meeting in the Sacramento Area

34. 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

Embassy Suites-San Francisco Airport
Mendocino / Burlingame Room
150 Anza Blvd.
Burlingame, CA 94010

February 2-3, 2012

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 February 2, 2012 at 4:00 p.m. A quorum was present and notice had been sent to interested parties.

Members Present:
Barbara Yaroslavsky, President
Janet Salomonson, M.D., Vice President
Michael Bishop, M.D.
Jorge Carreon, M.D.
Hedy Chang
Silvia Diego, M.D.
Shelton Duruisseau, Ph.D.
Dev GnanaDev, M.D.
Sharon Levine, M.D.
Reginald Low, M.D.

Members Absent:
Gerrie Schipske, R.N.P., J.D., Secretary

Staff Present:
Douglas Becker, Investigator
Susan Cady, Enforcement Manager
Tim Einer, Administrative Assistant
Kurt Heppler, Staff Counsel
Teri Hunley, Business Services Manager
Kimberly Kirchmeyer, Deputy Director
Armando Melendez, Business Services Staff
Regina Rao, Business Services Staff
Anthony Salgado, Licensing Manager
Kevin Schunke, Outreach Manager

DRAFT

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Anita Scuri, Department of Consumer Affairs, Supervising Legal Counsel
Jennifer Simoes, Chief of Legislation
Laura Sweet, Deputy Chief of Enforcement
Susan Thadani, Senior Investigator
Cheryl Thompson, Licensing Analyst
Renee Threadgill, Chief of Enforcement
Linda Whitney, Executive Director
Dan Wood, Public Information Officer
Curt Worden, Chief of Licensing

Members of the Audience:

Teresa Anderson, California Academy of Physician Assistants
Molly Burke, Member of the Public
Yvonne Choong, California Medical Association (CMA)
Paul Costa, Department of Consumer Affairs
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)
Jack French, ConsumersUnion Safe Patient Project
Amanda Friedman, CPIL
Faith Gibson, Midwifery Advisory Council
Julia Haskins, Blue Shield of CA
Rick Hanley, Member of the Public
Laurel Holmes, CPIL
Tina Minasian, ConsumersUnion Safe Patient Project
Joy Mobley, Member of the Public
Carlos Ramirez, Office of the Attorney General
Simone Renteria, Department of Consumer Affairs
Tom Riley, CA Society of Dermatology and Dermatologic Surgery
Angelique Scott, Department of Consumer Affairs
Rehan Sheikh, Member of the Public
Cheryl Simmons, Blue Shield of CA
Carrie Sparrevohn, Midwifery Advisory Council
John Toth, M.D., California Citizens for Health Freedom

Agenda Item 2 Introduction and Swearing in of New Board Members

Ms. Yaroslavsky welcomed and administered the Oath of Office to two new Board members, Michael Bishop, M.D. and Dev GnanaDev, M.D., appointed to the Board by Governor Brown on December 21, 2011.

Dr. Michael Bishop is director of anesthesia for same-day surgery at the University of California, San Diego Hillcrest and is attending anesthesiologist and clinical professor of anesthesiology at the University of California, San Diego.

Dr. Dev GnanaDev, is a surgeon and Medical Director at Arrowhead Regional Medical Center in San Bernardino County.

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Agenda Item 3 Public Comment on Items not on the Agenda
Frank Cuny, Director of California Citizens for Health Freedom complemented the new Board members and wished them luck. He also praised the administration for their previous support of the bill that allows physicians to do complimentary medicine in the holistic area, as long as it is safe and effective. Next year his group hopes to introduce a bill on the issue of the alternative holistic treatment of cancer and hopes that the Board will join them in its support.

Agenda Item 4 Approval of Minutes from the October 27-28, 2011 Meeting
Dr. Salomonson made a motion to approve the minutes from the October 27-28, 2011 meeting; s/Low; motion carried, with Dr. Bishop, Ms. Chang and Dr. GnanaDev abstaining.

Agenda Item 5 Discussion of Strategic Plan Objective 5.4 Annual Review of Committees; Establishment of Board Committees
Deputy Director Kimberley Kirchmeyer led the discussion of Strategic Plan Objective 5.4, Annual Review of Committees and the establishment of Board Committees. During the last meeting, there was not enough time to discuss the Board Committees according to Objective 5.4 of the new strategic plan. In order to expedite the process, a survey was sent to Board members to ask for their input on the Committees of the Board. Ms. Kirchmeyer referred the members to the consolidated information that was provided for each Committee of the Board. She stated that she would like to review each Committee individually to determine if the members would like to keep the Committee, change the goals of the Committee, change the meeting times of the Committee, or make any other modifications.

- **Executive Committee.**
  Based on the comments received, it was determined that the Executive Committee should remain as it is, with one exception. One recommendation was for the Committee to do a periodic assessment by the members to identify perceptions of effectiveness and efficiency of Board meetings and suggestions for improvement. Ms. Kirchmeyer recounted that the Board used to survey members at each meeting and inquired if perhaps the Executive Committee might want to conduct an annual survey to see if there is anything that needs to be reviewed and then changed.

Dr. Levine made a motion to keep the Executive Committee as it is with the addition to conduct an annual survey by the members to identify perceptions of effectiveness and efficiency of Board meetings and suggestions for improvement. In addition, the Executive Committee would meet when needed and primarily meet at the quarterly meetings or in between, if necessary; s/GnanaDev; motion carried.

- **Licensing Committee.**
  It was determined that the Licensing Committee should also stay the same with the addition of maintenance of licensure as an issue for the Committee to discuss and the addition of Polysom and Outpatient Surgery Centers to the programs of the Board related to licensing. This committee would meet at quarterly meetings, when issues that need discussion arise, and when it has a full agenda.

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Dr. Low made a motion to keep the Licensing Committee as it is with the addition of maintenance of licensure as an issue for the committee to discuss and the addition of Polysom and Outpatient Surgery Centers to the programs of the Board related to licensing. This Committee would meet at quarterly meetings, when issues arise that need discussion, and when it has a full agenda; s/GnanaDev; motion carried.

- **Enforcement Committee.**
  From the comments it seems this Committee should also remain as is and it also appears that the issues identified are appropriate. It should continue to meet at quarterly Board meetings and again when needed. For this Committee there are also sub-committees which may need to meet in between if necessary.

Dr. GnanaDev made a motion to keep the Enforcement Committee as it is. This committee would meet at quarterly meetings and when needed; s/Duruisseau; motion carried.

- **Application Review Committee, Special Faculty Permit Review Committee, Special Program Committee and Midwifery Advisory Council.**
  For the statutory Committees, they are to be retained and a motion is not necessary to keep them intact. There was just one comment pertaining to the Special Faculty Review Committee and Mr. Worden will be bringing forward this issue on the 2168 candidates.

- **Access to Care Committee**
  The suggestion to combine Access to Care Committee with the Education and/or Wellness Committees was discussed. It was decided that a motion should be made to table the vote on this Committee. Staff will survey the Board members to clarify the role that the Access to Care Committee should have and if it should be collapsed or condensed into the Education Committee. Dr. Low requested that the staff also look into the amount of money that can be devoted to this effort annually. Motion to table the vote on this committee passed unanimously.

- **Advisory Committee on Physician Responsibility in the Supervision of Allied Health Care Professionals**
  Ms. Kirchmeyer communicated that the Advisory Committee on Physician Responsibility in the Supervision of Allied Health Care Professionals is the logical committee to deal with the SB100 requirement of determining physician availability in cosmetic surgery settings that use lasers. There is a requirement for the Committee to look into that and develop regulations. Staff recommends that this Committee remain intact and meet off cycle of the quarterly Board meetings. When looking to set up regulations, it is necessary to have interested parties meetings. Meeting off cycle for this particular Committee would help to increase the time involved for the robust discussions that take place prior to the introduction of new regulations.

Public comment was provided for this agenda item.

Tom Riley with the California Society of Dermatology and Dermatologic Surgery commended the Board on the complex discussion and shared that appropriate comments had been made. SB100 is a very important issue for two reasons. One of them has to do with licensing and the other has to do with what the doctors' responsibility inside of these facilities will be. The clock is

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now ticking on the regulatory process and it makes the work of this Committee even more important. Mr. Riley affirmed that the Board should move forward. They should find a chair for the Committee, aggressively collect public input, and then if after that process there are other things having to do with the scope to be addressed, use this Committee to address other things.

Tina Minasian, representing the ConsumersUnion Safe Patient Project spoke that since the Advisory Committee on Physician Responsibility in the Supervision of Allied Health Care Professionals will include discussion of aspects of the implementation of SB100, it is important that this Committee remain on schedule with the quarterly Board meetings. Ms. Minasian requested that the Board please make sure that the public has access to the implementation of SB100 by keeping this Committee on schedule with the quarterly Board meetings.

Dr. Low made a motion to keep the Advisory Committee on Physician Responsibility in the Supervision of Allied Health Care Professionals. This Committee would retain its current statement of responsibility, will meet off cycle from the quarterly Board meeting and will add the SB100 laser IPL issue to its tasks; s/Bishop; motion carried.

- **Education Committee**
  Ms. Kirchmeyer stated that there was a comment received from Michele Monserratt-Ramos from the ConsumersUnion which was intended for the strategic plan. Looking into this comment further, it is more applicable under this agenda item. Ms. Monserratt-Ramos asked the Board to educate the public on how complaints are prioritized, as well as the legislatively mandated priorities. Another comment was to increase the priority of expanding current outreach to the public and provide information on the Board's programs, patients' rights, and how to file complaints. These suggestions really fit under the Education Committee and are issues where this Committee could be involved. It is also recommended that this Committee look at the requirements of SB380, related to education material regarding the prevention and treatment of chronic disease.

Dr. Levine made a motion to keep the Education Committee as it is. It should add the SB380 requirement as an issue. This Committee will meet off cycle from the quarterly Board meeting and would also bring forth goals for the future; s/Low; motion carried.

- **Physician Recognition Committee**
  Ms. Kirchmeyer discussed that based on the majority of comments received from the Board members, the Physician Recognition Committee is no longer a priority and should be discontinued at this time.

Dr. Levine made a motion to discontinue the Physician Recognition Committee at this time; s/Duruisseau; motion carried.

- **Wellness Committee**
  Ms. Kirchmeyer provided information that there was a suggestion to combine the Wellness Committee with the Education Committee and also a comment requesting the elimination of this Committee. Staff recommends that a motion be entertained to move the Wellness Committee to the work of the Education Committee.

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Dr. Bishop made a motion to move the Wellness Committee to the Education Committee; s/Duruisseau; motion carried.

- **Cultural and Linguistic Competency Work Group**
  Ms. Kirchmeyer asked the Board to have a discussion to provide a clear direction on the Cultural and Linguistic Competency Work Group. After discussing the scope and goals of this Committee, a recommendation was made by Ms. Whitney suggesting merging the responsibilities of the Access to Care Committee with the Cultural and Linguistic Committee and hold a meeting to see if the new mission and goals could be defined with clear objectives.

Dr. GnanaDev made a motion to merge the responsibilities of the Access to Care Committee with the Cultural and Linguistic Competency Work Group and hold a meeting off cycle from the quarterly Board meeting to see if the new mission and goals could be defined with clear objectives; s/Chang; motion carried.

Dr. Levine asked for a clarification of SB1195.

Ms. Whitney explained that SB1195 is legislation that required the Board set up a workgroup to determine if those individuals providing continuing medical education (CME) were in fact incorporating cultural and linguistic portions within their training. The Board is supposed to determine if, in fact, the CME providers are correctly including that within their training.

Ms. Yaroslavsky adjourned the meeting at 5:40 p.m. and announced that the Board Meeting would reconvene on Friday, February 3, 2012 at 9:00 a.m.

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Agenda Item 6 Call to Order/ Roll Call
Ms. Yaroslavsky called the meeting of the Medical Board of California (Board) to order on February 3, 2012 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
Michael Bishop, M.D.
Jorge Carreon, M.D.
Hedy Chang
Silvia Diego, M.D.
Shelton Duruisseau, Ph.D.
Dev GnanaDev, M.D.
Sharon Levine, M.D.
Reginald Low, M.D.

Members Absent:
Gerrie Schipske, R.N.P., J.D., Secretary

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Staff Present:

Tim Einer, Administrative Assistant
Kurt Heppler, Staff Counsel
Teri Hunley, Business Services Manager
Kimberly Kirchmeyer, Deputy Director
Armando Melendez, Business Services Staff
Regina Rao, Business Services Staff
Kevin Schunke, Outreach Manager
Anita Scuri, Department of Consumer Affairs, Supervising Legal Counsel
Jennifer Simoes, Chief of Legislation
Victor Sandoval, Supervising Investigator
Melinda Sundt, Investigator
Laura Sweet, Deputy Chief of Enforcement
Cheryl Thompson, Licensing Analyst
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
Molly Burke, Member of the Public
Yvonne Choong, California Medical Association (CMA)
Paul Costa, Department of Consumer Affairs
Zennie Coughlin, Kaiser Permanente
Bryce Doeherty, The Doeherty Group
Catherine Dower, UCSF Center for the Health Professions
Karen Ehrlich, L.M., Midwifery Advisory Council
Julie D'Angelo Fellmeth, Center for Public Interest Law (CPIL)
Conrad Del Rosario, San Francisco District Attorney's Office
Reichel Everhart, Department of Consumer Affairs
Jack French, ConsumersUnion Safe Patient Project
Amanda Friedman, CPIL
Faith Gibson, Midwifery Advisory Council
Rick Hanley, Member of the Public
Laurel Holmes, CPIL
Tina Minasian, ConsumersUnion Safe Patient Project
Joy Mobley, Member of the Public
Carlos Ramirez, Office of the Attorney General
Tom Riley, CA Society of Dermatology and Dermatologic Surgery
Rehan Sheikh, Member of the Public
Shannon Smith-Crowley, American Congress of OB/GYNS – CA
Carrie Sparrevohn, Midwifery Advisory Council
Ryan Spencer, California Medical Association (CMA)
Archie Wong, San Francisco District Attorney's Office

Ms. Yaroslavsky introduced special guest, Reichel Everhart. Ms. Everhart was appointed on January 11, 2012 as the new Deputy Director for Board and Bureau Relations for the Department of Consumer Affairs. Ms. Everhart addressed the Board and let the members know that she is

looking forward to working with them. She stated that if there are any concerns or questions that they may have on any issue related to working with the Department Consumer Affairs, to contact her or let Linda know and she will be happy to help.

Agenda Item 7 Public Comment on Items not on the Agenda

Julie D'Angelo Fellmeth, the Administrative Director of the Center for Public Interest Law (CPIL) spoke to the Board. For the benefit of the new Board members, she advised them that CPIL is an advocacy and academic organization based at the University Of San Diego School Of Law. For 30 years CPIL has been monitoring California state agencies that regulate business and professions and trades, including the Medical Board of California.

Ms. D'Angelo Fellmeth thanked Dr. Reggie Low for his work in chairing the Board's Enforcement Committee. His efforts and good work were commended in trying to get the Board's investigative staff and the Attorney General's office Health Quality Enforcement Section on the same page in compiling and reporting of enforcement data.

Last fall a complaint was made to the Governor by Public Citizen, a Washington D.C. based public interest organization. The complaint alleged that this Board failed over the last 20 years to take disciplinary action against a number of California licensed doctors who had been disciplined by hospitals through the peer review process and had been reported to the National Practitioner Data Bank (Data Bank). Public Citizen also reported that about 100 of these doctors were labeled imminent risk by the hospitals that reported them to the Data Bank but they were not disciplined by the Board. The Governor's office was concerned and Board staff did an analysis of Public Citizen's allegations. According to the minutes of the October 2011 Board meeting, 2/3 of the cases reported by Public Citizen were past the statute of limitations and had been purged due this Board's retention requirements. It has been learned that the Board's staff only queries the Data Bank at the point of initial licensure. It does not query the Data Bank every two years upon the renewal of a physicians' license. If this was done, it might have picked up some of the hospital disciplinary actions before the statute of limitations ran out. It costs $4.75 to query the Data Bank and this fee could be added to the physicians' renewal fee. The Board was encouraged to investigate this issue and have staff do a cost benefit analysis of what it would cost and the good it would do to complete a Data Bank query every two years at renewal. Currently the Data Bank is not open to the public and individuals cannot query their doctor. The Board should look into this issue as part of their public protection mandate.

Tina Minasian and Jack French, representing ConsumersUnion, spoke that two weeks prior to this meeting, several of their members had met with Ms. Whitney and Ms. Kirchmeyer. They wanted the Board to know about concerns they have with the appropriate oversight and safety of outpatient surgery centers.

There were three areas of concern that were discussed. One would be opportunities for consumers to interact with the Board and they requested that the Board teleconference all of their public meetings and include committee meetings. This would mean that the public can listen over the phone and provide public testimony over the phone during public comment periods. Numerous other agencies do this including the CA Healthcare Acquired Infections Committee and the CA Health Benefit Exchange. Both of those agencies are governed by the Bagley Keene Act. It was requested that the Board ask that DCA webcast all of the Board's public meetings and make clear on its website the opportunities and rules for public participation at Board

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meetings. The second item is the statute of limitations that governs patient complaints with the Board. The Board website has confusing information to patients who are trying to understand and comply with deadlines for filing complaints. This has resulted in the Board refusing to review complaints that patients believe were filed timely. Board staff has been provided with some examples of unclear and misleading communications on its website related to its statutes of limitations. It was requested that the Board clarify the information provided on the website, in brochures, and on the forms. It was also recommended that the Board immediately notify the patient involved when the Board learns of an alleged improper act or omission by a physician from a source other than the patient which triggers the statutes of limitations and when a patient makes a complaint to the Board. The Board should explain the statutes of limitations and inform the patient how much time is left before the statute of limitations will run out in their case. The third concern pertains to the implementation of SB100. It was suggested that the Board include on its website historic information about outpatient settings violations that have been noted by accrediting agencies in the past and work quickly to coordinate a clear process with the Department of Public Health regarding the reporting of adverse events. When appropriate, the Board should investigate whether an adverse event involves physician misconduct. The Board should communicate to California physicians that they must report adverse events and if they do not do so in a timely manner, they could be fined.

Agenda Item 26 Update of Pharmacy Board Actions

Virginia Herold, Executive Officer of the Board of Pharmacy, introduced herself to the Board. She explained that the Board of Pharmacy is currently dealing with severe drug diversion from pharmacies. An example was provided of two pharmacies, one of which lost 1.5 million vicodin pills and the other which lost 2 million pills. The Board of Pharmacy remains rigorous in watching pharmacies to make sure this does not occur. They have mandatory reporting requirements as does the DEA for controlled substances. Last year AB507 was sponsored by the American Cancer Society in the belief that patients are being denied adequate pain treatment. It is claimed that when patients go to prescribers and then go to pharmacies, the pharmacy is being overregulated and the patient is being denied access to medication they need for pain relief.

Agenda Item 27 Discussion and Consideration of Co-Sponsoring Pain Management Summit with Pharmacy Board

Ms. Herold continued by explaining that in 1994, the Department of Consumer Affairs brought together the Board and the Board of Pharmacy to convene a pain summit. This happened 18 years ago. There have been suggestions to revisit this issue of pain management. In order to increase the impact of this summit, the Board of Pharmacy would like to join the Board in working to help educate prescribers and dispensers. This will ensure that they know how to work together and use the available resources of technology or medication therapy so they can better care for patients.

Ms. Herold proposed to the Board that they authorize staff to work with the Board of Pharmacy staff to develop a concept for a pain summit to take place later in 2012.

It was also discussed that Ms. Herold would like to see prescribers and pharmacies have a dialogue on how they can communicate better. When a pharmacist calls a prescriber to inquire about a patients' treatment, frequently it is not well received. Many dispensers are hesitant to make those calls and yet they are held responsible if they dispense drugs that they should have not because they didn't make the call.

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Ms. Herold stated that the Board of Pharmacy would also like to do some educational pieces for long term state of the art thinking in pain management. The Board has access to various experts throughout the country and that could be used to develop something that will lend to better patient care.

Dr. GnanaDev inquired if the Board of Pharmacy will also be working with the CA Pharmacy Association and the CA Medical Association. Ms. Herold responded that they would need the support of all associations as well as a number of others, for example, the Board of Registered Nursing. There are still many pieces and the general agenda is still being assembled to determine the input and output from various agencies.

Dr. Levine asked Ms. Herold if she was confident that the CURES program would be funded. Ms. Herold advised that the CURES program currently does not have any direct funding per se. It is funded through grants that the former Bureau of Narcotic Enforcement would get and that is how they chose to pay for this program. Dr. Low suggested that perhaps surtax on pain medication could be used to fund the CURES program. It would not be a large amount but, enough to fund the program. Ms. Herold stated that California is one of the few states that does not have a separate registration for those that prescribe and dispense controlled substances. That could be a potential area for funding the CURES program but, that would require legislation and it may not be warmly received because that would create a fee in this economic climate.

Ms. Change made a motion to direct staff to work with the Board of Pharmacy 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; s/Levine;

Public comment was provided for this agenda item by Yvonne Choong with the CA Medical Association (CMA). Ms. Choong informed the board that the CMA would appreciate being included in this effort as well. This remains a high priority issue for them and currently the CMA has a group of pain management specialists and other physicians that are working on developing a physician advisory for physicians who are not pain management specialists to educate on how they can appropriately prescribe opiates.

Ms. Whitney informed the Board that she was approached by Ms. Herold with this idea because the Board of Pharmacy president was very interested in this issue. This would be a great effort for the two Boards to jointly work together and then reach out to the stakeholders. There has not been a strong partnership in the past few years and by working together now, a strong partnership will be developed. Ms. Whitney intends to attend the Board of Pharmacy meetings, as appropriate, to provide updates on activities of the Board to solidify this partnership. It is desired to form a strong alliance with the Board of Pharmacy board there are so many things that interact between the two Boards.

Ms. Yaroslavsky called for the vote. Motion carried.

Agenda Item 8 Physician Assistant Committee Update

Dr. Low announced that the Physician Assistant Committee (PAC) has elected a new Chair, Bob Sachs who is well known to the committee and a PA at USC. Steve Klompus was the former Chair and will now serve in the role as Vice-chair.

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The PAC is working on a regulation pursuant to AB2699 which allows out of state licensees to offer their professional services at sponsored free health care events. That PAC will discuss regulation language at the February 6, 2012 meeting.

The PAC is also considering amending the regulations regarding the interpretation of the "personal presence" of a physician as well as the scope of practice of a PA. Since this regulation involves scope of practice it will need to be promulgated by the Board on behalf of the PAC. At the next meeting on Feb 6, 2012, the PAC will review the final draft language and if approved, bring it back to the next Board meeting for consideration.

The PAC is also working on amending the disciplinary guidelines in order to incorporate SB1441.

The PAC approved the final 2012 sunset report and it will be submitted to the legislature by the requested date. The sunset hearing is scheduled for March 19, 2012 and the chair and Executive Officer will be attending. The Executive Officer has been very effective at coordinating her staff to deal with the licensing backlog that occurred because one of the staff members retired. A new employee has been hired and will begin on February 6, 2012.

Agenda Item 9 Enforcement Committee Update

Dr. Low reported that the Enforcement Committee had a meeting, February 2, 2012, during which he provided an update of the subcommittee's activities.

Dr. Low reminded the Board that at the last Board meeting it learned that the Board and the Attorney General's (AG's) office maintain data but they do it independently and the data does not match completely. That is because they calculate it differently and manage it differently. One of the Enforcement Committee's primary purposes is to resolve that problem. Several meetings have taken place. On January 3, 2012 the Board staff met and on January 9, 2012 the Board staff, met with Dr. Low and Mr. Carlos Ramirez and Ms. Gloria Castro from the AG's office. This was an extremely productive meeting. It was decided at that meeting that the supervisory staff of the Health Quality Enforcement Section (HQES) of the AG's office and the supervisor staff of the Board would meet to reconcile the previous month's statistics. Moving forward, every month a meeting will be conducted to reconcile this data. The AG's office agreed to provide monthly reports from their case management system. Ms. Sweet from the Board's enforcement section stated that the Board staff would provide specific case activity reporting forms to the HQES of the AG's office. After each district office and the AG's office reconcile the data, one single report will be provided to the Board. There will no longer be two separate reports, which is tremendous progress.

On January 18, 2012, there was another meeting between the AG's HQES staff and the Board staff to facilitate the implementation of this new procedure.

Dr. Low reported that Mr. Ramirez had explained to him that he previously provided data to the Board but it was difficult for Ms. Whitney to use this data because it was in a format that was inconsistent with how the Board tracks items. In the end it turns out that the Board will be getting reports from the CMS section of the AG's office that will meet the needs of the Board. The CMS is the entity within the Department of Justice (DOJ) that is responsible for the

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preparation of the reports reflecting the statistical data. Currently CMS is trying to program reports that will attach the attorney billing on a particular case. On January 23, 2012, the Board staff met with the DOJ CMS staff as well as with Mr. Ramirez and Ms. Castro and made requests for these specific reports.

On January 9, 2012, a meeting was held that discussed the need to incorporate the median as well as the mean times for the data that is being collected. Dr. Low suggested that the outlying cases receive independent review so the Board can understand the causes for inaction and remedy the situation as soon as possible.

It was also discussed that information about items relating to case aging, such as the DOJ wanting to acquire the ability to hold cases or toll during the pendency of criminal prosecution, is something that the Board already does and the cases will not age further. These changes would better reflect what is actually going on. Ms. Castro also reported that the LA office of the HQES is under orders to not slow down the investigation process, particularly when scheduling conflicts arise with the review of expert packages. Both agencies agreed to provide reports that may be of value to assist reconciling data and sharing information.

Dr. Low praised Ms. Sweet's energy in the effort of organizing the expert training project. Standardization amongst the experts will improve quality and efficiency. The first expert training meeting should occur in April.

Agenda Item 10 Licensing Committee Update

Dr. Salomonson reported that the Licensing Committee met on February 2, 2012. At the meeting, Mr. Worden provided an update on staffing in the licensing program and stated positions are being filled. Mr. Worden and Anthony Salgado, Licensing Manager, provided updates on the business process reengineering recommendations. Some of the highlights would be revision and streamlining of the physician application process and improvements on the website relative to the application process. There is still work to be done and decisions to be made regarding the post graduate training authorization letter process and revisions of the policy and procedure manual.

Another licensing project is implementation of SB100 which is the outpatient surgery center requirements. One of the requirements is that the status of the outpatient centers will be on the Board's website. Currently, the way the data has been provided it is not possible to look up a list of accredited centers, but, the public will be able to look this information up on the website in the future.

Agenda Item 11 Federation of State Medical Boards Update

Ms. Chang began by sharing several projects that the foundation, which was endowed by the Federation of State Medical Boards, is working on. One is a small project that was funded with the state of Washington's Medical Board. It is no longer under the Department of Health and Human Services and reports directly to the Governor. It needed to justify its existence and whether it is doing a good job or not. The final evaluation stage is the project that the foundation is doing.

The other project is still in the discussion stage and pertains to the scope of practice. It is a best practice evaluation and education piece for investigators and will be a joint project among four

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states.

Ms. Chang described the Federation's upcoming 100 year celebration and annual conference in April. The conference will be held in Dallas and consists of various education topics. Ms. Chang and Ms. Yaroslavsky will be attending and all board members were encouraged to attend.

Ms. Whitney updated the Board on a number of things that staff is working on with the Federation. Ms. Whitney participated on the workgroup to define minimal data sets. The final meeting was on Tuesday, January 31, 2012, and discussed comments provided from the other boards on the document developed by the committee. This report will now go to the Federation Board, the Reference Committee, and it will be presented at the full membership meeting in April. Over the past few months, several teleconference meetings were held with the Federation staff regarding the new USMLE validation process that may hold up the release of some scores for physicians. California Program directors have been notified and the MBC is working very closely with Federation staff to monitor this so all who need licensure by July 1, 2012, will have their scores in plenty of time.

Ms. Whitney also reported that on January 25, 2012, the staff at the Board participated in a webinar presented by the Federation regarding a proposal similar to national licensure. The Board will continue to track this issue and continue to report back to the Board members. The Board has assigned a manager to track the Federation pilot project on maintenance of licensure and will provide updates at future licensing committee meetings. This will include tracking what ABMS is doing regarding maintenance of certification too.

The Federation's foundation is surveying boards regarding members and staff being targets of violence. Results will be shared with the Board in the future. Other reports being completed by the Federation staff for presentation at the annual meeting are: a report on physician re-entry into the practice of medicine; guidelines to physicians and state boards on the use of social media; and, a report on the composite action index and summary of state board actions. (This is the summary that is put out each year on statistics from all the various boards.)

Dr. Levine inquired in terms of the issue of physician reentry into practice and asked if the Board or the Federation have any sense of the size or scope of what that population is, and, how often does this come up.

Ms. Whitney replied that it is obviously coming up more frequently than it has in the past. The size of the issue is unknown and different states are reacting differently. Ms. Whitney gave an example from the disciplinary guidelines: if someone has been out of practice for 18 months, then he/she would have to take some remediation courses in order to reenter the practice of medicine. If someone has not renewed his or her license for up to five years, there is no examination whether that person has been practicing or not during the five years. Those are looked at on a case by case basis and may require different types of remediation. Some states require that physicians who have been out of practice for two years, have to take certain remediation. States are a little bit different and no one has put together the actual number of individuals the states are talking about but, the Federation is trying to bring all of this material together so the states are not acting independently; and have a sense of what the other states are doing; and how they are addressing the reentry issue. This process is looking at how ABMS is dealing with recertification because that has to be factored into the problem.

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Ms. Chang commented that there is possibly a visitor from the Arizona board and liaison of the Federation that will attend the next Board meeting and the Board could suggest that they provide a presentation on reentry.

Agenda Item 12 Health Professions Education Foundation Update
Dr. Duruisseau made a comment about how impressed he has been by the testimonies given by the participants who are receiving the loan repayment program awards. The work that these individuals are doing in underserved communities is very impactful. Dr. Duruisseau shared that it might be useful for the Board to at least hear some of these compelling and compassionate testimonies given by these individuals and how the work they are doing is related to access to care.

Ms. Yaroslavsky agreed with Dr. Duruisseau's comments. Dr. GnanaDev spoke that usually if physicians stay in a community for three to four years, they will remain there permanently. He requested staff to provide statistics to examine the percentage of these physicians staying in these underserved communities even after the loan repayment program is over.

Agenda Item 13 Board Member Communications with Interested Parties
No interested party communications were reported by members.

Agenda Item 14 President's Report
During the past quarter, Ms. Yaroslavsky participated in three DCA board president calls. These calls include the various Board presidents and the Executive Officers of DCA to discuss issues of common concern. It is a learning experience and an opportunity to have a voice at the table and be in partnership with DCA, under the leadership of this Governor and his staff.

Ms. Yaroslavsky also continues to have a weekly call with Board Executive Staff. These calls provide an opportunity to review information and stay on top of all aspects that affect the Board from licensing and statistics to enforcement and legislation.

Ms. Yaroslavsky reported that she attended the December 14, 2012 Board staff holiday party. It was apparent that everyone seemed to have a wonderful time. The organizational skill of the staff is totally amazing. Their support and engagement indicates their teambuilding abilities. On January 20, 2012, Ms. Yaroslavsky participated in an orientation with the new Board members in Sacramento. She thanked Ms. Whitney and her staff for the excellent work that was put forth. It was so informative that Ms. Yaroslavsky recommends that Board members should have the opportunity to go through an orientation such as this on a regular basis.

Agenda Item 15 Executive Director's Report
A. Staffing and Administrative Update
Ms. Whitney announced the appointment of Tim Einer, the new Administrative Assistant. With this hiring, it will be Cheryl Thompson's last Board meeting. Ms. Whitney thanked Ms. Thompson for a job very well done. In December, the new Public Information Officer, Dan Wood was hired. Mr. Wood has 30 years experience in journalism and television broadcasting and has already made an impact on the Newsletter. Letitia Robinson has been hired as the Research Program Specialist to replace Janie Cordray. Ms. Cordray will continue working on special projects and for historical reference. Ms. Robinson is a former manager in the licensing

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unit. She will focus her efforts on the VEP evaluation, various statistical analysis and preparing the sunset review report that will be due in the fall of 2012.

In early December, Ms. Herold, the Executive Office of the Board of Pharmacy, invited Ms. Whitney and Ms. Simoes to attend the California Endowment Shareholder Group on improving prescription medication labeling. Ms. Herold has provided a great service to the Board to ensure that it is at the table and participating in the information regarding improving prescription medication labeling. This information will eventually be shared with the Board physicians in the Newsletters and on the website.

On January 12, 2012, the National Practitioner DataBank staff provided an excellent all day training session to the Board and DCA staff. There were over 60 people in attendance including several from the AG's office and from Kaiser. Ms. Whitney thanked Ms. Kirchmeyer for taking the lead and setting up this training.

On January 18, 2012, Ms. Whitney and Ms. Kirchmeyer met with representatives from ConsumersUnion; they requested broader webcasting of Board meetings to include committees which had already been planned for this meeting. They requested that Board meetings be available via teleconferencing. This is a legal matter and has been referred to DCA Legal Office. They also made a number of suggestions for improving the website and brochures regarding clarity on the statute of limitations. They asked questions about the implementation of SB100 and information that would be posted on the website. Ms. Whitney advised them that a written response would be provided to these items after the Board meeting.

Ms. Whitney reported that on January 20, 2012, the two new Board members came to the Board headquarters to receive orientation from executive staff and various managers in the licensing and enforcement sections. They will still need to go through DCA orientation.

On January 23, 2012, staff met with the AG's office regarding information systems referred to as CMS and worked on additional details to get the data needs to the Board for VEP evaluation. Staff hope to have the data in the very near future so it can be compared with some of the analysis that was done in the Ben Frank Report and recommendations that were there.

Ms. Whitney discussed that she and the new DCA Deputy Director Ms. Everhart, met on January 24, 2012 and will have a meeting with the new Director and Chief Deputy Director by the end of February.

Deputy Director Kimberly Kirchmeyer added several more administrative updates. Ms. Kirchmeyer mentioned that most of the Board members have been receiving their Board information via a thumb drive or USB. It is now being considered to have these items sent via email to the members via their Board email account. This suggestion was enthusiastically received by several members. Ms. Kirchmeyer said that she would look into implementing this with the Information Services Branch (ISB).

Ms. Kirchmeyer also wanted to let the members know that the Board has been working with both the Department of Healthcare Services and the Centers for Medicare and Medicaid Services to notify physicians of two opportunities to receive funding for electronic health records. An email blast was sent to physicians notifying them of this program and its deadline for application. The

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Board also partnered with the University of CA at San Francisco (UCSF) to assist the Department of Healthcare Services in being able to provide a base line or a starting point for the use of EHR's statewide. The UCSF drafted a survey that was sent out to physicians along with their renewal notice from the Board. The information gathered from this survey by UCSF is being used to draft a report for the department. The Department of Healthcare Services and UCSF may wish to present to the Board at a future meeting on this report. The Board is also working with the centers for Medicare and Medicaid services for their Medicare EHR incentive program. An email blast will be sent to all physicians in the future on this program and its application deadlines too. Both of these programs are important to physicians and the public and the Board is happy to partner with these sister agencies. As information is received on these programs, it will be provided to the board. There will also be links on the website providing information for these programs as well as putting articles in the newsletter on the programs and the deadlines.

Moving onto the staffing update Ms. Kirchmeyer, reported that since the last board meeting the hiring freeze has been lifted. It has been possible to advertise, interview and hire individuals for positions. At the last Board meeting it was reported that the Board had 71 vacancies that included the CPEI positions. At the end of January, the Board had 51 vacancies including the CPEI positions and of those 51 vacancies there are approximately 14 individuals either awaiting a background investigation or confirmation of eligibility. There are also three future vacancies occurring from staff transferring to other agencies. 51 vacancies equates to an 18% vacancy rate compared to 25% at the last board meeting. If the CPEI positions are removed from those figures, there is actually about a 13% vacancy rate.

B. Budget Overview

Ms. Kirchmeyer continued with an overview of the budget. The first item discussed was the Board's fund condition. The Governor's budget included the reestablishment of six positions for operations safe medicine however, the funding for these positions was not approved and the board will therefore have to absorb the costs of the unit within its existing budget.

The BreEZe project was also included in the Governor's budget for a one time augmentation of $1.278 million in fiscal year 12/13.

Ms. Whitney and Ms. Kirchmeyer will be reviewing the Board's budget to ensure that the Board can absorb the costs for the operation safe medicine in the future and if necessary may again put forward a request for the funding for these positions. Additionally, based upon future workload for this unit staff may be requesting position authority and funding for a Northern California unit as well.

If the Board spends as planned, it will be within its statutory mandate of less than four months reserve at the end of fiscal year 2011/2012 and in the middle of the mandate in fiscal year 2012/2013. This is important to note because as reported at the last meeting, the Bureau of State Audits is monitoring the Board's fund condition to see if it is within the statutory mandate of 2-4 months. Also, as reported at the last meeting the Board did respond to the Bureau of State Audits regarding its recommendation that the Board consider reducing licensing fees in order to not exceed its mandate. The Bureau has released its report on recommendations not fully implemented for all state agencies and included the Board's response in this report. The Board's response indicated that at this time, the Board is projected to be at the mandated level at the end

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of this fiscal year and projected to be even lower in the following fiscal years. The response stated that it would not be prudent for the Board to consider a reduction at this time. Based upon the Board's response and the Bureau's review the Bureau stated in its report that its assessment was that the Board will not implement this recommendation. The Board staff continues to review its fund condition to determine if fees need to be reduced, but if the Board continues this plan, it will be within the mandate by fiscal year 12/13.

Dr. Salomonson inquired if the 2013/2014 reserves were down, would there be a possibility of recouping the Board's loan.

Ms. Kirchmeyer explained that based on the fund conditions, when the Board is at the point where it is going to be without sufficient funding to continue the program, DCA would request from the Department of Finance the refund or repayment of the loan. The statute actually states that you cannot go through the process of increasing licensing fees until the money is recouped into the Board's fund.

Ms. Kirchmeyer reminded the members of the legislation which changed the Board's reserve mandate from two months to between two and four months. It also included a requirement that the Department of Finance Office of State Audits and Evaluations perform a preliminary review of the Board's financial status "including but not limited to its projection related to expenses, revenues, and reserves and the impact of the loan from the contingent fund of the Board to the general fund made pursuant to the budget act of 2008." This review is to be completed by June 1, 2012. Beginning on January 17, 2012, the auditors from the Department of Finance started reviewing the budget documents from the Board. They have met with DCA and reviewed all of their documents. They came to the Board on January 20, 2012 and began reviewing Board specific documents and interviewing staff. They have met with Ms. Whitney, budget analysts Debbie Titus and Tamiko Heim and Ms. Kirchmeyer. They are looking at how the Board reviews the budget documents and makes projections on revenue and expenditures. Ms. Kirchmeyer will continue to update the Board members as more information from these auditors is received and she will also provide the Board with a copy of the final report.

Ms. Kirchmeyer also addressed the budget bill. Because the Board has a budget change proposal for operation safe medicine, it will be following this bill and may be required to testify at budget hearings regarding this unit. The hope is that this bill goes through as planned and the Board will receive final approval for operation safe medicine for fiscal year 2012/2013 and ongoing.

Also presented were the Board's actual expenditures as of November 30, 2011. The Board has stayed on target for this time of year and there is nothing that raises concerns. Ms. Kirchmeyer did make the Board aware that there will be a request forthcoming for video conferencing equipment for three field offices as well as for the Headquarters office. It is believed that this will allow and provide better training and more meetings for the field as well as opportunities for meetings with other departments located throughout the state. The documentation is being prepared for review by the DCA. Ms. Kirchmeyer thanked Dr. Low for his suggestion on this idea and his support on that item as well.

Ms. Kirchmeyer reminded Board members that is important for them to submit their travel claims and work hours in a timely manner. This will assist the Board in monitoring its spending and also ensure that accurate reports are produced for the meetings.

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C. BreEZe Update

Ms. Kirchmeyer reported the BreEZe vendor began on the project in late September and is in full swing at this time. Board staff has been very involved in this project. The ISB unit has approximately six staff involved in different aspects of this project. Additionally, seven staff members have been identified that will be trained on the system and will be able to provide training for all Board staff as well as training for boards and bureaus for DCA. DCA has hired a new chief information officer, Amy Cox-O'Farrell and she came from the CSLB, where she was head of its IT unit. The BreEZe system is scheduled to be implemented in the fall of 2012. The Board will be working on communication plans for licensees, interested parties, and the public on this new system. Staff is planning on providing a complete presentation at the July Board meeting.

D. FISMA Update

Ms. Kirchmeyer reminded members of a request from DCA to identify the most significant risks to the Board. The request was based upon the Financial Integrity and State Managers Accountability act known as FISMA. The definition of risk was defined as those objects or impediments that stand in the way of achieving the Board's goals and objectives. The four top risks identified include: staff resources, enforcement, BreEZe implementation and appropriate budget funding. The report was submitted to the Department of Finance by DCA.

Agenda Item 16 Special Faculty Permit Review Committee Update and Consideration of Applicant

Ms. Yaroslavsky announced that this item was pulled from the agenda as there were no special faculty permits for review.

Agenda Item 18 Licensing Chief's Report

Mr. Worden reported that the Special Faculty Permit Review Committee meeting was held on Jan 23, 2012. One applicant was presented but the committee decided to request additional information. There is currently one application for Specialty Board Application and that is awaiting response from the board.

Polysomnography program regulations become effective on Feb 18, 2012. Work continues on implementing the new program with website information, notifications to interested parties, and procedures for processing the applications.

The implementation of AB1424 has been added to the Board website homepage, licensee page, and the applicant page. AB1424 pertains to individuals who have over $100,000 in delinquent taxes. The tax delinquency will result in the denial of application for licensure or the suspension of license or certification.

A. Staffing

Mr. Worden thanked all of the licensing staff. They are continuing to do an excellent job. They have maintained processing goals for almost every week. Licensing currently has five vacancies. Approximately 25% of licensing staff are in various stages of training for their positions. Even though vacancies have been significantly reduced there is still a great deal of training going on and that equates to staff not working at their full capability at this time.

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Dr. Salomonson inquired for clarification of the increased responsibilities regarding outpatient surgery centers and if that position had been budgeted.

Mr. Worden stated that this is part of the midwifery analyst position. Currently Mr. Worden, Mr. Salgado, and Ms. Robinson are working with the ISB staff to develop a system that will be on the website with all the information. The required information the outpatient surgery centers will submit will be provided electronically.

Dr. Salomonson inquired if this is an unfunded mandate or if outpatient surgery centers pay a fee to be listed.

Mr. Worden explained that outpatient surgery centers pay a fee to the accreditation agency. The Board requires a $5,000 application fee from a potential accreditation agency and they pay $100 per facility at renewal every three years.

B. Program Statistics

Mr. Worden provided program statistics. In the second quarter for the fiscal year, the Board received 1,666 physician and surgeon applications. 1,689 physician and surgeon applications were reviewed, this included PTALs. There are a total of 4,225 pending physician and surgeon applications, of those 3,530 have been reviewed, 795 are pending review, and 1,203 physician and surgeon licenses were issued this quarter.

There were 121 pending applications for senior staff review. Per the request of the Chair of Licensing a breakdown of the senior review categories was provided.

For the physician and surgeon application data for January 7, 2012, the initial review for US files was actually 50 days. Last year at that time it was 30 and for the IMG files it was 33. The pending mail was seven for US and IMG. Currently the US files are at 42 days for initial review and IMG files are at 29. Pending mail is at seven and seven for both US and IMG.

C. Status of International Medical School Program

Mr. Worden explained that charts provided to the members have been revised to include: schools that have requested recognition; and, schools where the Board has received an application or PTAL, where the medical school is not on the Board's recognized list and applicants have requested the Board to evaluate their school for recognition. This list includes international medical schools applying for recognition pursuant to either CA Code of Regulations §1314.1 (a)(1) or §1314.1(a)(2). At the time these statistics were compiled, there were 75 international medical schools on this list. With an analyst finally assigned after a year vacancy, this process will be able to move along at a quicker pace. Several schools have applied and are in the process of the review and have been on hold for over a year. Two of those are schools that are applying for their A2 recognition.

Ms. Yaroslavsky thanked Mr. Worden and his staff and wanted the entire Board to recognize the efforts of the entire licensing unit.

Dr. Levine told Mr. Worden how much she appreciated the frequent emails that are sent to the Board members to keep them updated and apprised of their progress.

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Agenda Item 19 Licensing Outreach/Education Report

Mr. Schunke clarified that all state agencies are still subject to the Governor's executive order regarding restrictions on travel. Starting in February, Mr. Schunke will begin the 2012 outreach to the teaching hospitals in California. Currently there are 14 trips that have been approved that cover about 20 primary teaching hospitals and the affiliated hospitals. In recognizing and in trying to adhere to the spirit travel restrictions, Mr. Schunke is trying to condense and combine as many visits to teaching hospitals in one area as he can.

In December the Board sent out about 1,000 letters to all the program directors and to the GME offices and to the designated institutional officers in California. This letter offered the Board's services for applicants. The matrix is for residents that are coming up to a licensing deadline at the end of their training year when they must be licensed. The letter not only encouraged them to get in contact with the Board and to provide the names but, to use the Board as a resource.

Several hospitals have contacted the Board for the first time. Coincidently, the first initial contact has been made with Arrowhead Regional Medical Center, coinciding with Dr. GnanaDev's appointment with the Board. .

Mr. Schunke has been in frequent contact with City of Hope down in the Los Angeles area. He has never had the opportunity to go visit them but plans to go during his visit to the UCLA Olive View Center in the San Gabriel Valley.

A license fair will be conducted for the first time at Cedars Sinai Hospital. When traveling down to UCSF in Fresno, he will be making several stops at some of the other locations in the Central Valley. This will not only save costs but it is an opportunity to expand outreach.

Also with the encouragement of individual members on the Board and Ms. Whitney, Mr. Schunke is starting to increase his outreach to the hospital recruiters as they hire new staff members at the hospital to try and discourage them from hiring new staff to start in the summer when the Board is really focused on getting the residents licensed in a timely manner.

As mentioned, the matrix for 2012 is being created. Last year there were almost 2,000 names on it. Mr. Schunke anticipates the matrix to be smaller this year because Mr. Worden and his staff have been so efficient. In fact, one of the teaching hospitals surprised him when it responded that all of its residents already were licensed by December.

Dr. GnanaDev thanked Mr. Schunke for his outreach efforts. He suggested that perhaps Mr. Schunke could see about providing training to the staff at the GME and DIO offices. They will be the surrogates when it comes to the residents and the Board could educate them on the licensing process.

Agenda Item 20 Midwifery Advisory Council Update

A. Licensed Midwife Update

Karen Ehrlich, L.M. introduced Carrie Sparrevohn, L.M. to the Board. Ms. Ehrlich informed the Board that this would be her last report as Chair of the MAC as Ms. Sparrevohn had been elected Chair of the MAC and she would be moving to the Vice-Chair position for the next term.

At the last MAC meeting on Dec 13, 2012, the MAC discussed ACOG's new position statement

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on collaboration between OB/GYN's and Certified Nurse Midwives and Licensed Midwives. She is hopeful that this might help to change the climate for the licensed midwives in California and is very happy to see that collaborative care statement coming forward.

Ms. Ehrlich reported that there had been a discussion about modifying the MAC membership. She wanted the Board to clearly know that the MAC wants and needs physician input on the council. One of the slots on the council should remain as an obstetrician licensed by the Board. There is also a preference that the second slot be potentially filled by a consumer of midwifery services.

There will also be some regulations that are going to be proposed to the Board. One pertains to appropriate levels of supervision of midwives and essentially will move into a realm that more resembles collaboration. Another will be to finally authorize licensed midwives to be able to use the tools of their trade like ordering lab work, ordering ultrasounds and being able to purchase medications and oxygen that are necessary for the well being and safe keeping of mothers and babies.

Ms. Ehrlich stated the midwives will soon be moving into the fifth year of statistical reporting. There has been some difficulties associated with it and the council will study the reporting through the Midwives Alliance of North America. This Program is prospective and all data is reviewed by the staff and validated. It is believed that by having prospective data it would be clearly understood the work that is being provided by the midwives. Ms. Ehrlich wished to repeat what was stated at the Board meeting last fall that the four years that have already been reported shows that the midwives are doing good work in California.

Carrie Sparrevohn, L.M., introduced herself to the Board. She stated she is looking forward to chairing the MAC. Ms. Sparrevohn informed the members that she has been licensed since the first group of midwives were licensed in 1996-1997. She currently holds a different position in her community than a lot of licensed midwives as she works in a private physician office but is not attending any births.

B. Discussion and Consideration of the Following Regulatory Proposals

1) Section 1379.23 – Physician Supervision and Collaborative Relationship

Curt Worden provided background on this agenda item. The 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. Mr. Worden described that staff has drafted a potential solution which is physician collaboration. The next step is to request the Board to consider the draft language and to authorize the staff to hold an interested parties meeting so that input is provided to see what would need to be modified or make it acceptable and actually useful for the midwives. If the regulation process is started without an interested party forum, it will become a more lengthy process.

Kurt Heppler reminded the members that this is an administrative board and that civil liability is not its forte and this is left to the judicial system. Administrative discipline is the forte of this Board and it takes action based upon the parameter of public protection.

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Dr. Duruisseau made a motion that 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 is directed 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; s/Chang.

Ms. Yaroslavsky called for public comment for this agenda item.

Shannon Smith-Crowley representing American Congress of OB/GYN's in California, stated that some progress is being made and they are at the point and time where they have enough people that they can really bring something to the table in terms of an interested party meeting. Some liability carriers, including the University of CA, a self funded or self insured entity, and UCSF are specifically looking at work force and the roles of different types of providers. She would be very happy to work with the Board in identifying some of these interested parties. She believes that it would not solve everything but the single biggest barrier is the liability coverage, and her organization supports the interested party meeting.

Julie D'Angelo Fellmeth, from CPIL suggested that if an insurance company is refusing to cover an activity of a physician, which is mandated by law, that staff approach Insurance Commissioner, Dave Jones. The Insurance Commissioner has the authority to hold hearings on this issue of the insurance industry refusing to cover this activity or refusing to cut off physicians who provide supervision. The MBC is recommended to bring the Insurance Commissioner into this conversation.

Ryan Spencer with CMA stated that the CMA wanted to officially support how very important physician supervision is in terms of patient safety particularly when there are medical complications. If the Board does decide to move forward with this action, the CMA would like to be a part of the group.

Faith Gibson, L.M. provided background history for the Board, in the years before the passage of the LMPA. She appreciates the concept of the conversation about the safety of the patient however there has not been any supervision available where she lives. Ms. Gibson stated that there are zero people who are willing to participate. She shared that she remembered years ago when she was a labor and delivery room nurse and when she and the obstetricians were on the same side. They were once a team and now it could not be worse.

Ms. Yaroslavsky called for the vote. Motion carried.

The Board returned to agenda item 17.

Agenda Item 17 Presentation: California's Health Care Workforce – Are We Ready for the Affordable Care Act?

Catherine Dower, J.D., the Associate Director for Research at the UCSF Center for the Health Professions provided a presentation for the Board entitled: California's Heath Care Workforce – Are we Ready for the Affordable Care Act (ACA)?

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Ms. Dower informed the Board that the Center for the Health Professionals team had put together a report regarding California's health care workforce readiness for the ACA era. This report is available in two formats. One is a book and the other is smaller issue brief. These reports are available at the website: www.futurehealth.ucsf.edu

The key point that Ms. Dower wished to share with the Board is that the health workforce is a major part of the labor sector. It was the only labor sector that grew during the economic recession. Continued growth is expected. It is estimated that 5 million jobs in healthcare will be the driving component of the job creation in the next decade. California is expected to see about 10% of that so about 500,000 more people employed in healthcare in the next eight years. One of the biggest issues facing the state of California is the significant misdistribution of practitioners not practicing equally in all areas of the state. With the growing population, more diverse population, and the aging population, the ACA implementation will strain primary care providers first.

Ms. Dower's full slideshow presentation is available on the MBC website under agenda item 17.

Ms. Yaroslavsky thanked Ms. Dower for her insightful presentation and asked that the meeting continue with the agenda item prior to the guest speaker.

Agenda Item 20 Midwifery Advisory Council Update
B. Discussion and Consideration of the Following Regulatory Proposals
2) Section 1379.24 – Midwifery Practice: Tests, Drugs, and Devices

Kurt Heppler discussed that this item is presented in an attempt to address a dichotomy in the regulations that talk about the educational requirements for a licensed midwife with no corresponding reference to the tools and implements that may be used in the that practice. This attempts to rectify that inconsistency.

Ms. Scuri further clarified that this is an attempt to help remove some of the other barriers to practice that occur if licensed midwives cannot get the supplies because the law or the regulations don't specifically say that they may utilize these materials.

Ms. Chang made a motion 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; s/Levine.

Dr. Diego asked if the Board knew why they were having a hard time getting the supplies.

Ms. Yaroslavsky requested that Ms. Sparravohn and Ms. Ehrlich come forward to answer the question.

Ms. Sparravohn stated in response to this question that there is no provision to date that allows a licensed midwife to obtain things that are normally obtained by a written prescription from a physician and that includes oxygen, other devices and drugs.

Faith Gibson provided public comment that currently they are doing a workaround. Some

midwives will, for example, order Pitocin from Washington state. If there was a supervising physician, all of these things would be handled through the aperture of the supervising physician.

Dr Bishop asked Mr. Heppler if there were any of the other allied health professionals in California legally able to obtain to prescription drugs such as Nurse Practitioners or Physician Assistants.

Mr. Heppler replied that he is council to the Physician Assistant Committee and they are able to obtain them through drug orders and obtained with proper delegation of services agreement between the supervising physician and the physician assistant.

Ms. Scuri provided additional background that physician assistants and nurse practitioners, when they are utilizing drug orders, do have a supervising physician but then they are usually performing medical tasks. Midwifery is a separate type of practice that is not a part of medicine. It is hard to comprehend, but that is the way it is setup in the law. This proposal does not allow unfettered access. It is the authority, limited to the practice of midwifery, to obtain and administer these particular drugs, agents, diagnostic tests and services for which they are in fact trained to use in their three year program.

Yvonne Choong from the CMA provided public comment. Ms. Choong made a suggestion that since this current topic is tied to supervision and an interested parties meeting is going to held related to the previous proposed regulations, perhaps this item should be considered in the interested parties meeting as well.

Carlos Ramirez from the Attorney General's office stated that perhaps he would offer the assistance of his office in perhaps drafting a formal or informal opinion as to whether this regulation either expands or merely compliments the practice of midwifery. Perhaps some of the questions that have been presented by the board members could be addressed in that context.

Ms. Yaroslavsky thanked Mr. Ramirez for this offer and suggested that staff work together and examine if they can utilize these services.

After much debate from the Board Members Dr. Low stated that he thought that a regulatory hearing on this issue is premature. There are too many definitions and issues that are yet undefined. He proposed that there be a workgroup of interested parties who will lay a foundation for the Board. Everything would be presented and all the definitions explained to the Board and what the training entails that they go through. If this workgroup can present it to the Board in an organized fashion then they can more intelligently make a decision with proceeding with a hearing.

Ms. Chang made a motion to amend the original motion and to send this item back for an interested parties meeting with issues to be addressed and then brought before the Board before a regulatory hearing is set; s/Levine; motion carried.

C. Consideration of Proposal to Modify Appointment Process to the Council

Curt Worden advised the Board that there are currently two vacancies on the MAC due to resignations. Prior to this, the Board had authorized the MAC to check into the expansion of its membership. The MAC would still like to have an OB/GYN but would also like to have a non

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board licensee as well. The public member would be a consumer that has been a user of the midwifery services.

Ms. Whitney spoke that in the past when the MAC had a vacancy coming up staff would send out notices, MAC would select individuals and bring them back to the Board for approval. There has never been an instance where the Board has not approved a recommendation from the council. In this particular case, there are two vacancies so there are only four members of the council and no physician member. The MAC is asking to be allowed to move ahead through the process of finding two individuals to sit on the council one being a physician and one being a public member. They would be selected and seated at the March meeting before this Board confirms them as members. The question that has to be resolved is if the Board would want to delegate that to the MAC. Or, it could come back come back before the Board in May for confirmation having authorized those two individuals to sit in the MAC meeting in March.

Dr. Levine made a motion asking staff to work with the MAC to send out a notice to recruit members as described, that they be invited to sit with the council in the March meeting and the Board formally approve them in May; s/Duruisseau; motion carried.

Dr. Low requested to make an addendum to his Enforcement Committee report earlier in the meeting. He stated that it is his hope that the enforcement leadership at the Board would have the ability to hold a training session for the expert review course and invite their investigators to that meeting and also that the investigators be allowed to be invited to the other meetings that they hold throughout the state. He requested from the Board to know if this would be possible.

Ms. Yaroslavsky clarified if he was asking for a motion or just adding it as a point of information.

Dr. Low stated that he wanted to be sure that the Board has the authority to accomplish this and this would be mission critical for the enforcement program.

Ms. Whitney responded that staff will take his direction.

Agenda Item 21 Enforcement Chief's Report

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

Ms. Threadgill requested approval for 15 orders restoring license to clear status following completion of probation and five orders for license surrender during probation or administrative action.

Dr. GnanaDev made a motion to approve the orders; s/Bishop; motion carried.

B. Expert Utilization Report

Ms. Threadgill reported that the District Offices used 450 experts in 2011 to review 786 cases and the total active list of experts as of January 3, 2012 is 1,172.

C. Enforcement Program Update

The Enforcement Program is currently focusing on reducing the time for the following data markers:

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- Average days from request to receipt of medical records
- Average days from request to completion of physician interview
- Average days from request to receipt of expert opinion

The Enforcement Program anticipates improvement as a result of policy changes and legislation implemented to encourage cooperation. During the Enforcement subcommittee meeting Dr. Low suggested staff reduce the amount of time experts are allowed to review a case, which is something that staff are implementing. Instead of 30 days, the program is directing experts to review non-voluminous cases within 15 days.

This quarter has been extremely busy concentrating on filling Investigator and Supervising Investigator vacancies. As soon as the freeze was lifted, Enforcement staff immediately began conducting interviews and selecting candidates for background investigations. Enforcement staff identified seventeen candidates, nine of whom were from the Department of Justice and in jeopardy of being laid off. Because the DOJ candidates were in such high demand and numerous agencies were competing for these candidates (Dept of Insurance, Dept of Alcoholic Beverage Control), Board staff expedited the backgrounds. Unfortunately, after the backgrounds were nearly completed and staff were awaiting authority from the State Personnel Board to hire, four of the candidates withdrew from the background process because their jobs were saved at the Department of Justice. The program is interviewing again. Unfortunately, most of the candidates who are now being identified will require the 16-week academy whereas the agents did not. The current vacancy rate for investigators in 17% however, when the number of vacancies is adjusted to reflect those investigators in background the rate is 4%. The current vacancy rate for Enforcement Supervisors is 25%. The program has had difficulty filling three supervising investigator vacancies and is optimistic there will be more viable candidates as a new supervising investigator list will be available around the second week of February.

The Enforcement section has had significant investigative activity this quarter with unlicensed practice of medicine cases. The San Jose District Office led the investigation of an unlicensed individual who was performing liposuction in his home. Investigators served a search warrant early in the morning and the suspect was apprehended and arrested as he tried to flee out the back door. He is being held on $750,000 bond.

Operation Safe Medicine has also been extremely busy arresting unlicensed practitioners. During January, an investigator unwittingly walked in on a subject who was performing a hemorrhoidectomy. The subject was arrested and the patient was taken to a local emergency room.

A productive meeting was conducted with the Supervising Deputy Attorneys General, area Supervisors, Susan Cady, Laura Sweet and Renee Threadgill, where numerous issues were resolved. The program has disseminated the revised Vertical Enforcement Guidelines to staff. Thanks and much appreciation goes to Deputy Chief Laura Sweet and Supervising Deputy Attorney General, Tom Lazar for their work on this project. The program was able to schedule quarterly meetings for the remainder of this year and the beginning of next. As Dr. Low reported, the program has worked out a system to reconcile statistics with the Office of the Attorney General at both the district office level and the disciplinary coordination unit level. At the beginning of the year, program records reflected 118 cases that had been referred to the AG's office for more than 60 days and not filed. As of this report, only 27 remain over 60 days.

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Despite investigator vacancies, staff has managed to reduce case aging by 31 days since this same time last year and by 71 days since the same time fiscal year 09/10. As the travel restriction eases, Deputy Chief Laura Sweet and Ms. Threadgill will resume the very successful aged case council to develop plans to quickly resolve troublesome cases that have aged.

Ms. Threadgill reported that at the last Board meeting she would be tracking the status of how the new law requiring contracts of all experts impacted the enforcement program. She is pleased to report that due to the effort of Susan Goetzinger, with assistance from CCU staff, 1207 contracts were sent out between December 27, 2011 and January 23, 2012. As of this Monday, 376 contracts were in place and more are being received daily.

The 11th edition of the Model Disciplinary Guidelines, were approved by the Office of Administrative Law and became effective on January 11, 2011. They are now available online and Ms. Threadgill provided the Board with soft copies. There are hard copies for them to reference as well. She thanked Susan Cady for her work to get these regulations approved.

The Central Complaint Unit underwent an audit by DCA which they passed successfully. The auditors will be invited to present the results of the entire DCA Enforcement audit during the July enforcement committee meeting.

The CURES program is undergoing some significant changes as a result of Department of Justice staffing cuts. CURES is the Controlled Substances Utilization and Review program within the Department of Justice that provides data upon which the enforcement program relies to investigate prescribing trends of physicians. Susan Cady met with DOJ staff and learned that the responsibility for the CURES program has been transferred to the Bureau of Criminal Identification and Investigative Services, but all previous staff were eliminated. At the present time, staff has been redirected from other units to provide support to CURES. The redirected staff has been successful in eliminating the backlog of applications for access to the system. These applicants are usually physicians or pharmacists attempting to determine if patients are doctor shopping or are heeding physician instructions regarding controlled medications. The CURES program has updated its website. http://ad.ca.gov/bne/cures.php.

The Enforcement Program's ability to access ad-hoc reports was lost more than six months ago, so the administrator is committed to working with the program to re-activate access to CURES data. At this point in time, DOJ staff is trying to restore the program as much as possible, but will more than likely need outside support from the Board, the Board of Pharmacy and other interested parties in its efforts to obtain permanent staffing for the program.

Staff will begin working with the new Research Program Specialist on Data analysis for the upcoming VEP report and sunset review.

As was discussed yesterday in Enforcement committee, staff is working with OAH to include ALJ perspective in the training to be presented to Expert Reviewers. Staff is also working on scheduling training for Administrative Law Judges pursuant to their listing of training interests.

Dr. GnanaDev asked Ms. Threadgill about the amount of training invested in investigator staff, what is the retention rate. Ms. Threadgill stated that she would need to review that and provide

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that number to him.

Agenda Item 22 Vertical Enforcement Program Report

A. Status on Statistics

Mr. Carlos Ramirez began by thanking Dr, Low for his leadership on the enforcement committee and especially for his leadership in getting the data case reconciliation project started. This is a project that has been needed for quite some time he is glad it is on its way now. On Jan 23, 2012, AG staff and CMS staff met with Executive Director Linda Whitney and her executive staff and presented the three reports that have previously been requested from DOJ. Those have been delivered to the Board. Following that meeting, Board staff requested additional reports from CMS. Some of those can be readily accumulated and presented, while others may take a little more time but they are going to work on those as fast as they can.

B. HQE Organization and Staffing

With the result of two retirements, there are two vacancies in San Diego. One more deputy has been added to the Sacramento office to accommodate the work that has been transferred by the staff at the Board office.

Agenda Item 23 Legislation/Regulation

A. 2012 Legislation

Jennifer Simoes, Chief of Legislation, announced that the new 2012 law books are now in print and will be sent to the Board. This law book will have the changes that were made last year through legislation.

Board Sponsored Bill:

- **AB 1533** (Mitchell) UCLA IMG Pilot Program

  This bill is being co-sponsored by the Board with the University of California (UCLA). It would authorize a pilot for the UCLA international medical graduate (IMG) program. The bill proposes to allow program participants to engage in supervised patient care activities in this pilot program for up to six weeks. It allows individuals to get clinical training as a pilot part of that program and all training would occur with supervision provided by licensed physicians. The bill also requests the UC to prepare a report to the Board and the legislature after the pilot program has been operative for five years it includes specified information and also includes the potential for retention or expansion of the pilot program.

  The bill sunsets the pilot program on January 1, 2019. It will likely be heard in policy committee in March.

- **Omnibus**

  All of the other sponsored proposals were approved by the Board at the last board meeting and have been approved to be included in the senate omnibus bill.

  - **Non-Practice License Status – Authority to Impose Discipline** – The Board recently lost a court case related to taking disciplinary action against a licensee that held a retired license. This bill would make it clear that the Board does have that authority and retains jurisdiction over all licensees, regardless of the status of his or her license.

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- **Renewal Notices – Ability to Send via E-Mail** – This will provide the ability to send renewal notices via email if physicians opt to receive their correspondence via email. There will be some language added that the Board must confirm the email addresses every year to ensure that notices are being sent to the correct email account.
- **Licensed Midwives – Retired Licensed Status** – The Board will provide a new provision that will establish a retired licensed status for licensed midwives.

Other Legislation:

- **AB 1548** (Carter) Cosmetic Surgery: Employment of Physicians

This bill is exactly the same as AB 2566 that was vetoed last year. It is sponsored by the American Society of Dermatologic Study (ASDS). The bill would prohibit outpatient cosmetic surgery centers from violating the prohibition of the corporate practice of medicine. Ms. Simoes' recommendation is that the Board takes a support position on this bill.

Ms. Chang made a motion that the Board support AB 1548; s/GnanaDev

Ms. Yaroslavsky called for public comment on this agenda item.

Bryce Docherty, from the American Society for Dermatologic Surgery Association provided public comment for this agenda item. The bill is intended to raise the penalties to go after the corporate entities that are luring in physicians and putting some patients in harm's way. It is believed that this bill gives the tools for a local district to go after unscrupulous corporate behavior. Mr. Docherty requested the Board's support of this bill.

Ms. Yaroslavsky called for the vote. Motion carried.

- **SB 352** (Huff) Chiropractors: Allergies

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

Ms. Simoes provided background on this item for the purposes of analysis. The Board of Chiropractic Examiners (BCE) has drafted regulations relating to the use of cold laser therapy. BCE's 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 including but 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.

Board staff attended the BCE meeting and asked for inclusion of cosmetic procedures in that list. Board staff and others are seeing a lot of advertisements such as Groupon, for laser-lipo, non-surgical facial lifts things of that nature. It is believed that this would clarify to patients the chiropractic scope of practice.

Dr. GnanaDev made a motion to support this bill if amended to specifically list the things that should not be in a chiropractic scope of practice; s/Chang; motion carried.

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- **SB 924** (Price, Walters, and Steinberg) Physical Therapists: Direct Access to Services: Professional Corporations

This bill would add licensed physical therapists to the current list of chiropractors, acupuncturists, naturopathic doctors, occupational therapists, marriage and family therapists and clinical social workers of healing arts practitioners who may be shareholders, officers, directors, or professional employees of a medical or podiatry corporation. This bill would allow a patient to directly access PT services, without being referred by a physician, provided that the treatment is within the scope as long as specified conditions are met. This bill would also require a PT to provide a patient that has directly accessed their PT services to provide a specified written notice, orally and in writing and signed by the patient, before performing PT services.

Ms. Simoes stated that staff suggests an amendment to shorten, or cut in half, the amount of time that a patient can directly see a PT to perhaps 15-30 calendar days or six visits, whichever occurs first.

Ms. Chang made a motion to oppose bill SB 924 unless amended; s/Levine

There was a discussion about the difference of taking an opposed position on a bill versus an opposed unless amended position.

Dr. Levine discussed the policy issue which is under the scope of practice of a physical therapist, their scope does not include making a diagnosis. This direct access to physical therapy is essentially accessing treatment without the establishment of a diagnosis. Much of the time that is probably harmless but from a policy perspective that is exactly what this bill would do. People already have the ability to go to a trainer or massage therapist on their own. The difference of course is insurance coverage. What this bill does is essentially say that physical therapy services for the first 30 days will be covered by insurance in the absence of a diagnosis and that is the policy side. So the choice would be oppose unless amended and the amendment would be to remove the direct access. It is not known if that will happen so alternatively to limit the period of time which patients would have the guarantee of the insurance coverage for the physical therapy visits without the establishment of a diagnosis prior to initiating therapy.

Dr. GnanaDev stated that he does like the position of oppose unless amended. The concern is clearly someone getting "treatment" for 30 calendar days.

Ms. Chang expressed her viewpoint that she would like to see a person go to the doctor first before going to physical therapy.

Ms. Yaroslavsky stated that currently anyone can go for any kind of treatment the issue is with this bill the person could go and have insurance cover it.

Dr. Levine clarified that it is very hard to get a claim paid without a diagnosis. A physical therapists scope of practice does not include diagnosing. In order for there to be a diagnosis, the patient would need to see a physician first. The challenge facing the Board is there is support for half of the bill and it has been married to an issue that is more complex.

Ms. Yaroslavsky called for public comment on this agenda item.

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Ryan Spencer, from the CMA provided public comment. CMA has been one of the most interested stakeholders with this bill and actually started speaking with Senator Steinberg when he opened negotiations early in January to try to come to some type of compromise. CMA does not officially have a position on this bill. There are concerns with the bill just on its face and one thing that needs clarification is if physical therapists are specifically prohibited in law from treating a patient without a diagnosis. This bill will allow them to be treated without a diagnosis. It has nothing really to do with insurance because it is left up to the independent insurance companies to determine if they want to cover their enrollee without a diagnosis or referral. There is actually specific language in the bill that says that this is not an insurance mandate. They are trying to keep that separate from this bill. This is just allowing physical therapists to treat something that they really do not know what they are treating because CMA would argue that PTs do not have the education to perform those treatments. CMA appreciates the comments being offered and can assure that there will be other suggestions that they will be offering the author.

Mr. Spencer continued that there is an ironic part in the bill. CMA understands that there is a legislative desire to take a look at direct access. The CMA is not trying to be obstinate to the idea of direct access, unless there is some type of patient protections involved. Current law does require there to be a diagnosis. This bill removes the word diagnosis completely and just says that as long as there is sign off on the plan of care with an examination.

Mr. Spencer also addressed the employment issue of the bill. One of the parts that the physical therapists wanted included was the establishment of physical therapy corporations which allowed them to employ physicians. They were opposed to physicians employing physical therapists but now suddenly they are okay with it if they have a physical therapy corporation employing physicians.

Ms. Chang stated that she would like the motion to be defined unless amended. She wanted to be sure that doctors look at the patient before the physical therapy.

Ms. Simoes clarified that the key point of the amendment would be to shorten the timeframe before a patient is actually required to see the physician. What staff is suggesting with this amendment is to shorten the timeframe from 15 to 30 calendar days instead of business days or 6 visits whichever occurs first. That would bring the Board to the table to shorten that timeframe.

Ms. Chang removed her motion.

Ms. Chang modified her motion to suggest that direct access to be taken out or provide some kind of alternative greater public protection proposal; s/GnanaDev

Dr. GnanaDev discussed concerns with being protectors of the practice of medicine and condoning the number of times that someone could be seen without a diagnosis.

Ms. Yaroslavsky cautioned that taking an opposed stand on the bill would not be a wise decision. If the public would like to go today to a physical therapist or any kind of health professional, that is what free will is about.

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Dr. Duruisseau voiced concern that the Board should be at the table to have participatory engagement. If there is an additional item in the bill that the Board does not like they can always go back and have a voice. He stated that that not being at the table is problematic for him.

Dr. Levine agreed with Dr. Duruisseau that the Board cutting themselves out of the conversation would be a mistake.

Ms. Chang withdrew her modified motion and made a new motion.

Ms, Chang made a motion to oppose the bill unless it is amended to remove the direct access provisions that allow for direct patient access to PT services without a diagnosis; s/GnanaDev. Ms. Yaroslavsky called for the vote. Motion carried, with Dr. Levine and Ms. Yaroslavsky abstaining.

B. Status of Regulatory Action

Mr. Schunke discussed three bits of good news. The first being the polysomnography regulations have been approved by the Office of Administrative Law and filed with the Secretary of State.

The second item is the disciplinary guideline regulations have been approved and filed with the Secretary of State. Mr. Schunke thanked Susan Cady for doing a tremendous job and her dedication brought this three year project to a close.

The final item is the implementation of regulations for sponsored free healthcare events. This regulation file has been pending at the Department of Finance for almost two and a half months. Information received yesterday confirmed that the regulation packet has finally been approved. The file will be completed with the hope of submitting it in its final format to the Office of Administrative Law (OAL). It is anticipated that a thorough review will be conducted by OAL with identification of some further issues to be addressed. The Board is the first board that has been able to move forward with this regulatory package. This is a new program and concept that has never been reviewed. Once this regulatory package is approved, it will provide better guidance to the other boards which are currently moving forward with their own regulatory packages and it will be an asset to them to use this as an example for the process.

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

Ms. Scuri briefed the Board that in 2011 a bill took effect that allowed sponsored healthcare events to use the services of individuals licensed in another state. It provides a mechanism for registering those sponsoring healthcare entities as well as vetting the qualifications of the licensees from out of state who would be participating. Given that these events usually include multiple types of healthcare providers, dentists, optometrists, physicians, nurses, etc., the Board in its regulations, provides that the Board may delegate to the DCA the authority to register those healthcare entities, not the providers, just the entities. The reason for that inclusion in the regulation was that it made more sense to have one centralized place to say yes or no to registering an entity so there are not contradictory responses from different boards.

Dr. Levine asked for an example of an entity and if this is just the sponsorship of the event.

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Ms. Scuri provided as an example of Care Now, they are usually non-profit entities that put on the health fair or a screening program and upon approval of this regulation would make that delegation to DCA to review and register sponsoring entities.

Dr. Levine made a motion that the Board delegate to the DCA, by formal resolution, the authority to receive and process forms related to the registration of sponsored health care fairs and other sponsored events; s/Bishop

Dr. GnanaDev inquired about who would regulate the providers and if it would be the other states where they hold their licenses.

Ms. Scuri answered that the providers that are not California licensees must go through an approval process with the Board.

Ms. Whitney further clarified that there is a whole process that a provider must go through, including fingerprints in order to provide services at one of these events.

Ms. Yaroslavsky called for the vote. Motion carried.

Agenda Item 25 Discussion and Consideration of Regulatory Proposal to Implement Assembly Bill 1267 (Misdemeanor Conviction-Inactive Licensure)

Mr. Heppler discussed AB 1267 which essentially requires the Board to place an inactive status on a physicians' medical license, also called a certificate, when he or she is incarcerated following the conviction of a misdemeanor.

The issue is when that physician is no longer incarcerated, what are the mechanisms that he or she can provide notice to the Board that he/she is no longer incarcerated. In addition, what would the board display during this previous incarceration on his or her license status. The proposed language on page 113, attempts to answer those two questions. The way that the physician would need to inform the Board, after release from incarceration would require that he or she provide a certified copy of release issued by the local jurisdiction in which he or she was incarcerated. The licensees would provide that by mail or personal service at their option. They could not just call up and provide a verbal notification.

For a physician that is incarcerated on a misdemeanor conviction, the Board website would state: -Inactive Misdemeanor Conviction licensee was convicted of a misdemeanor and is currently incarcerated-no practice is permitted.

Staff is recommending that this be set for regulatory hearing at the next board meeting. Meaning that a statement of reasons would be prepared and a notice to have a public comment period, a written public comment period and also take public comment at that board meeting and then at the conclusion of that the Board could decide whether to proceed with the regulations.

Dr. GnanaDev made a motion that the staff set the proposed regulation of implementing regulations for AB 1267 for hearing at the May 2012 board meeting; s/Duruisseau

Dr. Duruisseau asked for clarification, when licensees send the required information by mail or personal services and is successful in getting their license back, if the website would be updated?

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Mr. Heppler confirmed that the website display would then be corrected to reflect their actual license status. The condition of the bill says within 5 days of receiving that notice, the Board would be obligated to correct or refresh the status on the website.

Ms. Yaroslavsky called for the vote. Motion carried.

Agenda Item 29 Discussion and Consideration of Proposed Chiropractic Regulations Related to the Use of Lasers and Comments Thereto
The Board of Chiropractic Examiners (BCE) attempted to promulgate a regulation regarding the use of lasers by chiropractors.

Staff has met with BCE staff of the Board and offered some comments about what they wanted to do and that comment is on page 152.4: *"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."*

The suggestion of the Board was not well received by the BCE.

Dr. Duruisseau made a motion that the Executive Director 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; s/Chang

Dr. Diego inquired if the BCE is concerned that the Board underscored cosmetic surgery and was it an issue or if there was anything that was said that they do not intend to practice cosmetic surgery.

Ms. Simoes reflected that at the hearing, the BCE members suggested that they already knew cosmetic procedures were not in the chiropractic scope. Ms. Simoes requested that they specifically add it like they had added other things like surgical procedures and laser ablation. They then suggested that cosmetic procedures might be too broad of a term and that the regulations may be returned by the Office of Administrative Law because the Medical Board offered some suggested definitions. The BCE informed Ms. Simoes that this item should be taken back to the Board which is why it is on the agenda.

Ms. Yaroslavsky called for the vote. Motion carried.

Agenda Item 28 Discussion and Consideration of Final Draft Strategic Plan
Ms. Kirchmeyer presented the final draft strategic plan. Edits from the subcommittee had been received and were included in the packets. There were eight items that needed discussion by the Board with decisions that needed to be made on those certain objectives.

Objective 1.1 – This objective is scheduled take about 18 months for completion. The priority of this objective may necessitate it be completed more quickly than 18 months. If so it will be necessary to know that the Board has the resources to complete this earlier than identified.

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Objective 1.2 – This objective would be a prerequisite to Objective 1.1. Both of these objectives have to do with the CME structure and requiring that physicians remain current. It is recommended that Objective 1.1 and Objective 1.2 be reversed so they are better placed in the plan.

Dr. Levine made a motion to change the order of Objective 1.1 and Objective 1.2; s/Duruisseau; motion carried.

Objective 1.4 – This objective states to establish a committee and task force to examine the FSMB Maintenance of Licensure and ABMS Maintenance of Certification.

Dr. Levine made a motion that Objective 1.4 should be under the purview of the licensing committee or a subcommittee of it; s/Duruisseau; motion carried.

Objective 1.6 and Objective 2.5 – Objective 1.6 pertains to conducting a literature review and internal study of the performance of physicians. Objective 2.5 is a study of disciplinary cases to identify trends or issues that may signal dangerous practices or risks.

Dr. Duruisseau made a motion that Objective 1.6 and Objective 2.5 should be moved up from priority C to priority B; s/Salomonson; motion carried.

Objective 2.8 – This objective would add a new activity of communicating to all interested parties, the scope of the Board's authority and what is outside of the Board's authority in order to avoid confusion.

Dr. Levine made a motion on Objective 2.8, adding a new activity to inform and clarify the Board's responsibility to regulate outpatient surgery centers; s/GnanaDev; motion carried.

Objective 3.6 – This objective would add another activity by expanding the newsletter to better inform physicians and medical students.

Dr. Bishop made a motion on Objective 3.6, adding a new activity to evaluate through focus groups and survey instruments how the current newsletter is being utilized by licensees; s/Duruisseau; motion carried.

Objective 5.4 – This objective was a recommendation to conduct an annual review of all the committees established by the Board. The previous day it was recommended that this be changed from an annual review to every other year. Another recommendation that was pointed out is that when a committee is established, there should also be a sunset date placed on them.

Dr. Bishop made a motion on Objective 5.4, to conduct a review every other year of all committees established by the Board and also to place a sunset date on a newly established committee; s/Duruisseau; motion carried.

Objective 6.2 – This objective is to identify issues and areas in which the Board may assist in promoting better public health.

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Dr. Bishop made a motion on Objective 6.2, to identify issues and areas in which the Board may assist in promoting better public health; s/Duruisseau

Ms. Yaroslavsky inquired where this objective came from.

Ms. Kirchmeyer stated that this came from a recommendation from the subcommittee.

Ms. Whitney requested that the Board consider tabling at least this one objective and approving the entire plan with the exception of this objective. The Board could send this item to the Access to Care Committee to be reexamined.

Dr. Duruisseau withdrew the motion.

Dr. Levine made a new motion to take out Objective 6.2 for now; s/Duruisseau; motion carried.

Ms. Whitney asked for confirmation that the Board was okay with the edits that were submitted.

The Board confirmed that they were okay with the edits that were submitted.

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

Ms. Chang and Ms. Yaroslavsky requested that staff be directed to provide information on the feasibility of accessing the National DataBank every two years and bring it forward to the next meeting.

Ms. Yaroslavsky reported that the Board will hear back from staff and the Midwifery Advisory Council regarding the workshop of physician supervision and tests, drugs and devices. The Board will also hear back from the council regarding the candidates who filled the two vacant positions.

Ms. Yaroslavsky also reported that there will also possibly be one regulatory hearing on the scope of practice for physician assistants. There is also an approved pain management summit that will need to be updated on the progress that has been made to co-host that with the State Board of Pharmacy.

The Access to Care Committee and its new shape and format has been tabled and staff is to report back on this issue and their research.

There will be a regulatory hearing on the inactive status for misdemeanor conviction.

Ms. Whitney reported that Dr. GnanaDev has agreed to provide a presentation on the use of hospitalists in medical centers.

Staff is examining the need to revise some of the information on the website regarding medical marijuana, thus this may be ready for a topic for discussion in May.

There is hope to have data finalized on the time it takes other states to process physician applications.

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The Federation of State Medical Boards will be coming to the May meeting to make a presentation on their annual meeting that will be held in April.

Agenda Item 31 Adjournment

There being no further business, Dr. GnanaDev made a motion to adjourn; s/Duruisseau; motion carried.
The meeting was adjourned at 3:27 p.m.

_____
Barbara Yaroslavsky, President

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

_____
Linda K. Whitney, Executive Director

DRAFT

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PHYSICIAN ASSISTANT COMMITTEE
2005 Evergreen Street, Suite 1100, Sacramento, CA 95815
Telephone: 916 561-8780 Fax: 916 263-2671 Website: www.pac.ca.gov

TO: Members
Medical Board of California

FROM: Elberta Portman, Executive Officer
Physician Assistant Committee

DATE: April 9, 2012

SUBJECT: Regulatory Proposal - Title 16, California Code of Regulations Section 1399.541 – Physician Assistants: Medical Services Performable – Personal Presence

The Physician Assistant Committee (PAC) is asking the Medical Board (Board) to amend a regulation that addresses the medical services that can be performed by a physician assistant (PA) and the personal presence of a physician in supervising the PA. The purpose of this proposed regulatory change is to update and clarify PA supervision requirements.

The PAC lacks authority to adopt, amend, or repeal regulations affecting the scope of practice of PAs and supervising physicians. The authority has been granted to the Board by statute.

The background information for the proposal, and the language approved by the PAC, is attached.

The PAC respectfully submits and presents this language for your consideration, and if approved, the PAC is requesting that a regulatory hearing be scheduled at the July, 2012 meeting.

On behalf of the PAC, I wish to thank you for taking this time to consider this important matter.

Attachment(s): Background
Proposed language

REGULATORY PROPOSAL TO AMEND
TITLE 16, CALIFORNIA CODE OF REGULATIONS, SECTION 1399.541

Background Information

In 2005, the Physician Assistant Committee (PAC) requested legal counsel to review and interpret Section 1399.541 of Title 16 of the California Code of Regulations. Specifically, the inquiry related to the term "personal presence", as it was used in subsection (i) of section 1399.541. Subsection (i) of Section 1399.541 relates to the opening and closing of surgical procedures upon a patient under general anesthesia.

The question raised was, "May a physician assistant perform these surgical procedures on a patient under general anesthesia without the personal presence of a supervising physician and surgeon?"

The opinion stated that "No, a physician assistant may not perform opening and closing surgical procedures on a patient under general anesthesia without the personal presence of a supervising physician and surgeon".

In early 2011, this question was raised again by physician assistant licensees and subsequently discussed at the PAC's meeting. The PAC discussed the matter and determined that the best way to respond to this issue was to form the Physician Assistant Personal Presence Subcommittee. The Subcommittee was asked to review the regulation and current PA practice to determine if amendments were appropriate.

The Subcommittee reviewed the current regulation and determined that amendments would be appropriate to update the language so it conforms to current medical standards with regard to this practice.

Legal counsel drafted amendments to Section 1399.541 and the PAC approved the final draft at its February 6, 2012 meeting. The proposed changes include allowing PAs to perform surgical procedures under local anesthesia and general anesthesia.

The PAC lacks authority to adopt, amend or repeal regulations affecting the scope of practice of physician assistants and supervising physicians. This authority has been statutorily granted to the Medical Board of California.

Action Requested:

The PAC requests that a regulatory hearing be scheduled at the July, 2012 meeting of the Medical Board.

Physician Assistant Committee

Draft Proposed Amendments

"Physician Assistants: Medical Services Performable – Personal Presence"

LEGEND: Single Underline represents language being added. ~~Strikeout~~ represents language being deleted. This modified language was approved by the Physician Assistant Committee at the February 6, 2012 meeting.

Section 1399.541 is amended to read:

1399.541. Because physician assistant practice is directed by a supervising physician, and a physician assistant acts as an agent for that physician, the orders given and tasks performed by a physician assistant shall be considered the same as if they had been given and performed by the supervising physician. Unless otherwise specified in these regulations or in the delegation or protocols, these orders may be initiated without the prior patient specific order of the supervising physician. In any setting, including for example, any licensed health facility, out-patient settings, patients' residences, residential facilities, and hospices, as applicable, a physician assistant may, pursuant to a delegation of services of agreement executed pursuant to subdivision (b) of section 1399.540 and protocols where present:

(a) Take a patient history; perform a physical examination and make an assessment and diagnosis therefrom; initiate, review and revise treatment and therapy plans including plans for those services described in Section 1399.541(b) through Section 1399.541(i) inclusive; and record and present pertinent data in a manner meaningful to the physician.

(b) Order or transmit an order for x-ray, other studies, therapeutic diets, physical therapy, occupational therapy, respiratory therapy, and nursing services.

(c) Order, transmit an order for, perform, or assist in the performance of laboratory procedures, screening procedures and therapeutic procedures.

(d) Recognize and evaluate situations which call for immediate attention of a physician and institute, when necessary, treatment procedures essential for the life of the patient.

(e) Instruct and counsel patients regarding matters pertaining to their physical and mental health. Counseling may include topics such as medications, diets, social habits, family planning, normal growth and development, aging, and understanding of and long-term management of their diseases.

(f) Initiate arrangements for admissions, complete forms and charts pertinent to the patient's medical record, and provide services to patients requiring continuing care, including patients at home.

(g) Initiate and facilitate the referral of patients to the appropriate health facilities, agencies, and resources of the community.

(h) Administer or provide medication to a patient, or issue or transmit drug orders orally or in writing in accordance with the provisions of subdivisions (a)-(f), inclusive, of Section 3502.1 of the Code.

(i) (1) Perform surgical procedures as follows:

(A) ~~l~~Local ~~a~~Anesthesia. A physician assistant may perform those procedures customarily performed under local anesthesia without the physical ~~personal~~ presence of the supervising physician. ~~which are customarily performed under local anesthesia.~~

(B) General Anesthesia. A physician assistant may perform surgical procedures, including the closure of surgical wounds to all layers of the skin and fascia, upon a patient sedated to a level of general anesthesia without the physical presence of a supervising physician and surgeon in the operating room or suite provided that the supervising physician and surgeon is immediately available and the licensed health care practitioner administering the anesthetic(s) is physically present in the operating room. For the purposes of this section, "immediately available" means that the supervising physician and surgeon remains located on the same floor and within the same operating complex in the event assistance is requested.

Prior to delegating any such surgical procedures, the supervising physician shall review documentation which indicates that the physician assistant is trained and competent to perform the surgical procedures. ~~All other surgical procedures requiring other forms of anesthesia may be performed by a physician assistant only in the personal presence of an approved supervising physician.~~

(2) A physician assistant may also act as first or second assistant in surgery under the supervision of an approved supervising physician.

NOTE: Authority cited: Sections 2018, 3502 and 3510, Business and Professions Code. Reference: Sections 2058 and 3502, Business and Professions Code.

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MEMORANDUM

DATE	April 16, 2012
TO	Board Members Medical Board of California
FROM	Curtis Worden Chief of Licensing
SUBJECT	**HEALTH CARE FAIR**

This regulatory package is once again before you. You will recall that the Board previously approved these regulations which will implement the provisions of section 901 of the Business and Professions Code, relating to sponsored health care events, aka health care fairs.

The proposed regulations were disapproved by the Office of Administrative Law for reasons relating to the clarity of the registration forms. Board staff met with OAL and the Department of Consumer Affairs to make the appropriate revisions to the forms and supporting documents. The Board has circulated the revised text for the required fifteen days and as of the date of this memorandum, has received no comments.

Staff Recommendation:

To approve these revisions and authorize the Executive Director to complete the rulemaking file and to request the regulation be effective immediately upon filing with the Secretary of State.

AVAILABILITY OF SECOND MODIFIED TEXT and DOCUMENT RELIED UPON

NOTICE IS HEREBY GIVEN that the Medical Board of California has proposed modifications to the text of sections 1333, 1333.1, 1333.2 and 1333.3 in Title 16 California Code of Regulations and forms incorporated by reference therein. This regulatory proposal was the subject of a regulatory hearing on May 6, 2011. A copy of the modified text is enclosed.

NOTICE IS ALSO GIVEN that the following document relied upon is being added to the rulemaking record for the regulatory proceeding concerning sections 1333, 1333.1, 1333.2 and 1333.3 of Title 16 of the California Code of Regulations:

1. Application Fee Justification

The above document is now available for public inspection and/or comment until April 25, 2012 at the location mentioned below during the hours of 8:00 a.m. to 5:00 p.m. Monday through Friday, except state holidays.

Any person who wishes to comment on the proposed modifications or the document relied upon may do so by submitting written comments on or before April 25, 2012 to the following:

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

DATED: April 10, 2012

MEDICAL BOARD OF CALIFORNIA

SECOND MODIFIED TEXT

Changes to the First Modified Text, made available to the public June 16, 2011 through July 5, 2011 are shown by double underline for new text and underline with strikeout for deleted text.

Add Article 9.1, commencing with Section 1333, in Chapter 1 of Division 13 of Title 16, Cal. Code Regs., to read as follows:

Article 9.1.
Sponsored Free Health Care Events—Requirements for Exemption.

§1333. Definitions.

For the purposes of section 901 of the code:

(a) "Community-based organization" means a public or private nonprofit organization that is representative of a community or a significant segment of a community, and is engaged in meeting human, educational, environmental, or public safety community needs.

(b) "Out-of-state practitioner" means a person who is not licensed in California to engage in the practice of medicine but who holds a current valid license or certificate in good standing in another state, district, or territory of the United States to practice medicine.

NOTE: Authority cited: Sections 901 and 2018, Business and Professions Code. Reference: Section 901, Business and Professions Code.

§1333.1. Sponsoring Entity Registration and Recordkeeping Requirements.

(a) Registration. A sponsoring entity that wishes to provide, or arrange for the provision of, health care services at a sponsored event under section 901 of the code shall register with the board not later than 90 calendar days prior to the date on which the sponsored event is scheduled to begin. A sponsoring entity shall register with the board by submitting to the board a completed "Registration of Sponsoring Entity under Business & Professions Code Section 901," Form 901-A (~~MBC~~ DCA/2011), which is hereby incorporated by reference.

(b) Determination of Completeness of Form. The board may, by resolution, delegate to the Department of Consumer Affairs the authority to receive and process the "Registration of Sponsoring Entity under Business & Professions Code Section 901," Form 901-A (~~MBC~~ DCA/2011) on behalf of the board. The board or its delegatee shall inform the sponsoring entity in writing within 15 calendar days of receipt of the form that the form is either complete and the sponsoring entity is registered or that the form is deficient and what specific information or documentation is required to complete the form and be registered. The board or its delegatee shall reject the registration if all of the identified deficiencies have not been corrected at least 30 days prior to the commencement of the sponsored event.

(c) Recordkeeping Requirements. Regardless of where it is located, a sponsoring entity shall maintain at a physical location in California a copy of all records required by section 901 as well as a copy of the authorization for participation issued by the board to an out-of-state practitioner. The sponsoring entity shall maintain these records for a period of at least five years after the date on which a sponsored event ended. The records may be maintained in either paper or electronic form. The sponsoring entity shall notify the board at the time of registration as to the form in which it will maintain the records. In addition, the sponsoring entity shall keep a copy of all records required by section 901(g) of the code at the physical location of the sponsored event until that event has ended. These records shall be available for inspection and copying during the operating hours of the sponsored event upon request of any representative of the board.

(d) A sponsoring entity shall place a notice visible to patients at every station where patients are being seen by a physician and surgeon. The notice shall be in at least 48-point type in Arial font and shall include the following statement and information:

NOTICE

Medical doctors providing health care services at this health fair are either licensed and regulated by the Medical Board of California or hold a current valid license from another state and have been authorized to provide health care services in California only at this specific health fair.

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www.mbc.ca.gov

(e) Requirement for Prior Board Approval of Out-of-State Practitioner. A sponsoring entity shall not permit an out-of-state practitioner to participate in a

sponsored event unless and until the sponsoring entity has received written approval of such practitioner from the board.

(f) Report. Within 15 calendar days after a sponsored event has concluded, the sponsoring entity shall file a report with the board summarizing the details of the sponsored event. This report may be in a form of the sponsoring entity's choosing, but shall include, at a minimum, the following information:

(1) The date(s) of the sponsored event;

(2) The location(s) of the sponsored event;

(3) The type(s) and general description of all health care services provided at the sponsored event; and

(4) A list of each out-of-state practitioner granted authorization pursuant to this article who participated in the sponsored event, along with the license number of that practitioner.

NOTE: Authority cited: Sections 901 and 2018, Business and Professions Code. Reference: Section 901, Business and Professions Code.

§ 1333.2. Out-of-State Practitioner Authorization to Participate in Sponsored Event.

(a) Request for Authorization to Participate. An out-of-state practitioner ("applicant") may request authorization from the board to participate in a sponsored event and provide such health care services at the sponsored event as would be permitted if the applicant were licensed by the board to provide those services. Authorization must be obtained for each sponsored event in which the applicant seeks to participate.

(1) An applicant shall request authorization by submitting to the board a completed "Request for Authorization to Practice Without a California License at a Sponsored Free Health Care Event," Form 901-B (MBC/2011), which is hereby incorporated by reference, accompanied by a non-refundable, non-transferable processing fee of $25.

(2) The applicant also shall furnish either a full set of fingerprints or submit a Live Scan inquiry to establish the identity of the applicant and to permit the board to conduct a criminal history record check. The applicant shall pay any costs for furnishing the fingerprints and conducting the criminal history record check. This requirement shall apply only to the first application for authorization that is submitted by the applicant.

(b) Response to Request for Authorization to Participate. Within 20 calendar days of receiving a completed request for authorization, the board shall notify the sponsoring entity or local government entity whether that request is approved or denied.

(c) Denial of Request for Authorization to Participate.

(1) The board shall deny a request for authorization to participate if:

(A) The submitted form is incomplete and the applicant has not responded within 7 calendar days to the board's request for additional information; or

(B) The applicant has not graduated from a medical school approved or recognized by the board; or

(C) The applicant has failed to comply with a requirement of this article or has committed any act that would constitute grounds for denial of an application for licensure by the board; or

(D) The applicant does not possess a current valid active license in good standing. The term "good standing" means the applicant:

1. Has not been charged with an offense for any act substantially related to the practice for which the applicant is licensed by any public agency;
2. Has not entered into any consent agreement or been subject to an administrative decision that contains conditions placed upon the applicant's professional conduct or practice, including any voluntary surrender of license; and
3. Has not been the subject of an adverse judgment resulting from the practice for which the applicant is licensed that the board determines constitutes evidence of a pattern of negligence or incompetence.

(E) The board has been unable to obtain a timely report of the results of the criminal history check.

~~The term "good standing" means the applicant:~~

~~(i) Has not been charged with an offense for any act substantially related to the practice for which the applicant is licensed by any public agency;~~
~~(ii) Has not entered into any consent agreement or been subject to an administrative decision that contains conditions placed upon the applicant's professional conduct or practice, including any voluntary surrender of license;~~
~~(iii) Has not been the subject of an adverse judgment resulting from the practice for which the applicant is licensed that the board determines constitutes evidence of a pattern or negligence or incompetence.~~

(2) The board may deny a request for authorization to participate if:

(A) The request is received less than 20 calendars days before the date on which the sponsored event will begin; or

(B) The applicant has been previously denied a request for authorization by the board to participate in a sponsored event; or

(C) The applicant has previously had an authorization to participate in a sponsored event terminated by the board.

(d) Appeal of Denial. An applicant requesting authorization to participate in a sponsored event may appeal the denial of such request by following the procedures set forth in section 1333.3(d).

(e) An out-of-state practitioner who receives authorization to practice medicine at an event sponsored by a local government entity shall place a notice visible to patients at every station at which that person will be seeing patients. The notice shall be in at least 48-point type in Arial font and shall include the following statement and information:

NOTICE

I hold a current valid license to practice medicine in a state other than California. I have been authorized by the Medical Board of California to provide health care services in California only at this specific health fair.

Medical Board of California
(800) 633-2322
www.mbc.ca.gov

NOTE: Authority cited: Sections 144, 901, and 2018, Business and Professions Code. Reference: Section 901, Business and Professions Code.

§1333.3. Termination of Authorization and Appeal.

(a) Grounds for Termination. The board may terminate an out-of-state practitioner's authorization to participate in a sponsored event for any of the following reasons:

(1) The out-of-state practitioner has failed to comply with any applicable provision of this article, or any applicable practice requirement or regulation of the board.

(2) The out-of-state practitioner has committed an act that would constitute grounds for discipline if done by a licensee of the board.

(3) The board has received a credible complaint indicating that the out-of-state practitioner is unfit to practice at the sponsored event or has otherwise endangered consumers of the practitioner's services.

(b) Notice of Termination. The board shall provide both the sponsoring entity or local government entity and the out-of-state practitioner with a written notice of the termination, including the basis for the termination. If the written notice is provided during a sponsored event, the board may provide the notice to any representative of the sponsored event on the premises of the event.

(c) Consequences of Termination. An out-of-state practitioner shall immediately cease his or her participation in a sponsored event upon receipt of the written notice of termination.

Termination of authority to participate in a sponsored event shall be deemed a disciplinary measure reportable to the national practitioner data banks. In addition, the board shall provide a copy of the written notice of termination to the licensing authority of each jurisdiction in which the out-of-state practitioner is licensed.

(d) Appeal of Termination. An out-of-state practitioner may appeal the board's decision to terminate an authorization in the manner provided by section 901(j)(2) of the code. The request for an appeal shall be considered a request for an informal hearing under the Administrative Procedure Act.

(e) Informal Conference Option. In addition to requesting a hearing, the out-of-state practitioner may request an informal conference with the executive officer regarding the reasons for the termination of authorization to participate. The executive officer shall, within 30 days from receipt of the request, hold an

informal conference with the out-of-state practitioner. At the conclusion of the informal conference, the Executive Director or his/her designee may affirm or dismiss the termination of authorization to participate. The executive officer shall state in writing the reasons for his or her action and mail a copy of his or her findings and decision to the out-of-state practitioner within ten days from the date of the informal conference. The out-of-state practitioner does not waive his or her request for a hearing to contest a termination of authorization by requesting an informal conference. If the termination is dismissed after the informal conference, the request for a hearing shall be deemed to be withdrawn.

NOTE: Authority cited: Sections 901 and 2018, Business and Professions Code. Reference: Section 901, Business and Professions Code.

SPONSORED FREE HEALTH CARE EVENTS

REGISTRATION OF SPONSORING ENTITY UNDER BUSINESS & PROFESSIONS CODE SECTION 901

In accordance with California Business and Professions Code Section 901(d), a non-government organization administering an event to provide health care services to uninsured and underinsured individuals at no cost may include participation by certain health care practitioners licensed outside of California if the organization registers with the California licensing authorities having jurisdiction over those professions. This form shall be completed and submitted by the sponsoring organization **at least 90 calendar days prior to the sponsored event**. *Note that the information required by Business and Professions Code Section 901(d) must also be provided to the county health department having jurisdiction in each county in which the sponsored event will take place.*

~~[Only one form (per event) should be completed and submitted to the Department of Consumer Affairs. The Department of Consumer Affairs will forward a copy of the completed registration form to each of the licensing authorities indicated on this form.]~~

PART 1 – ORGANIZATIONAL INFORMATION

1. Organization Name: _____

2. Organization Contact Information (*use principal office address*):

Address Line 1	Phone Number of Principal Office
Address Line 2	Alternate Phone
City, State, Zip	Website
County	

Organization Contact Information in California (*if different*):

Address Line 1	Phone Number
Address Line 2	Alternate Phone
City, State, Zip	
County	

3. Type of Organization:

Is the organization operating pursuant to Section 501(c)(3) of the Internal Revenue Code? ____ Yes ____ No

If not, is the organization a community-based organization*?
____ Yes ____ No

Organization's Tax Identification Number _____

If a community-based organization, please describe the mission, goals and activities of the organization (*attach separate sheet(s) if necessary*): _____

_____
_____
_____
_____
_____
_____

* A "community based organization" means a public or private nonprofit organization that is representative of a community or a significant segment of a community, and is engaged in meeting human, educational, environmental, or public safety community needs.

PART 2 – RESPONSIBLE ORGANIZATION OFFICIALS

Please list the following information for each of the principal individual(s) who are the officers or officials of the organization responsible for operation of the sponsoring entity.

Individual 1:

Name	Title
Address Line 1	Phone
Address Line 2	Alternate Phone.
City, State, Zip	E-mail address
County	

Individual 2:

Name	Title
Address Line 1	Phone
Address Line 2	Alternate Phone
City, State, Zip	E-mail address
County	

Individual 3:

Name	Title
Address Line 1	Phone
Address Line 2	Alternate Phone
City, State, Zip	E-mail address
County	

(Attach additional sheets if needed to list additional principal organizational individuals)

PART 3 – EVENT DETAILS

1. Name of event, if any: _____

2. Date(s) of event (not to exceed ten calendar days): _____

3. Location(s) of the event (be as specific as possible, including address):

_____
_____
_____
_____

4. Describe the intended event, including a list of all types of healthcare services intended to be provided (*attach additional sheet(s) if necessary*): _____

_____
_____
_____
_____
_____
_____

5. Attach a list of all out-of-state health care practitioners who you currently believe intend to apply for authorization to participate in the event. The list should include the name, profession, and state of licensure of each identified individual.

___ *Check here to indicate that list is attached.*

~~6. Please check each licensing authority that will have jurisdiction over an out-of-state licensed health practitioner who intends to participate in the event:~~

~~___ Acupuncture Board~~
~~___ Board of Behavioral Sciences~~
~~___ Board of Chiropractic Examiners~~
~~___ Dental Board~~
~~___ Dental Hygiene Committee~~
~~___ Physician Assistant Committee~~
~~___ Physical Therapy Board~~
~~___ Board of Podiatric Medicine~~
~~___ Board of Psychology~~
~~___ Board of Registered Nursing~~

___ ~~Medical Board of California~~
___ ~~Naturopathic Medicine Committee~~
___ ~~Board of Occupational Therapy~~
___ ~~Board of Optometry~~
___ ~~Osteopathic Medical Board~~
___ ~~Board of Pharmacy~~
___ ~~Respiratory Care Board~~
___ ~~Speech-Language Pathology, Audiology & Hearing Aid Dispensers Board~~
___ ~~Veterinary Medical Board~~
___ ~~Board of Vocational Nursing & Psychiatric Technicians~~
___ ~~Other~~

Note:

- Each individual out-of-state practitioner must request authorization to participate in the event by submitting an application (Form 901-B) to the applicable licensing Board/Committee.
- The organization will be notified in writing whether authorization for an individual out-of-state practitioner has been granted.

This form, any attachments, and all related questions shall be submitted to:

Department of Consumer Affairs
Attn: Sponsored Free Health Care Events
1625 North Market Blvd.
Sacramento, CA 95834

- I understand that I must maintain records in either electronic or paper form both at the sponsored event and for five (5) years in California, per the recordkeeping requirements imposed by California Business and Professions Code Section 901 and the applicable sections of Title 16, California Code of Regulations for the ~~agencies listed~~ regulatory bodies with jurisdiction over the practice to be engaged in by out-of-state practitioners.
- I understand that our organization must file a report with each applicable board/committee within fifteen (15) calendar days of the completion of the event.

I certify under penalty of perjury under the laws of the State of California that the information provided on this form and any attachments is true and current and that I am authorized to sign this form on behalf of the organization:

Name Printed	Title
Signature	Date

PERSONAL INFORMATION COLLECTION, ACCESS AND DISCLOSURE

Disclosure of your personal information is mandatory. The information on this form is required pursuant to Business and Professions Code section 901. Failure to provide any of the required information will result in the form being rejected as incomplete. The information provided will be used to determine compliance with the requirements promulgated pursuant to Business and Professions Code section 901. The information collected may be transferred to other governmental and enforcement agencies. Individuals have a right of access to records containing personal information pertaining to that individual that are maintained by the applicable Board or Committee, unless the records are exempted from disclosure by section 1798.40 of the Civil Code. An individual may obtain information regarding the location of his or her records by contacting the Deputy Director of the Legislative and Policy Review Division at the address and telephone number listed above.

MEDICAL BOARD OF CALIFORNIA
Licensing Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(916) 263-2389 Fax (916) 263-2487

REQUEST FOR AUTHORIZATION TO PRACTICE WITHOUT A CALIFORNIA LICENSE AT A SPONSORED FREE HEALTH CARE EVENT

In accordance with California Business and Professions Code Section 901 any physician and surgeon licensed and in good standing in another state, district, or territory in the United States may request authorization from the Medical Board of California (Board) to participate in a free health care event offered by a local government entity or a sponsoring entity, registered with the Board pursuant to Section 901, for a period not to exceed ten (10) days.

PART 1 - APPLICATION INSTRUCTIONS

An application must be complete and must be accompanied by all of the following:

- A processing fee of $25, made payable to the board.
- A copy of each valid, current active license and/or certificate authorizing the applicant to engage in the practice of medicine issued by any state, district, or territory of the United States.
- A copy of a valid photo identification of the applicant issued by one of the jurisdictions in which the applicant holds a license or certificate to practice.
- A full set of fingerprints or a Live Scan inquiry. This will be used to establish your identity and to conduct a criminal history record check. The applicant shall pay any costs for furnishing the fingerprints and conducting the criminal history record check. However, this requirement shall apply only to the first application for authorization that you submit.
- Educational records to prove you graduated from a medical school that is approved or recognized by the board.

The board will not grant authorization until this form has been completed in its entirety, all required enclosures have been received by the board, and any additional information requested by the Board has been provided by the applicant and reviewed by the board, and a determination made to grant authorization.

The board shall process this request and notify the sponsoring entity or the local government entity listed on this form whether the request is approved or denied within 20 calendar days of receipt. If the board requires additional or clarifying information, the board will contact you directly, but **written approval or denial of requests will be provided directly to the sponsoring entity or local government entity**. It is the applicant's responsibility to maintain contact with the sponsoring entity or the local government entity.

PART 2 – GENERAL INFORMATION*

1. Applicant Name: _____
First Middle Last

2. U.S. Social Security Number*: _____ - _____ - _____ Date of Birth: _____

3. Applicant's Contact Information:

Address Line 1	Phone
Address Line 2	Alternate Phone
City, State, Zip	E-mail address

4. Applicant's Employer: _____

Employer's Contact Information:

Address Line 1	Phone
Address Line 2	Facsimile
City, State, Zip	E-mail address (if available)

5. Name and Location of Medical School from which Applicant Graduated:

_____

***The information provided on this application is maintained by the Executive Director of the Medical Board of California, 2005 Evergreen Street, Suite 1200, Sacramento, California 95815, pursuant to Business and Professions Code § 901. It is mandatory that you provide all information requested. Omission of any item of information will result in the application being rejected as incomplete. The information provided will be used to determine compliance with the requirements of Section 901 and may be transferred to other governmental and enforcement agencies.**

You have the right to review the records maintained on you by the board unless the records are exempt from disclosure. You may gain access to the information by contacting the board at the above address.

PART 3 – LICENSURE INFORMATION

1. Do you hold a valid, current active license in good standing issued by a state, district, or territory of the United States authorizing the unrestricted practice of medicine in your jurisdiction(s)? The term "good standing" means you:

- Have not been charged with an offense for any act substantially related to the practice for which the applicant is licensed by any public agency;
- Have not entered into any consent agreement or been subject to an administrative decision that contains conditions placed upon the applicant's professional conduct or practice, including any voluntary surrender of license; and
- Have not been the subject of an adverse judgment resulting from the practice for which the applicant is licensed that the board determines constitutes evidence of a pattern ~~or~~ of negligence or incompetence.

No ☐ If no, you are not eligible to participate as an out-of-state practitioner in the sponsored event.

Yes ☐ If yes, ~~in the chart on the top of the next page~~ in the following chart, list every license, certificate, and registration authorizing you to engage in the practice of medicine in the following table. If there are not enough boxes to include all the relevant information please attach an addendum to this form. Please also attach a copy of each of your current licenses, certificates, and registrations.

State/ Jurisdiction	Issuing Agency/Authority	License Number	Expiration Date

2. Have you ever had a license to practice medicine revoked or suspended?
___ Yes ___ No

3. Have you ever been subject to any disciplinary action or proceeding by a licensing body?
___ Yes ___ No

4. Have you ever committed any act or been convicted of a crime constituting grounds for denial of licensure?
___ Yes ___ No

5. If you answered "Yes" to any of questions 2 – 4, above, please explain (*attach additional page(s) if necessary*): _____

PART 4 – SPONSORED EVENT

1. Name and address of local government entity, non-profit, or community-based organization hosting the free healthcare event (the "sponsoring entity"): _____

2. Name of event: _____

3. Date(s) & location(s) of the event: _____

_____

4. Date(s) & location(s) applicant will be performing healthcare services (if different):

_____

_____

5. Please specify the healthcare services you intend to provide: _____

_____

_____

_____

6. Name and phone number of contact person with sponsoring entity or local government entity:

_____

_____

PART 5 – ACKNOWLEDGMENT/CERTIFICATION

I, the undersigned, declare under penalty of perjury under the laws of the State of California and acknowledge that:

- I have not committed any act or been convicted of a crime constituting grounds for denial of licensure by the board.
- I am in good standing with the licensing authority or authorities of all jurisdictions in which I hold licensure and/or certification to practice medicine.

- I am responsible for knowing and will comply with all applicable practice requirements required of licensed physician and surgeons and all regulations of the Board.

- In accordance with Business and Professions Code Section 901(i), I will only practice within the scope of practice for California-licensed physicians and surgeons.

- I will provide the services authorized by this request and Business and Professions Code Section 901 to uninsured and underinsured persons only and shall receive no compensation for such services.

- I will provide the services authorized by this request and Business and Professions Code Section 901 only in association with the sponsoring entity or local government entity listed herein and only on the dates and at the locations listed herein for a period not to exceed 10 calendar days.

- I must post the notice required by 16 CCR 1333.2 if the event is sponsored by a local government entity.

- Practice of a regulated profession in California without proper licensure and/or authorization may subject me to potential criminal penalties.

- The Board may notify the licensing authority of my home jurisdiction and/or other appropriate law enforcement authorities of any potential grounds for discipline associated with my participation in the sponsored event.

- All information provided by me in this application is true and complete. By submitting this application and signing below, I am granting permission to the Board to verify the information provided and to perform any investigation pertaining to the information I have provided as the board deems necessary.

_____ _____

Signature Date

_____

Printed Name

AGENDA ITEM 10

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	May 3, 2012
ATTENTION:	Members, Medical Board of California
SUBJECT:	Strategic Plan Update
STAFF CONTACT:	Kimberly Kirchmeyer, Deputy Director

RECOMMENDED ACTION:

Review the updates and status on each Objective to determine how the Board is meeting the goals of the Strategic Plan.

BACKGROUND AND ANALYSIS:

At the February 3rd, 2012 Meeting, the Board voted to approve the Strategic Plan in its entirety. Upon approval, the plan was provided to the Board Members and posted on the Board's Web site.

Board staff met and reviewed the plan in order to identify work plans, update the objectives that are being completed, and ensure that deadlines and goals will be met as scheduled. In order to keep the Members informed on the status of the Strategic Plan, it has been updated to identify the status of each of the Objectives to date. Attached is the updated Plan, which includes a status on each item that has a current or past due date.

Please be aware that if the Objective did not have a current or past due date it has not been included in the attached document. These Objectives will be part of the update as their dates become due.

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

Goal 1: Professional Qualifications: Promote the professional qualifications of medical practitioners by setting requirements for education, experience, and examination.

Objective 1.1: Examine current continuing medical education (CME) structure, its effectiveness, the current California requirements, and opportunities for improvement.

Activity	Date	Staff	Priority	STATUS
• Provide annual CME audit statistics to the Medical Board members.	Winter 2012	Licensing	A	5/3/12 - Due to Licensing Manager vacancy these statistics have been deferred to the July 2012 Board meeting.
• 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 Accreditation Council for Continuing Medical Education (ACCME), the Institute for Medical Quality (IMQ), or the American Board of Medical Specialties (ABMS) Boards and their member societies] to educate the members on how requirements have changed, what is required for course accreditation, and what is done to ensure compliance. If needed, revise the paper written in 2009, and distribute.	Spring 2012	Licensing	A	5/3/12 - Due to Licensing Manager vacancy, this presentation has been deferred to the July 2012 Board meeting.
• Examine current CME environment 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	

Objective 1.1 (cont.): Examine current continuing medical education (CME) structure, its effectiveness, the current California requirements, and opportunities for improvement.

• Examine how CME requirements may relate to the Federation of State Medical Board's (FSMB) Maintenance of Licensure (MOL) initiative. (See objective 1.4)	Winter 2012-13	Licensing	B	5/3/12 - The FSMB will be making a presentation at the May 2012 Board meeting regarding MOL and discussion will ensue at future Board meetings.
• 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	Status
• Conduct a review of current data, including the ongoing work of the FSMB, to determine what physicians re-entering practice after long absences need/require prior to resuming clinical practice.	Spring 2012	Licensing	B	5/3/12 - The FSMB will be making a presentation at the May 2012 Board meeting regarding physician re-entry and discussion will ensue at future Board meetings.
• Determine what the Board's role should 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: The Licensing Committee (or subcommittee) will examine the FSMB Maintenance of Licensure (MOL) and ABMS Maintenance of Certification (MOC) initiatives and study what should be adopted in California, and determine how it can collaborate with the FSMB and ABMS certifying boards.

Activity	Date*	Staff	Priority	Status
• Appoint a subcommittee to evaluate the FSMB MOL Initiative and determine what is feasible in California.	Fall 2012	Licensing	B	5/3/12 - The FSMB will be making a presentation at the May 2012 Board meeting regarding MOL and discussion will ensue at future Board meetings.
• 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 published sufficient data from their MOL pilot programs.**

Objective 1.5: Conduct a comprehensive review of international schools.

Activity	Date*	Staff	Priority	Status
• Establish a working task force including the Chief of Licensing and an experienced Medical Consultant.	Winter 2012	Licensing	A	5/3/12 – Completed. The Chief of Licensing has established a task force.
• 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	5/3/12 – Due to the lack of staff in the Licensing Program and the travel restrictions this presentation has been deferred to July 2012 Board meeting.
• Staff to present a complete overview of the California Code of Regulations and educate the Board on the extent and limits of its legal authority.	Fall 2011	Licensing	A	5/3/12 – Completed. A presentation was conducted at the October 27, 2011 Board Meeting. The presentation can be viewed at http://www.dca.ca.gov/publications/multimedia/mbc_20111027a.wmv
• Identify those schools that may need site visits or additional information.	Summer 2012-Winter 2014	Licensing	A	5/3/12 - At the July 2012 Board meeting the Licensing Program will present a plan for review.
• 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, identify ways to expedite the approval process, and determine if application fees cover the Board's cost.	Winter 2012-Summer 2012	Licensing	A	5/3/12 - Due to the lack of staff in the Licensing Program, this review and update has been delayed until Summer 2012 – Fall 2012.

*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.

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	Status
• Staff will 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	Legislative/ Licensing	A	5/3/12 - The Chief of Legislation and Chief of Licensing developed a licensing staff task force and held an introductory meeting to discuss the process for reviewing the laws and regulations. A timeline will be established and presented at future meetings.
• Schedule interested parties meetings by legal topic and statute/regulation under analysis.	Summer 2012 - Winter 2015	Legislative/ 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, proposals will be taken to the full Board for regulations to be promulgated and legislation sought.	Summer 2012 - Winter 2015	Legislative/ Licensing	A	
• As appropriate, develop and promulgate regulations; develop and seek legislation.	Various 2013-15	Legislative/ Licensing	B	

Objective 2.2: Develop a plan to conduct a complete review of all laws and regulations relating to enforcement. Identify those laws /regulations 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	Status
• Staff will 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	Legislative/ Enforcement	A	5/3/12 - The Chief of Legislation and Chief of Enforcement developed an enforcement staff task force and held an introductory meeting to discuss the process for reviewing the laws and regulations. A timeline will be established and presented at future meetings.
• Schedule interested parties meetings by legal topic and statute/regulation under analysis.	Summer 2012 - Winter 2015	Legislative/ 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, proposals will be taken to the full Board for regulations to be promulgated and legislation sought.	Summer 2012 - Winter 2015	Legislative/ Enforcement	A	
• As appropriate, develop and promulgate regulations; develop and seek legislation.	Various 2012- 15	Legislative/ Enforcement	B	

Objective 2.3: Conduct a review of the Vertical Enforcement/Prosecution (VEP) 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	Status
• Initiate a review of the VEP performance data.	Summer 2011	Enforcement	A	5/3/12 –In October 2011 a task force was established to review the Board's enforcement data. This task force, made up of a Board Member, the AG's office, and staff, will provide quarterly reports of their findings to the Enforcement Committee.
• Begin to conduct 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	Enforcement	A	5/3/12 – The review of the enforcement data by the task force has begun. However, the task force is awaiting further data from the Attorney General's Office so a comparative review can be performed.
• Begin to conduct a statistical analysis of the enforcement timelines to indentify which steps may be delaying the process.	Summer 2011	Enforcement	A	5/3/12 – See notes above – a task force has been established and it has begun to look at the timelines. The task force has identified the length of time it takes for the Central Complaint Unit expert review as an issue and steps are being performed to improve this delay.
• Compare the California process to other states' and other California licensing Boards, including those handled by the Attorney General's (AG) licensing section rather than Health Quality Enforcement Section (HQES). (As an example, how default decisions are handled.)	Summer 2011- Fall 2012	Enforcement	A	5/3/12 – Board staff have begun to look at other states' processes by reviewing information from the FSMB. Staff will also be looking at other California agencies' processes.

Objective 2.3 (cont.): Conduct a review of the Vertical Enforcement/Prosecution (VEP) model to assure uniform implementation in all offices and identify any aspects of the model that are increasing cost without producing benefits.

• 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.	Fall 2012	Enforcement	A	
• Depending upon findings and within budgetary restraints, amend policies and procedures, promulgate regulations, or seek legislation.	Fall 2012	Enforcement	A	

Objective 2.4: Examine complaint handling priorities. Educate Board 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	Status
• Educate the Board members on the current policy and legislative priorities in complaint handling.	Winter 2012	Enforcement	A	5/3/12 – A presentation will be made at the July 2012 Board meeting.
• Review and evaluate the complaints and their relation to physician disciplinary action.	Winter – Summer 2012	Enforcement	A	5/3/12 – The presentation above will include information obtained by the Department of Consumer Affairs' Internal Audits Office during their review of the Central Complaint Unit and its processing/complaint prioritization.
• Present a report on review of complaint handling, including whether current priorities are congruent with public safety or what 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	Legislative/ Enforcement	A	

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	Status
• Evaluate, revise, and update the training program and materials for experts.	Fall 2011	Enforcement	A	5/3/12 – The Enforcement Program has established a new Expert Reviewer Training Program, which will provide CME to the experts attending. At the February 2012 Enforcement Committee meeting a presentation on the components of this new training was provided.
• Educate the Board as to the current policies, laws, and regulations governing the Expert Reviewer program.	Winter 2012	Enforcement	A	5/3/12 - At the February 2012 Enforcement Committee meeting a presentation on the components of the new Expert Reviewer Training Program was provided. Further discussion will be provided to Members at future meetings.
• Examine the training and evaluation measures, as well as policies to identify problem areas and those that should be amended.	Spring 2012	Enforcement	A	5/3/12 - Board staff will provide the new training program to the Northern California Expert Reviewers in May 2012. Board staff will review the Expert Program after the training and determine if changes need to be made to the new training program. An update on the training will be provided at the July 2012 Enforcement Committee meeting.
• Examine the use of experts by other states and by other California boards and commissions.	Spring – Fall 2012	Enforcement	A	5/3/12 – The Board will offer the Board's Expert Reviewer Training Program to other states and will be obtaining any information regarding differences in the programs at that time.
• Examine which policies and regulations (under the Board's authority) should be amended to further the program's efficiency.	Fall 2012	Enforcement	A	5/3/12 – An evaluation will be performed after the roll out of this new program to identify where changes, if any, need to be made.
• 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	Legislative/ Enforcement	A	

Objective 2.7: Identify opportunities to better educate judges/hearing officers.

Activity	Date*	Staff	Priority	Status
• Evaluate the current training and information furnished to the Office of Administrative Hearing judges/hearing officers.	Winter 2012	Enforcement	B	5/3/12 – Completed. The Executive Director, Chief of Enforcement and a Board Member have reviewed the training being provided to the Administrative Law Judges (ALJ). Based upon this review, they have been working with the Presiding ALJs to identify training that would be appropriate for the ALJs. An update will be provided at the May 2012 Enforcement Committee meeting.
• Conduct OAH training semiannually.	Spring 2012-Ongoing	Enforcement	B	5/3/12 – A June 2012 training has been scheduled with the ALJs.
• Examine disciplinary decisions to determine if they meet the Board's mission to protect the public.	Winter 2012-Spring 2012	Enforcement	B	5/3/12 – Due to staffing vacancies this item has deferred; however, it will begin during the Summer 2012.
• Identify any inconsistent outcomes in disciplinary cases and present the findings to the Board.	Spring 2012	Enforcement	B	5/3/12 – Due to staffing vacancies this item has deferred; however, it will begin during the Summer 2012.
• 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/ Research Program Specialist/ Legislative	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	Status
• Evaluate the impact of SB 100. Begin developing goals and timelines for SB 100 implementation.	Fall 2011	Licensing/ Enforcement	A	5/3/12 – Completed. The Chief of Legislation has worked with both the Chief of Licensing and the Chief of Enforcement on the implementation of SB 100. A presentation was provided at the Licensing Committee Meeting in February 2012 on the implementation of SB 100.
• 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	5/3/12 – Completed initial review and will continue to evaluate the Board's role with outpatient surgery facilities.
• Identify the resources needed to implement an effective program.	Spring 2012	Licensing/ Enforcement	A	5/3/12 – Board staff will review the need for more investigators based upon this new legislation. If necessary, more staff will be requested.
• Communicate to all interested parties what is within the Board's authority in regards to outpatient surgery centers and what is outside of the Board's authority	Spring 2012	Licensing/ Enforcement	A	5/3/12 – In addition to the Licensing Committee presentation that was completed in February 2012, there will be a presentation at the July 2012 Enforcement Committee meeting. Both Committees will receive quarterly updates on this legislation.
• Work with the Legislature to enact legislation or gain resources and procure what is necessary for California to have an effective program, ensuring a minimum standard of safety in outpatient settings.	Fall 2012	Licensing/ Enforcement/ Legislative	A	

***Dates for these tasks are pending the hiring of staff for the outpatient surgery regulation program.**

Objective 2.10: Examine the decline of the number of reports received pursuant to Business and Professions Code section 805 (reporting peer review actions).

Activity	Date	Staff	Priority	Status
• Review the history of Business and Professions Code (BPC) section 805 reports, the history of the law, statistical data, and how they relate to the Board's disciplinary actions.	Spring 2012	Research Program Specialist	C	5/3/12 – Board staff have begun an internal study of 805 reporting and will provide a report to the Board at its October 2012 Board meeting. Based upon the study, this information may be provided to the legislature during the Sunset Review Hearings.
• Obtain information from those required to file BPC section 805 reports (individual hospitals, medical groups, societies and associations) and the reasons the reports have declined over the years.	Spring – Fall 2012	Research Program Specialist	C	5/3/12 – Board staff have begun an internal study of 805 reporting and will provide a report to the Board at its October 2012 Board meeting.
• Evaluate Peer review – what it does, how it impacts what the Board does, what institutions file BPC section 805 reports.	Fall 2012	Research Program Specialist	C	
• Study practices not subject to peer review to determine if quality of care can be monitored.	Fall 2012	Research Program Specialist	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	Research Program Specialist	C	
• Review how other states handle peer review and mandatory reporting, and how, or if, they correlate with disciplinary action.	Summer 2013	Research Program Specialist	C	

Objective 2.10 (cont.): Examine the decline of the number of reports received pursuant to Business and Professions Code section 805 (reporting peer review actions).

• Determine if there are problems with the reporting system. 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	Research Program Specialist/ Legal/ Legislative	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	Status
• Review the Board Web site to determine what can be improved.	Winter 2012	Public Affairs	B	5/3/12 – The Public Information Officer (PIO) has developed a plan to implement the Objectives of Goal 3. This information will be provided to the Education Committee at its Summer 2012 Meeting. Also, in January 2012, the new PIO began looking at the Board's Web site layout and identified improvements that are needed. He will be working with the Board's Information Systems Branch to improve the Web site by July 1, 2012. The Board also has developed a Web Design Committee that meets to review the Web Site for improvements.
• Utilize the Board Web site 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 Affairs		
• Work with state, county and federal agencies to inform licensees.	Fall 2012	Public Affairs	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	Public Affairs	B	

Objective 3.1(cont.): Improve and expand professional educational outreach, including outreach to students and new graduates, about the laws and regulations that govern medical practice.

• 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	Public Affairs	B	5/3/12 – After the Education Committee in Summer 2012 the Public Affairs Unit will provide a plan to Board Members about re-establishing the MBC speakers' bureau "Teams of 2". Board Members will be asked if they are willing to commit to being part of the team. Once teams of two are established, we will offer a catalog of speaking topics. This catalog will be made available to educational institutions and professional organizations that have a stake in the work of the MBC. Such groups will be asked to book a "Team of 2" presentation at a minimum of six months in advance. Teams and the catalog are projected to be available in late December 2012.
• Conduct outreach to various organizations such as hospitals and group practices through providing speakers or articles for their publications.	Spring – Fall 2012	Public Affairs	B	5/3/12 – Specific outreach will be identified in the PIO's plan provided to the Education Committee.

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	Status
• Review the Board Web site to determine what can be improved.	Winter 2012	Public Affairs	C	5/3/12 – The Public Information Officer (PIO) has developed a plan to implement the Objectives of Goal 3. This information will be provided to the Education Committee at its Summer Meeting. Also, in January 2012, the new PIO began looking at the Board's Web site layout and identified improvements that are needed. He will be working with the Board's Information Systems Branch to improve the Web site by July 1, 2012. The Board also has developed a Web Design Committee that meets to review the Web Site for improvements.
• Identify consumer education groups and publications to distribute Board material.	Various 2012-13	Public Affairs	C	
• Schedule meetings with editorial boards of major media at least once a year; more, when necessary.	Various 2012-13	Public Affairs	C	
• Update the content of brochures to reflect the current practice environment.	Various 2012-13	Public Affairs	C	
• Work with other state agencies to provide Board materials to consumers	Various 2012-13	Public Affairs	C	
• Work with the Department of Consumer Affairs (DCA) and State and Consumer Services Agency (SCSA) to develop an integrated communications plan that would promote the Board and its services.	Various 2012-15	Public Affairs	C	
• Explore the use of social media in outreach to the public.	Summer 2012	Public Affairs	C	5/3/12 – This process has begun and the Board staff is exploring social media as a conduit to the public.

Objective 3.2 (cont.): 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.

• Add Board information to the California Healthcare Insurance Exchange Web site, with timing to be established after discussion with California Health Benefit Exchange (HBEX) Executive Director and the Board.	Fall 2013	Public Affairs	C	

Objective 3.3: Identify more effective methods to promote the Expert Review Program to recruit qualified physicians.

Activity	Date	Staff	Priority	Status
• 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 / Public Affairs	A	5/3/12 - Due to the new Expert Reviewer Training Program, this objective has been suspended until this training is completed. However, an article regarding this program was placed in the Spring 2012 Newsletter; and the Chief of Enforcement contacted a society who agreed to post an advertisement on its Web site educating members about the Program and seeking experts.

Objective 3.4: Establish a more 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	Status
• Build relationships with major media so that all disciplinary cases are provided to the appropriate outlets.	Winter 2012	Public Affairs	C	5/3/12 – The PIO is reaching out to major media outlets to ensure that all disciplinary cases are provided to the appropriate individuals. News releases are sent to local media in close proximity to the disciplined physician's practice location or the areas where the violation(s) occurred. Subscriber blasts also report disciplinary actions to media and interested partied.
• Work with the DCA and the District Attorney's office to establish joint news release procedures to use on joint investigations or actions.	Winter 2012	Public Affairs	C	5/3/12 – The PIO has begun to communicate with the DCA's Public Affairs Office and will establish a procedure on joint actions.
• When the budget allows, provide press kits about the Board to all media outlets.	Winter 2013	Public Affairs	C	
• Participate in professional/public outreach programs (see Objective 3.2)	Various 2012-15	Public Affairs	C	

Objective 3.5: Expand the Newsletter to better inform physicians, medical students, and the public.

Activity	Date	Staff	Priority	Status
• Using focus groups, surveys, etc., evaluate how the current Newsletter is being utilized by licensees, what is useful and what is not.	Spring 2012	Public Affairs	C	5/3/12 – This item will be addressed in the plan developed by the PIO and discussed with the Education Committee.
• Allow applicants to receive the Newsletter by e-mail or social media, as well as licensees.	Various 2011-13	Public Affairs	C	5/3/12 – Completed via email, social media pending. Currently, approximately 6,000 applicants and 89,000 licensees and interested parties receive an email alert each quarter when the Newsletter is posted online. The PIO is working on developing social media (Facebook, Twitter, etc.) for the Board and these will be used to inform readers that the most recent Newsletter is available online.
• Establish some kind of feedback for the Newsletters' content to determine who is reading it, and for what information.	Various 2012-13	Public Affairs	C	
• Examine ways of promoting the Newsletter to encourage more readers.	Winter 2012	Public Affairs	C	5/3/12 – This item will be addressed in the plan developed by the PIO and discussed with the Education Committee. However, the Board currently sends out an email blast to subscribers and licensees notifying them of the Newsletter to encourage review/readership.
• Reach out to other agencies and foundations to contribute to the Newsletter.	Various 2012-13	Public Affairs	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	Public Affairs	C	5/3/12 – Completed and ongoing. The two most recent Newsletters included information about both Board activities and topics at the Board Meeting, including pictures of presenters.
• Encourage professional associations and societies to include a link to the Newsletter.	Various 2011-13	Public Affairs	C	5/3/12 – This item will be addressed in the plan developed by the PIO and discussed with the Education Committee.

<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	Status
• Develop a plan to visit legislators and their staffs with Board members, at the Capitol and field offices.	Fall 2011	Legislative	B	5/3/12 – Completed and ongoing. The Chief of Legislation will report quarterly during the Legislative Report at the Board meetings on the status of any legislator visits.
• Provide training and briefing to the Board members about the Board's legislative initiatives, and who is contacted and why.	Winter 2012	Legislative	B	5/3/12 – The Chief of Legislation will provide a briefing at each quarterly Board meeting regarding any legislative initiatives and discuss any interested party contacts.
• Prepare Board members to be effective when communicating with legislators and their staff.	Various 2012-13	Legislative	B	
• Invite legislative field staff to board meetings, and visit field offices.	Winter 2012	Legislative	B	5/3/12 – Completed and ongoing. The Chief of Legislation has continued to invite legislative field staff, in the area of the Board meeting, to attend the meeting. The Chief will report on the invitations at the quarterly Board meetings.

***Goal 5: Organizational Effectiveness*: 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	Status
• Goal communicated to staff	Fall 2011	Licensing	A	5/3/12 – Completed and ongoing. The Chief of Licensing has communicated this goal to all of his staff and provides weekly statistics to each of the staff to indicate where they are in meeting this goal.
• 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	A	5/3/12 – Completed and ongoing. The Chief of Licensing sends out weekly reports to the Licensing Managers.
• Report to the Board at every quarter on the time taken to review licensing applications.	2011 Ongoing	Licensing	A	5/3/12 – Completed and ongoing. The Chief of Licensing sends out weekly reports to the Board Members regarding the Licensing statistics. In addition, the Chief of Licensing will report at the quarterly Board meeting where the Licensing Program is with meeting this goal.

Objective 5.2: Reduce discipline, complaint processing, and investigation timelines by 10-20%; reduce complaint processing average to less than 70 days, with 50-60% less than 50 days.

Activity	Date	Staff	Priority	Status
• Analyze current process, including breaking down types of cases by time taken for each element of the process.	Winter 2012	Enforcement	A	5/3/12 – Completed. The Chief of Enforcement has put together reports to review the complaint process by each element by the type of case. Additionally, the Chief of Enforcement will report at the quarterly Board meeting where the Enforcement Program is with reaching the goal stated in the Objective title.
• Identify reasons for delays in the Board's processes from complaint handling through disposition.	Various 2012-13	Enforcement	A	5/3/12 – This is an ongoing process for the task force within the Enforcement Committee. The task force and staff have already identified delays and have worked towards resolutions to the delays. The first delay was the time for obtaining certified medical records in the district offices; legislation amended current statutes to require certified medical records from the onset of the complaint. Time frames for interviewing the respondent were also identified as an issue; legislation was implemented which strengthened the requirement for the respondent to attend the interview. Lastly, the task force has identified the time frames for the initial expert review to be a problem; staff are working on streamlining the process and asking for the reviews to be done more timely.
• 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	

Objective 5.2 (cont.): Reduce discipline, complaint processing, and investigation timelines by 10-20%; reduce complaint processing average to less than 70 days, with 50-60% less than 50 days.

• 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.	Various 2012	Enforcement	A	5/3/12 – This will be done during the research and analysis for the Sunset Report.
• In conjunction with Objective 2.3, identify how VEP 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, cost savings, and promote efficiency.

Activity	Date	Staff	Priority	Status
• 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)	Spring-Fall 2012	Administra-tion/Budget	B	5/3/12 – Staff is beginning to look into the spending and will provide a report at the July 2012 Board meeting.
• Conduct an analysis of spending through the years, broken down by function and region, to identify trends, and possible inconsistencies, if any.	Spring-Fall 2012	Administra-tion/Budget	B	5/3/12 – Staff is beginning to look into the spending and will provide a report at the July 2012 Board meeting.
• Identify areas that require discussion and examination by reviewing what areas have improved efficiency and those that have declined. (Incorporate data and analysis on VEP – see Objective 2.3)	Spring-Fall 2012	Administra-tion/Budget	B	5/3/12 – Staff is beginning to look into this spending and will provide a report at the July 2012 meeting. Staff is also awaiting information from the Attorney General's Office on spending due to VEP.
• Establish a procedure to regularly evaluate the value of spending to outside areas.	Spring-Fall 2012	Administra-tion/Budget	B	5/3/12 – Staff is looking at the type of report to provide to the Board for these expenditures.
• Establish a reporting method that will keep the Board updated, and also will be helpful in providing information at Sunset evaluation.	Spring-Fall 2012	Administra-tion/Budget	B	5/3/12 – Staff is looking at the type of report to provide to the Board for these expenditures.

Objective 5.4: Conduct a review every two years 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 continued, be eliminated, or be merged with other committees.

Activity	Date	Staff	Priority	Status
• Prior to new committee appointments by the Board President, the Board should conduct a review of all committees/subcommittees/task forces.	Every Other Fall Board Meeting	Deputy Director	A	5/3/12 – Completed. At the February 2012 Board meeting a full evaluation was completed. The next evaluation will be Fall 2013.

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	Status
• Executive Director to provide e-mail updates approximately every two months to inform staff of board activities and positions.	2011 ongoing	Executive Director	C	5/3/12 – Completed and ongoing. The Executive Director has and will continue to send an email to all staff prior to each meeting.
• 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	5/3/12 – Completed and ongoing. The Chiefs have begun to discuss the Board meetings with staff, and when meeting locations are nearby, staff will be encouraged to attend.

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	Status
• 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	5/3/12 – As appropriate, the Executive Director will provide an update. A plan to visit the Sacramento office and headquarters is planned for the July 2012 Board meeting.
• 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	5/3/12 – These tours will be conducted when the meeting locations are near the district offices, but may also need to be completed on an individual basis rather than during the full Board meeting.

Objective 5.8: Establish a method of obtaining feedback from our users about services.

Activity	Date	Staff	Priority	Status
• Continue the complaint survey and evaluate how it might be improved.	Winter 2012 Ongoing	Research Program Specialist	B	
• Establish a survey for newly licensed physicians about the application/licensing process	Spring 2012 Ongoing	Research Program Specialist	B	5/3/12 – The Research Program Specialist has begun to establish a survey for applicants and licensees and is establishing a survey monkey tool to use for the survey.
• Establish a survey on the Web site on other areas, including the usefulness of the Web site	Summer 2012 Ongoing	Research Program Specialist	B	
• Provide a report to the Board on the results at the time of the Annual report.	Fall 2012 Ongoing	Research Program Specialist	B	

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	Status
• Invite appropriate speakers to address the Board about implementation of the Affordable Care Act in the State, and how it will impact care delivery in California.	2011 Ongoing	Legislative	D	5/3/12 – Completed and ongoing. At the February Board meeting, a presentation was given by Catherine Dower, J.D. entitled "California's Health Care Workforce – Are We Ready for the Affordable Health Care Act?" Future presentations will also be provided.
• 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	Legislative	D	5/3/12 – Completed and ongoing. The California Medical Association provided a presentation at the July 2011 Board meeting entitled "Five Issues Facing California's Physician Workforce". Future presentations will also be provided.
• 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 or publicizing programs to help those in underserved populations, etc.	Spring 2013	Legislative	D	
• Take appropriate action based on the remedies identified by the committee.	Winter 2013	Legislative	D	

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

Memorandum

Date: April 18, 2012

To: Members
Medical Board of California

From: Barbara Yaroslavsky and Shelton Duruisseau, Board Members
Health Professions Education Foundation

Subject: Update on Loan Repayment Program Awardees: 2003-2005

The California Physician Corps Loan Repayment Program (program) was created in 2002, via legislation sponsored by the Medical Board of California (Board). This program encourages recently licensed physicians to practice in underserved locations in California by authorizing a plan for repayment of their educational loans, up to $105,000, in exchange for their service in a designated underserved area for a minimum of three years.

While the immediate goal of the program was to provide improved access to healthcare in underserved communities during each physician's three-year obligation, the Board envisioned the three-year period would allow salaried physicians to grow roots in each respective community, remaining where they are working, even after the program's last payment was made. In the alternative, if the awardee left that specific practice setting, it was hoped the physician would have reduced the loan debt to such a level that service to underserved populations would remain a viable career choice.

The program was administered by the Board for three years and then was transitioned to the Health Professions Education Foundation (HPEF), a 501(c)(3) public benefit corporation, which receives administrative support from the Office of Statewide Health Planning and Development. While the Board regretted relinquishing administration of the program, the experience of HPEF staff in raising funds and administering similar programs best allowed the program to flourish.

At the February 2012 Board meeting, members asked if staff could ascertain the current practice settings for the awardees honored during the early years of the program. Even though we no longer have access to those records beyond the names of the awardees, staff researched current addresses of

record, Google, and other on-line information; we believe the following is a close-to-accurate representation of the awardees' current work sites:

2003 Award Cycle: 32 awardees
Still working in same practice setting: 15
Not at same location but appear to be working in an eligible practice setting: 8
Appear to be no longer working in eligible practice setting: 9

2004 Award Cycle: 18 awardees
Still working in same practice setting: 6
Not at same location but appear to be working in an eligible practice setting: 7
Appear to be no longer working in eligible practice setting: 5

2005 Award Cycle: 19 awardees
Still working in same practice setting: 6
Not at same location but appear to be working in an eligible practice setting: 9
Appear to be no longer working in eligible practice setting: 4

We trust this information is helpful in addressing the question raised at the last Board meeting.

MEDICAL BOARD STAFF REPORT

May 3, 2012

ATTENTION: Members, Medical Board of California
SUBJECT: Data Bank Query for Physicians Renewal Candidates
STAFF CONTACT: Letitia Robinson, Research Specialist

Recommended Action
Staff recommends the Board review the analysis and recommend that staff not pursue either a continuous query or a one-time query of the Data Bank for physician renewal candidates.

Background
At the February 3rd Board Meeting, during "Public Comment on Items not on the Agenda" a suggestion was made to the Board. The suggestion encouraged the Board to look into the cost benefit analysis of querying the Data Bank every two years at the time of a physician's renewal.

This recommendation stemmed from a complaint made by Public Citizen, a Washington, D.C. consumer advocacy group, to the Governor of California. The complaint alleged the Board failed to take disciplinary action against 672 of its licensed physician and surgeons (alleged 710 physicians but 38 represent osteopathic physicians), all of whom were disciplined by California health care organizations, mainly hospitals. This information was based on an analysis of the Data Bank Public Use Data File from September 1990 through the end of 2009.

Analysis
Data Bank Information
The Data Bank, consisting of the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB), is a confidential information clearinghouse created by Congress to improve health care quality. The Data Bank does not disclose information on a specific practitioner to the general public. Authorized entities may query NPDB, HIPDB, or both.

The Data Bank offers two types of queries: one-time or continuous. For a one-time query, the name of the practitioner is provided to the Data Bank Web site and a query response is received within four hours. The report is available for about 45 days after the query. The current fee for each one-time query is $4.75 per practitioner for each report per year. If both the NPDB and the HIPDB were queried, the cost would be $9.50 per physician per year. For a continuous query, the initial query is processed; then continuous query automatically send alerts on any new reports or changes to reports on all enrolled practitioners for a 12-month period. The current fee for each continuous query is $3.25 per practitioner for each report per year. If both the NPDB and the HIPDB were queried, the cost would be $6.50 per physician per year.

Board's current use of Data Bank reports
Currently, the Board only conducts queries to the Data Bank for some at the initial licensing process (those licensed in another state), in some cases during an enforcement investigation,

and on all reinstatement cases. Most of the information that is provided by the Data Bank is already acquired by the Board through the fingerprinting process for criminal record query, Federation of State Medical Boards query, American Medical Association, and through reporting requirements by California law.

Existing California law, Business and Professions (B&P) Code §801.01, requires reporting to the Board of arbitration awards, civil judgments and settlements over $30,000 when a claim or action is based on a licensee's alleged negligence, error, or omission in rendering services. The Data Bank requires all such awards, judgments, or settlements of any amount be reported.

B&P Code §805 requires a peer review body to provide a written report (805 reports) to the Board when privileging actions have been taken against its licensees including terminations or revocations, suspensions for 15 days or more, restrictions on staff privileges for 30 days or more, etc. The Data Bank requires Health Care Entities to report privileging actions affecting clinical privileges for a period longer than 30 days. Board staff did a comparison of the Data Bank Public Use Data from September 1990 through the end of 2009 and found that approximately 20 reports of privileging actions were submitted to the Data Bank but an 805 report was not filed with the Board. This amounts to about one Data Bank report per year where an organization failed to provide the Board with an 805 report.

Board Options for Querying the Data Bank

The Board was encouraged to look into the cost benefit analysis of querying the Data Bank every two years at the time of a physician's renewal. If the Board decides to query the Data Bank and increase physician's renewal fee to cover the cost, this would require a change in law.

The Board processes approximately 61,735 physician renewals each year. If the Board decided to do a one-time query for both Data Bank reports ($9.50) at the time of renewal, the fiscal impact would be:

Board Cost	FY 1	FY 2	Ongoing
Staff Services	$190,207	$180,207	$180,207
Data Bank Reports	586,482	586,482	586,482
Supplies/Equipment	123,470	123,470	123,470
Total	$900,159	$890,159	$890,159

FY 1 Staff Services is a higher amount because of the work involved in setting up the initial program. Staff would be required to request, print, and review each report. In reviewing the report, staff would determine if it is necessary to open an enforcement case. Reports would be filed and maintained according to an adopted retention schedule.

If the Board decided to conduct continuous query for both Data Bank reports ($6.50), the fiscal impact would be:

Board Cost	FY 1	FY 2	Ongoing
Staff Services	$ 360,414	$ 60,069	$ 60,069
Data Bank Reports	849,395	849,395	849,395
Supplies/Equipment	261,340	20,000	20,000
Total	$1,471,149	$929,464	$929,464

In FY 1 Staff Services is a higher amount because of the work involved in setting up the initial program. Staff would be required to request, print, and review each report. In reviewing the report, staff would determine if it is necessary to open an enforcement case. Reports would be filed and maintained according to an adopted retention schedule. In FY 2 the cost would decline for staff services and supplies/equipment because the Board would only receive subsequent reports.

Based upon this initial analysis of the information provided by the Data Bank to the Board, the benefit for obtaining data at renewal or on a continuous basis may not be cost effective. An analysis of the data provided by the Data Bank pursuant to the Public Citizen report shows that less than five additional reports per year might be received, and these may not rise to the level of discipline. The cost effectiveness of this option is not supported.

As an alternative, staff has already initiated an annual request to the Data Bank of reports filed from peer review bodies to determine if the Board has received all of those reports and to pursue an investigation if it has not received the reports.

Dr. Bruce Gipe

Dr. Gipe was born in Corona, CA in 1953. He grew up in Orange County and in Phoenix and Prescott, Arizona where he graduated from Prescott High School. He attended Point Loma Nazarene University in San Diego, CA and graduated summa cum laude with a BS in Chemistry in 1976. He attended medical school at Loma Linda University School of Medicine where he graduated with his M.D. in 1979. From 1979 to 1982 he did his internship and residency in Family Medicine at San Bernardino County Medical Center (now Arrowhead Regional Medical Center). From 1982 to 1985 he completed further training in Internal Medicine at Loma Linda. From 1985 to 1987 he practiced emergency medicine in the Palm Springs area, and from 1987 to 1990 he completed a fellowship in Pulmonary and Critical Care Medicine at the UCLA Medical Center. From 1990 to 1992 he served on the full time faculty at UCLA. Dr. Gipe maintains board certification in Internal Medicine, Emergency Medicine, Pulmonary Medicine, and Critical Care Medicine. Since leaving UCLA he has been in private practice and is the founder and Medical Director of Primary Critical Care Medical Group, a hospitalist and intensivist physician practice management company. PCCMG is based in North Hollywood, CA, and Dr. Gipe lives with his wife and two sons in Studio City.

Update on Hospitalist Medicine in California and the United States

Bruce Gipe, MD, Medical Director
Primary Critical Care Medical Group
North Hollywood, CA

Physician Comp Will Decrease

- Healthcare is 17% of GDP
- SGR is still out there and could cut 20% from FFS payment
- Payment/procedure = “solve for income”
- Tax rates are going up and you are “rich”
- Taking advantage of pre tax advantaged options requires foresight and discipline if you don’t want to work until you are 70

NO PARKING
2:00am to 6:00am
DEATH FROM DROWNING HAPPENS
ONCE IN A LIFETIME
UNDERTOW & SURF CAN MAKE RETURN TO SHORE IMPOSSIBLE
PELIGRO
MOLUSCOS
ALMEJAS
WARNING
MUSSELS
CLAMS
Please do not
Feed the
Wildlife
as it is
Hazardous
to their health
and yours.
BEACH INFORMATION
MORRO ROCK ACCESS
Dogs Must be on Leash
Camping Prohibited
No Vehicles on Beach
No Smoking on Beach
Campfires in Designated
Containers Only
WARNING
Enter water at your own risk.
Emergency - Dial 911

Who to Work For?

- NYT, 3.25.10, More Doctors Giving Up Private Practices
- In 2005 2/3 of practices were physician owned
- In 2008 it was down to < 50%

Why the Decline?

- Concerns re medical errors
- Changes in payments, e.g. push to increase PCP comp has caused specialists to consider selling
- E.H.R. cost
- Call schedules

How to compete

- Be available
- Be nice
- Demonstrate competency
- There are about 85,000 licensed physicians in CA and about 24,000 in Los Angeles County!

Phyllis Maguire

A national hospitalist company finds a warm welcome on Wall Street

IPC-THE HOSPITALIST COMPANY, which is known for its strong embrace of the private practice hospitalist model, is now also known by a new symbol: IPCM.

That's how the company is being listed on the NASDAQ exchange. Earlier this year, IPC, which is based in North Hollywood, Calif., became the first national hospitalist company to go public, raising nearly $94 million before the fees and expenses related to the initial public offering were deducted.

According to chief executive officer Adam Singer, MD, that effort was the culmination of what has been the company's goal all along: to become a publicly traded company.

Dr. Singer talked to Today's Hospitalist about IPC's new business model.

Why did IPC decide to go public?

You go public for two classic reasons: to raise money and provide liquidity to your shareholders.

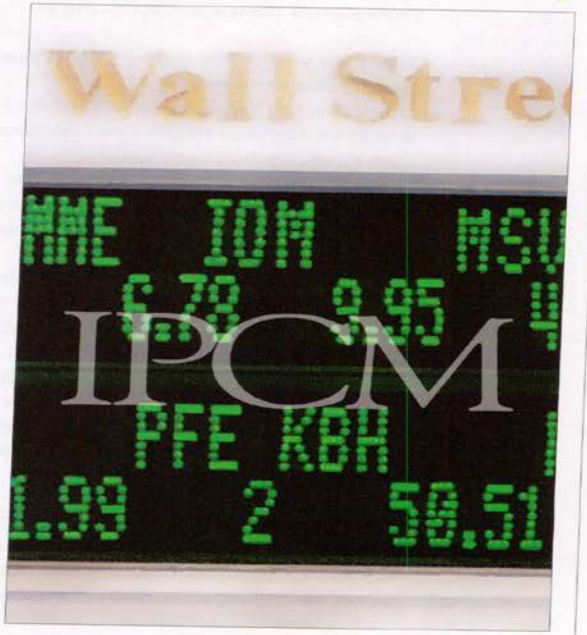
We had previously raised more than $40 million in venture capital—with the last raising of capital in 2002—and we have been profitable since 2002. When you raise venture capital, you're really setting the stage for going public, and we had planned to go public since our inception in 1997.

But there is a third reason: We wanted to be able to stand up and finally define for the public what is a hospitalist and to set the bar for how a hospitalist is going to be measured in the public domain.

What was the reaction from the investment community?

It reminded me very much of the early 1990s, when we had to educate other health care providers about hospital medicine. Within the financial community, there was just a complete blank in terms of knowing what hospital medicine was. Was it hospice? Or hospitality? They had no idea.

We found that lay investors, mutual fund managers, money managers, people in the Wall Street world are relatively young. So we are not talking to people who are big consumers of health care.



REGIONAL
MEDICAL CENTER
PCCMG
HOSPITALISTS

Beginnings ...

- 1980 ... license
- EM moonlighting/residency X 2
- Full time EM in Palm Springs, 1985-87
- Pulm/CCM fellowship at UCLA, 1987-90
- Faculty UCLA, 1990-92
- Private practice, 1992-present

Vision ...

- To create a medical group that provided hospitals with intensivists to staff their intensive care units

- Reasons why this couldn’t work in 1992

Contracts

- 1992 LTAC, California
- 1994 ED, Huntington Beach
- 1995 ED + hospitalist, Exeter
- 1995 IM Clinic, Huntington Beach
- 1996 Primary Care Clinic, Farmersville
- 1996 ED, Coalinga

Contracts

- 1997 Hospitalist, Bakersfield
- 1997 EM, Dinuba
- 1998 Kaiser
- 1998 Hospitalist, LTAC
- 1999 Hospitalist, Marysville
- 1998 EM, King City
- 2000 EM, Fallbrook

Contracts ...

- 2000 Hospitalist Oxnard
- 2002 Hospitalist ARMC
- 2002 Hospitalist Turlock
- 2004 Hospitalist Kona
- 2005 Hospitalist Hilo

Contracts

- 2006 Hospitalist MLK
- 2007 Hospitalist/Intensivist Rancho
- 2008 Hospitalist HUMC
- 2008 Hospitalist DRMC
- 2009 Hospitalist USC
- 2010 ED Hospitalist HUMC
- 2011 Neurohospitalist DRMC

Current

- 130,000 encounters/year
- Contracts to cover > 100 facilities
- Mix of traditional and non-traditional hospitalist contracts
- Academic and non-academic
- 1 EM
- 2 intensivist

STATE OF THE ART

- About 20,000 currently practicing hospitalists
- Estimated need: 30,000 (= same # of cardiologists in U.S.)
- 29% of hospitals have hospitalists
- 55% with >200 beds have a program

Demographics: 2011 SHM Survey

- 50% single specialty
- 6% founded in 2010, 21% prior to 2000
- 88% internists, 5% FM, 5% peds, 1.3% PA or NP
- 65% male, 35% female

Group Size

- 26% = 16 or more
- 26% = 10-15
- 38% = 4-9
- 11% = 3 or less

Finances

- Median support = $131,564/FTE; $119,064 in West
- $220,619 ... higher for local hospitalist only groups vs. employment by multi-state group or management company
- South = $247K, East = $212K

Why do you need support?

- A robust daytime program depends on an equally robust night and weekend program—the night coverage must be there but won’t generate as much revenue
- Unfunded care obligations
- Maintain the proper ratio to avoid burnout and achieve results

RESIDENCY PROGRAMS (JAMA 9/1/04—Vol. 292, # 9)

- 6,345 IM graduates in ’02-’03 (about 5% plan to stay in GIM)
- 86 CCM graduates
- 359 Pulm/CCM graduates
- 3,251 FM graduates
- 21,351 IM residents on duty—8,591 IMG residents, 1,183 AOA

HOW TO BUILD ONE

- Why are you doing it?
- Enlist support of key stakeholders.
- Define the size of the service.
- Define the payor mix.
- Estimate revenue from FFS billing.
- Select a staffing model and estimate expenses.

Advantages of Hospitalist Programs

- Finite group of contracted physicians allows potential for better results with quality initiatives: core measures, antibiotic stewardship, HCAHPS, sepsis, readmission
- Greater efficiency → reduced LOS
- Solves call panel coverage problem for unassigned
- Provides local PCPs with coverage options
- Communication around handoffs and sign outs
- In house night coverage for admissions and rapid response
- Collaboration with intensivists

Program Components

- Clinicians who are committed to achieving excellent results and who understand the value of teamwork and are able to empathize with patients and families in their time of need,
- A local Medical Director who actively participates in patient care while providing the clinical and administrative leadership with a point of contact for working through complaints and challenges,
- Infrastructure to support operations: recruitment, credentialing, scheduling, Call Center, billing, reporting, performance improvement, and risk management,

Components of Hospitalist Program … 2

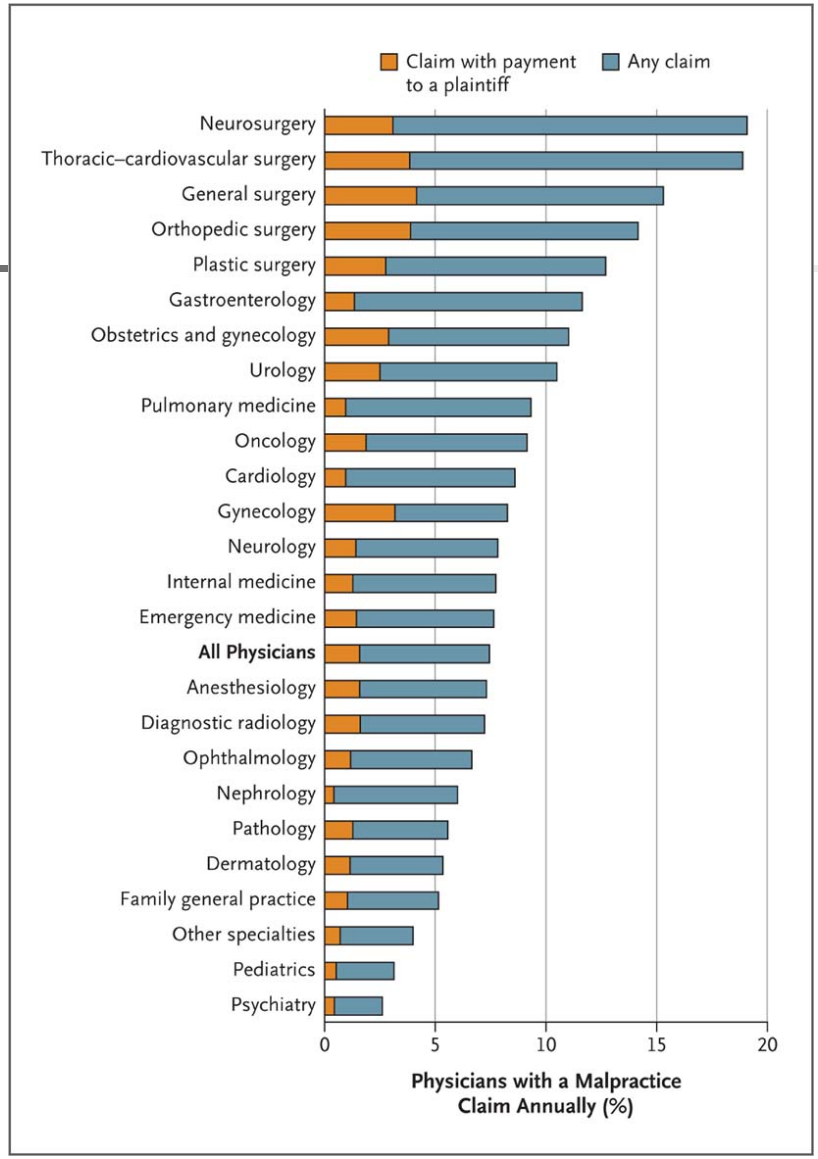
- Weekly hospitalist team meetings to focus group on key issues,
- Coaching and mentoring for hospitalists in order to facilitate orientation and collaboration with facility and medical staff,
- Active participation in medical staff committees by core hospitalists,
- Tracking and reporting on key metrics in order to achieve program goals: ALOS, timing of discharge order writing, satisfaction/HCAHPS, core measures, sepsis bundle, antibiotic stewardship, etc.

Credentialing, Professional

- Cognitive vs. procedural emphasis
- Society of Hospitalist Medicine: www.hospitalmedicine.org

Malpractice

- Communication: hospitalists don’t have a prior relationship
- Medication management
- Who’s in charge?
- Handoff communication


Claim with payment to a plaintiff
Any claim
Neurosurgery
Thoracic–cardiovascular surgery
General surgery
Orthopedic surgery
Plastic surgery
Gastroenterology
Obstetrics and gynecology
Urology
Pulmonary medicine
Oncology
Cardiology
Gynecology
Neurology
Internal medicine
Emergency medicine
All Physicians
Anesthesiology
Diagnostic radiology
Ophthalmology
Nephrology
Pathology
Dermatology
Family general practice
Other specialties
Pediatrics
Psychiatry
0
5
10
15
20
Physicians with a Malpractice Claim Annually (%)

- “Concern for man and his fate must always form the chief interest of all technical endeavors ... never forget this in the midst of your diagrams and equations.”

- Albert Einstein, 1885

TITLE 16. Medical Board of California

NOTICE IS HEREBY GIVEN that the Medical Board of California (hereinafter referred to as the "Board") is proposing to take the action described in the Informative Digest. Any person interested may present statements or arguments orally or in writing relevant to the action proposed at a hearing to be held at Doubletree by Hilton – Torrance – South Bay, 21333 Hawthorne Boulevard, Torrance, CA 90503 at 9:00 a.m. on May 4, 2012. Written comments, including those sent by mail, facsimile, or e-mail to the addresses listed under Contact Person in this Notice, must be received by the Board at its office not later than 5:00 p.m. on April 23, 2012 or must be received at the hearing. The Board, upon its own motion or at the instance of any interested party, may thereafter adopt the proposals substantially as described below or may modify such proposals if such modifications are sufficiently related to the original text. With the exception of technical or grammatical changes, the full text of any modified proposal will be available for 15 days prior to its adoption from the person designated in this Notice as contact person and will be mailed to those persons who submit written or oral testimony related to this proposal or who have requested notification of any changes to the proposal.

Authority and Reference: Pursuant to the authority vested by Section 2018 of the Business and Professions Code, and to implement, interpret or make specific the provisions in Section 2236.2 of the Code, the Board is considering changes to Division 13 of Title 16 of the California Code of Regulations as follows:

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

Adopt Section 1355.45 in Article 1, Chapter 2, Division 13, defining the notice required of a physician and surgeon in order to restore the license to active status following a period of incarceration after the conviction of misdemeanor; and, the license status description to be posted on Board's Internet site, to reflect current law.

Current law authorizes the Board to automatically place a physician's and surgeon's certificate on inactive status during any period of time that the holder of the certificate is incarcerated after the conviction of a misdemeanor. A physician's and surgeon's certificate which has been placed on inactive status pursuant to this law shall be returned by the Board to its prior or appropriate status within five business days of receiving notice that the physician is no longer incarcerated.

The proposed regulation will implement, interpret, and make specific the type of notice required to be submitted to the Board when the physician is no longer incarcerated. This regulation will also provide a definition to the public of the term "inactive" when posted to the Board's Internet site in connection to a physician who is incarcerated and unable to practice medicine. The Board notes that the status of a physician's and surgeon's certificate must be posted on its Internet site pursuant to the provisions of Sections 803.1 and 2027 of the Code.

FISCAL IMPACT ESTIMATES

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

Nondiscretionary Costs/Savings to Local Agencies: None

Local Mandate: None

Cost to Any Local Agency or School District for Which Government Code Section 17500-17630 Require Reimbursement: None

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

Impact on Jobs/New Businesses: The Board has determined that this regulatory proposal will not have a significant adverse economic impact on the creation of jobs or new businesses or the elimination of jobs or existing businesses or the expansion of businesses in the State of California.

Cost Impact on Representative Private Person or Business: The Board is not aware of any cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action.

Effects on Housing Costs: None

EFFECT ON SMALL BUSINESS

The Board has determined that the proposed regulations would not affect small businesses. The Board does not license businesses, the Board licenses individuals; therefore, there is no impact on small businesses or any business.

CONSIDERATION OF ALTERNATIVES

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

INITIAL STATEMENT OF REASONS AND INFORMATION

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

TEXT OF PROPOSAL

Copies of the exact language of the proposed regulations and of the initial statement of reasons, and all of the information upon which the proposal is based, may be obtained at the hearing or prior to the hearing upon request from the person designated in this Notice under Contact Person or by accessing the Board's website: http://www.medbd.ca.gov/laws/regulations_proposed.html.

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

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

You may obtain a copy of the final statement of reasons once it has been prepared, by making a written request to the contact person named below, or by accessing the Board's website: http://www.medbd.ca.gov/laws/regulations_proposed.html.

CONTACT PERSON

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

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

The backup contact person is:

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

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

Medical Board of California
Inactive License – Misdemeanor Convictions
Specific Language

1. Adopt Section 1355.45 of Title 16, Division 13, Chapter 2:

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.'

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Section 2236.2, Business and Professions Code.

MEDICAL BOARD OF CALIFORNIA
INITIAL STATEMENT OF REASONS

Hearing Date: May 04, 2012

Subject Matter of Proposed Regulations: Inactive License – Misdemeanor Convictions

(1) Section Affected: Title 16, Section 1355.45

Introduction

On August 3, 2011, Governor Edmund Brown signed Assembly Bill 1267 (AB 1267) (Halderman) which added Section 2236.2 to the Business and Professions Code effective January 1, 2012. This statute requires that the Board automatically place a physician's and surgeon's certificate, commonly known as a medical license, on inactive status during any period of incarceration after a misdemeanor conviction and requires that the board return the license to its prior or appropriate status within five days of receiving notice that the physician is no longer incarcerated.

Specific Purpose of each adoption, amendment, or repeal:

This proposed regulation defines the notice that the Board will accept to restore the physician's and surgeon's license to its prior appropriate status.

Business and Professions Code Section 803(B)(5) requires that the Board define the status of a license in regulation when disclosing that information on the Board's Internet site. This proposed regulation would provide a definition for the inactive license status as it applies to incarceration.

Factual Basis/Rationale

The Board has determined that it will accept a certified copy of a release issued by the applicable local jurisdiction where the physician was incarcerated as acceptable evidence that the physician is no longer incarcerated. The physician may provide the certified copy to the Board by either regular mail or by personal service and the Board will restore the license to its prior appropriate status. The Board currently accepts certified documents from the courts as acceptable evidence of a criminal conviction. Defining "notice" as a certified copy of the release from the applicable jurisdiction is consistent with existing practice.

The proposed regulation also provides a definition for the license status which will be displayed on the Board's Internet site when the physician's status is changed to inactive due to incarceration. The Board proposes that the status be updated to reflect: "Inactive Status – Misdemeanor Conviction" which will include a definition indicating that "Licensee was convicted of a misdemeanor and is currently incarcerated. No practice is permitted." The Board believes that this disclaimer provides sufficient explanation and information for the public to identify the physician's current status. The verbiage proposed is consistent with the Board's existing statuses and definitions provided to the public.

The proposed regulation will protect consumers in California by providing sufficient information to make an informed decision on their health care provider. By law, public protection is the highest priority of the Board, and the public protection is enhanced when patients and other

interested parties are made aware of the license status of a physician and any restrictions that may be imposed on the certificate.

This proposed regulation will also allow the license status to be updated in a timely manner upon the proper notice that a physician is no longer incarcerated.

Factual basis for determination that each proposed change is necessary:

Per section 2236.2 of the Business and Professions Code the Board shall adopt regulations that specify the type of notice required to be submitted to the Board and the information that will be provided to the public through the Board's Internet site.

As specified above, public protection is the highest priority of the Board whenever it exercises its regulatory authority, and this proposal is consistent with that objective, as an informed consumer is in a better position to make reasoned choices for him/herself.

Underlying Data

Technical, theoretical, or empirical studies or reports relied upon (if any): none

Business Impact

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

This regulation will only impact physicians who have been placed on inactive status following incarceration due to a misdemeanor conviction.

Specific Technologies or Equipment

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

Consideration of Alternatives

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

Set forth below are the alternatives which were considered and the reasons each alternative was rejected:

No alternatives were considered as the law requires the Board to adopt regulations to specify the type of notice required to be submitted to the Board, and requires disclosure on the Board's Internet site of the license status.

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.

4/16/2012

Medical Board of California

FY 11/12
Budget Expenditure Report
(As of February 29, 2012)
(66% 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	8,590,509	54.1	7,292,880
Board Members	31,500	33,900	107.6	(2,400)
Phy Fitness Incentive Pay	29,623	20,175	68.1	9,448
Temp Help	1,137,513	1,204,960	105.9	(67,447)
Overtime	12,143	36,045	296.8	(23,902)
Staff Benefits	7,515,777	3,864,896	51.4	3,650,881
Salary Savings	(892,664)			(892,664)
TOTALS, PERS SERVICES	23,717,281	13,750,485	58.0	9,966,796
OPERATING EXP & EQUIP				
General Expense	770,168	278,458	36.2	491,710
Fingerprint Reports	333,448	196,495	58.9	136,953
Minor Equipment	187,500	83,945	44.8	103,555
Printing	685,755	393,270	57.3	292,485
Communications	372,190	134,861	36.2	237,329
Postage	282,511	123,003	43.5	159,508
Insurance	41,053	13,345	32.5	27,708
Travel In-State	482,298	62,723	13.0	419,575
Travel Out-of-State	1,000	1,794	179.4	(794)
Training	78,895	22,458	28.5	56,437
Facilities Operation (Rent)	2,702,140	2,314,049	85.6	388,091
Consult/Prof Services	982,594	1,340,995	136.5	(358,401)
Departmental Prorata	4,118,830	2,745,986	66.7	1,372,844
Interagency Services	5,142	0	0.0	5,142
Consolidated Data Center	646,809	381,926	59.0	264,883
Data Processing	129,492	171,956	132.8	(42,464)
Central Admin Svcs (Statewide Prorata)	2,140,440	1,605,330	75.0	535,110
Attorney General Services	13,347,280	8,686,008	65.1	4,661,272
Office of Administrative Hearings	1,595,080	785,829	49.3	809,251
Evidence/Witness	1,893,439	1,168,576	61.7	724,863
Court Reporter Services	155,000	234,198	151.1	(79,198)
Major Equipment	633,000	0	0.0	633,000
Other Items of Expense	81	51,347	63,391.4	(51,266)
Vehicle Operations	261,925	182,297	69.6	79,628
Court-ordered Payments	0	2,250		(2,250)
Board of Control Claim	0	1,350		(1,350)
TOTALS, OE&E	31,846,070	20,982,449	65.9	10,863,621
TOTALS, EXPENDITURES	55,563,351	34,732,934	62.5	20,830,417
Scheduled Reimbursements	(384,000)	(249,579)	65.0	(134,421)
Distributed Costs	(780,000)	(539,680)	69.2	(240,320)
NET TOTAL, EXPENDITURES	54,399,351	33,943,675	62.4	20,455,676
Unscheduled Reimbursements		(1,038,963)		
		32,904,712		

Budget Expenditure Report.xls
Date: April 17, 2012

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
BUDGET REPORT
JULY 1, 2011 - FEB 29, 2012

	FY 10/11 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	2,252,648	1,402,656	current
Staff Benefits	1,089,713	606,273	current
TOTAL PERSONAL SERVICES	3,342,361	2,008,928	
OPERATING EXPENSES & EQUIPMENT			
General Expense	80,434	10,224	1-2
Fingerprint Reports*	333,448	194,221	1-2
Printing	61,000	22,505	1-2
Communications	52,246	12,207	1-2
Postage	125,000	59,039	1-2
Travel In-State	25,000	3,506	1-2
Training	8,500	7,263	1-2
Facilities Operation	226,000	225,552	current
Consult/Professional Services	601,873	700,359	1-2
Departmental Services	402,825	268,557	current
Interagency Services	500	0	current
Data Processing	4,000	6,685	1-2
Statewide Pro Rata	209,335	157,001	current
Attorney General	190,000	99,160	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	1,369	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	2,419,911	1,767,817	
SCHEDULED REIMBURSEMENTS	(384,000)	(249,579)	
DISTRIBUTED COSTS	(42,257)	(21,128)	
TOTAL BUDGET/EXPENDITURES	**5,336,015**	**3,506,038**	

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

4/17/2012

MEDICAL BOARD OF CALIFORNIA
ENFORCEMENT PROGRAM
BUDGET REPORT
JULY 1, 2011 - FEB 29, 2012

	FY 11/12 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	10,550,011	6,128,028	current
Staff Benefits	4,778,306	2,355,149	current
TOTAL PERSONAL SERVICES	15,328,317	8,483,177	
OPERATING EXPENSE & EQUIPMENT			
General Expense/Fingerprint Reports	436,406	168,978	1-2
Printing	305,755	241,337	1-2
Communications	224,358	93,969	1-2
Postage	70,000	58,773	1-2
Insurance	38,770	11,589	current
Travel In-State	290,298	30,624	1-2
Travel Out-of-State	0	1,794	1-2
Training	34,000	11,114	1-2
Facililties Operations	2,071,140	1,724,604	current
Consultant/Professional Services	300,000	214,096	1-2
Departmental Services	3,070,588	2,047,560	current
Interagency Services	3,833	0	1-2
Data Processing	19,000	5,963	1-2
Statewide Pro Rata	1,595,698	1,196,773	current
Attorney General 1/	13,157,280	8,586,848	current
OAH	1,595,080	785,829	1
Evidence/Witness Fees	1,820,939	1,137,108	1-2
Court Reporter Services	154,750	234,198	1-2
Major Equipment	511,000	0	1-2
Other Items of Expense (Law Enf. Materials/Lab, etc.)	81	49,296	1-2
Vehicle Operations	215,925	148,586	1-2
Minor Equipment	2,500	25,285	1-2
Court-Ordered Payments	0	3,070	current
TOTAL OPERATING EXPENSES & EQUIPMENT	25,917,401	16,777,394	
DISTRIBUTED COSTS	(735,630)	(517,494)	
TOTAL BUDGET/EXPENDITURES	**40,510,088**	**24,743,077**	
Unscheduled Reimbursements		(64,886)	
		24,678,191	

1/See next page for monthly billing detail

4/17/2012

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	5,269.50	170.00	895,815.00
	Paralegal Services	127.25	120.00	15,270.00
	Auditor/Analyst	62.75	99.00	6,212.25
	Cost of Suit			1,050.00
				918,347.25
			Total July-Dec =	**6,407,066.56**
			FY 11/12 Budget =	**13,157,280.00**

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

January	Attorney Services	6,445.75	170.00	1,095,777.50
	Paralegal Services	204.00	120.00	24,480.00
	Auditor/Analyst	96.50	99.00	9,553.50
	Cost of Suit			78.00
				1,129,889.00
February	Attorney Services	5,920.25	170.00	1,006,442.50
	Paralegal Services	238.75	120.00	28,650.00
	Auditor/Analyst	149.50	99.00	14,800.50
	Cost of Suit			0.00
				1,049,893.00
March	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst Services	0.00	99.00	0.00
	Cost of Suit			0.00
				0.00
April	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst Services	0.00	99.00	0.00
	Cost of Suit			0.00
				0.00
May	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst Services	0.00	99.00	0.00
	Cost of Suit			0.00
				0.00
June	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst Services	0.00	99.00	0.00
	Cost of Suit			0.00
				0.00
			FYTD Total =	**8,586,848.56**
			FY 11/12 Budget =	**13,157,280.00**

Revised 04/12/2012

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	3,932	40,589	50	10,281				55,952
Criminal Cost Recovery	0	0	150	0	50	250	605	504	1,055				2,614
Probation Monitoring	42,542	41,848	44,639	105,369	96,368	109,993	343,253	222,925	83,025				1,089,962
Exam	1,639	777	2,481	627	1,692	2,552	977	1,106	6,495				18,344
Cite/Fine	200	4,350	800	10,650	3,250	6,400	8,650	7,002	3,450				44,752
MONTHLY TOTAL	44,681	47,325	48,370	116,745	101,409	123,127	394,074	231,587	104,307	0	0	0	1,211,624
FYTD TOTAL	44,681	92,005	140,375	257,120	358,530	481,657	875,730	1,107,317	1,211,624	1,211,624	1,211,624	1,211,624	

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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*	1,393,217	24,678,191		3,506,038	1,033,018	2,019,445	274,803	32,904,712 *
Positions Authorized	8.8	164.1		53.3	15.0	17.0	25.0	283.2

* net expenditures (includes unscheduled reimbursements)

4/17/2012

Board Members' Expenditures - Per Diem/Travel
July 1, 2011 - June 30, 2012

NAMES	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APRIL	MAY	JUNE	YTD
DR. BISHOP - Per diem							$ 400.00	$ 600.00	$ 300.00				$ 1,300.00
Travel							$ 489.63	$ 794.65					$ 1,284.28
	$ -	$ -	$ -	$ -	$ -	$ -	$ 889.63	$ 1,394.65	$ 300.00	$ -	$ -	$ -	**$ 2,584.28**
DR. CARREON - Per diem	$ 1,300.00	$ 1,100.00	$ 1,100.00	$ 1,300.00	$ 1,000.00	$ 1,000.00	$ 600.00	$ 1,100.00	$ -	$ -			$ 8,500.00
Travel	$ 584.06	$ -		$ 473.45			$ -	$ 629.00					$ 1,686.51
	$ 1,884.06	$ 1,100.00	$ 1,100.00	$ 1,773.45	$ 1,000.00	$ 1,000.00	$ 600.00	$ 1,729.00	$ -	$ -	$ -	$ -	**$ 10,186.51**
MS. CHANG - Per diem	$ 400.00	$ 200.00	$ 100.00	$ 200.00	$ 200.00	$ 200.00							$ 1,300.00
Travel	$ 452.94												$ 452.94
	$ 852.94	$ 200.00	$ 100.00	$ 200.00	$ 200.00	$ 200.00	$ -	$ -	$ -	$ -	$ -	$ -	**$ 1,752.94**
DR. DIEGO - Per diem		$ 200.00	$ 1,000.00	$ 1,000.00	$ 1,400.00	$ 800.00	$ 800.00	$ 900.00	$ 1,200.00	$ -			$ 7,300.00
Travel				$ 1,052.64		$ -	$ -	$ 505.39					$ 1,558.03
	$ -	$ 200.00	$ 1,000.00	$ 2,052.64	$ 1,400.00	$ 800.00	$ 800.00	$ 1,405.39	$ 1,200.00	$ -	$ -	$ -	**$ 8,858.03**
DR. DURUISSEAU - Per diem	$ 1,000.00	$ 700.00	$ 600.00	$ 900.00	$ 800.00	$ 600.00	$ 1,000.00	$ 1,000.00	$ 700.00	$ -	$ -	$ -	$ 7,300.00
Travel	$ 71.04			$ 864.71	$ -		$ -	$ 540.25			$ -		$ 1,476.00
	$ 1,071.04	$ 700.00	$ 600.00	$ 1,764.71	$ 800.00	$ 600.00	$ 1,000.00	$ 1,540.25	$ 700.00	$ -	$ -	$ -	**$ 8,776.00**
DR. LEVINE - Per diem	$ 400.00												$ 400.00
Travel	$ 413.86						$ -						$ 413.86
	$ 813.86	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 813.86**
DR. GNANADEV - Per diem	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -
Travel	$ -			$ -	$ -	$ -	$ -	$ -			$ -		$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
DR. LOW - Per diem													$ -
Travel													$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
DR. MORAN - Per diem	$ 1,000.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -			$ 1,000.00
Travel													$ -
	$ 1,000.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 1,000.00**
DR. SALOMONSON - Per diem	$ -			$ 400.00			$ -				$ -		$ 400.00
Travel	$ -			$ 1,153.72			$ -						$ 1,153.72
	$ -	$ -	$ -	$ 1,553.72	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 1,553.72**
MS.SCHIPSKE - Per diem	$ 1,000.00	$ -	$ 300.00	$ 900.00	$ 100.00	$ 300.00	$ 600.00	$ -	$ -		$ -	$ -	$ 3,200.00
Travel	$ 618.06			$ 444.58			$ -		$ -				$ 1,062.64
	$ 1,618.06	$ -	$ 300.00	$ 1,344.58	$ 100.00	$ 300.00	$ 600.00	$ -	$ -	$ -	$ -	$ -	**$ 4,262.64**
MS. YAROSLAVSKY - Per diem	$ 1,800.00	$ 1,800.00	$ 1,500.00	$ 1,900.00	$ 1,100.00	$ 1,000.00	$ 1,900.00	$ 1,400.00	$ 1,700.00	$ -	$ -	$ -	$ 14,100.00
Travel	$ 709.66			$ 465.44	$ -	$ 620.02	$ 386.15	$ 742.00					$ 2,923.27
	$ 2,509.66	$ 1,800.00	$ 1,500.00	$ 2,365.44	$ 1,100.00	$ 1,620.02	$ 2,286.15	$ 2,142.00	$ 1,700.00	$ -	$ -	$ -	**$ 17,023.27**

TOTAL PER DIEM	$44,800.00
TOTAL TRAVEL	$ 12,011.25
TOTAL	**$ 56,811.25**

As of: 04/17/2012

Licensing Chief's Report

WORKLOAD REPORT

as of March 31, 2012

Agenda Item 27B

FISCAL YEAR 2011-2012

CONSUMER INFORMATION UNIT FY 11/12					
	FY 11/12	Q1	Q2	Q3	Q4
Total Calls Answered	***64,242***	15,725	20,456	28,061	
Calls Requesting Call Back	***12,898***	4,647	5,022	3,229	
Calls Abandoned	***11,629***	4,356	4,616	2,657	
Address Changes Completed	***7,493***	3,451	2,133	1,909	

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	***5,239***	1,711	1,666	1,862	
Initial Reviews Completed	***5,159***	1,491	1,689	1,979	
Total Pending	***N/A***	4,012	4,225	4,515	
Reviewed	***N/A***	3,273	3,530	3,928	
Not Reviewed	***N/A***	739	795	587	
(SR2s Pending)	***N/A***	108	121	124	
Licenses Issued	***3,981***	1,359	1,203	1,419	
Renewals Issued	***47,994***	16,092	14,067	17,835	

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.

SR 2 - CATEGORIES					
	FY 11/12	Q1	Q2	Q3	Q4
Alcohol/Drugs	***69***	30	12	27	
PG/Medical Knowledge	***159***	59	40	60	
Convictions	***77***	43	18	16	
Other	***157***	92	44	21	

WORKLOAD REPORT

as of March 31, 2012

INTERNATIONAL MEDICAL SCHOOL APPLICATIONS FY 11/12

	FY 11/12	Q1	Q2	Q3	Q4
New Self-Assessment Report Received	3	2	0	1	
Pending Self-Assessment Report	N/A	3	5	6	
New Applications Received w/o Recognized Schools	55	22	14	19	
Pending Application Received w/o Recognized Schools	N/A	35	56	72	
School Recognized Pursuant to CCR 1314(a)(1)	10	4	2	4	
School Recognized Pursuant to CCR 1314(a)(2)	1	1	0	0	
TOTAL Pending Applications w/o Recognized Schools	N/A	62	75	90	

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	27	9	5	13	
Applications Pending	N/A	6	3	5	
Licenses Issued	22	4	8	10	
Licenses Renewed	88	24	31	33	

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

FICTITIOUS NAME PERMITS FY 11/12

	FY 11/12	Q1	Q2	Q3	Q4
P&S - FNP Issued	1,079	384	380	315	
P&S - FNP Pending	N/A	59	63	72	
Podiatric FNP Issued	19	3	9	7	
Podiatric FNP Pending	N/A	0	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

WORKLOAD REPORT

as of March 31, 2012

FISCAL YEAR 2011-2012

RESEARCH PSYCHOANALYST FY 11/12					
	FY 11/12	Q1	Q2	Q3	Q4
RP Applications Received	***2***	1	0	1	
RP Licenses Issued	***3***	3	0	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

SPECIALTY BOARD APPLICATIONS FY 11/12					
	FY 11/12	Q1	Q2	Q3	*Q4*
Applications Received	***0***	0	0	0	
Applications Pending	***N/A***	1	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	***27***	10	9	8	
Pending Applications Business	***N/A***	30	30	18	
Out-of-State Business Registrations Issued	***0***	0	0	0	
Pending Applications Out of State Bus.	***N/A***	0	0	0	
Spectacle Lens Registrations Issued	***148***	47	29	72	
Pending Applications-Spectacle Lens	***N/A***	78	107	29	
Contact Lens Registrations Issued	***67***	13	11	43	
Pending Applications-Contact Lens	***N/A***	22	33	15	
Spectacle Lens Registrations Renewed	***709***	216	217	276	
Contact Lens Registrations Renewed	***286***	95	79	112	

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	***75***	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

Licensing Chief's Report

WORKLOAD REPORT

as of March 31, 2012

Agenda Item 27B

FISCAL YEAR 2011-2012

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	3		9	5	3		3	7	2		5	2	3		10	15	10	
2112	0	0	0		0	0	0		1	0	0		0	0	0		1	1	1	
2113	5	6	9		5	8	9		14	4	4		6	11	14		8	10	14	
2168	3	0	1		1	1	1		0	2	0		3	0	1		3	1	2	
2072	0	0	0		0	0	0		0	0	0		1	0	0		0	0	0	
1327	0	0	0		0	0	0		0	0	0		1	1	0		0	0	0	

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

2111 - Visiting Fellow (doesn't satisfy postgraduate training required for licensure)

2112 - Hospital Fellowship Program Non-Citizen (does not satisfy postgraduate training required for licensure)

2113 - Medical School Faculty Member (may satisfy postgraduate training required for licensure)

2168 - Special Faculty Permit (academically eminent; unrestricted practice within sponsoring medical school - not eligible for licensure)

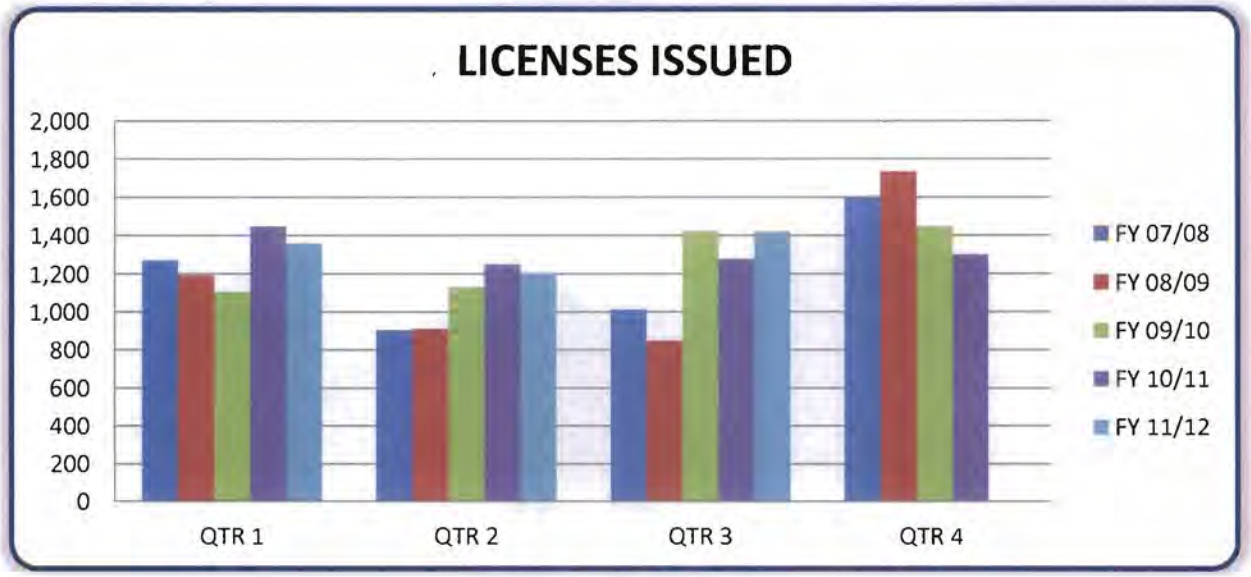
2072 - Special Permit - Correctional Facility

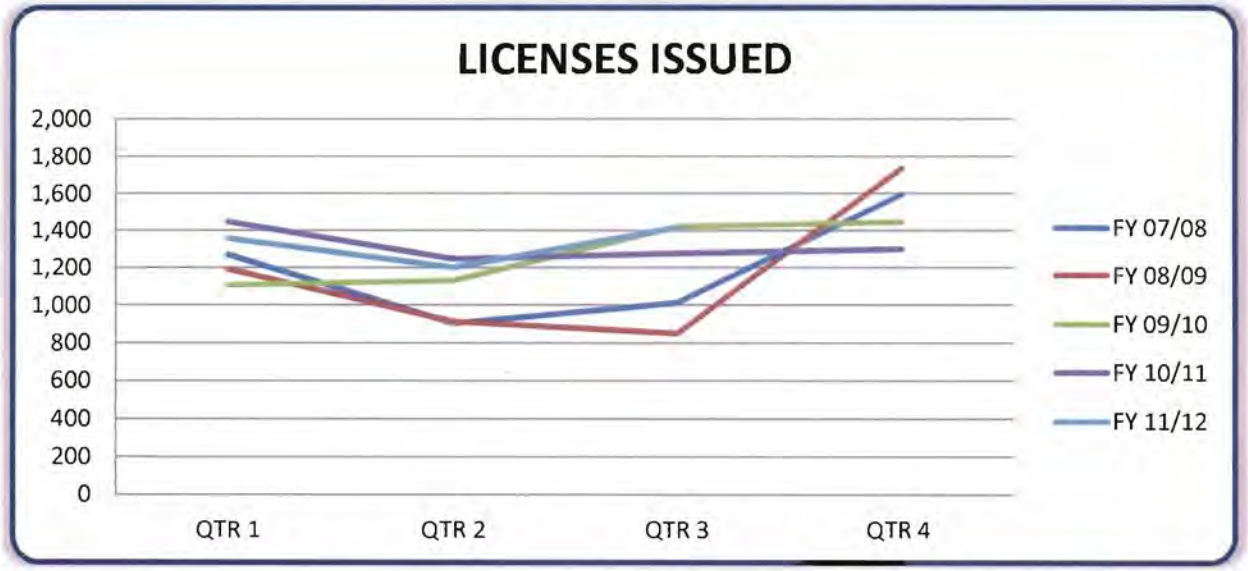
1327 - Medical Student Rotations - Non-ACGME Hospital Rotation

* The 11/12 Special Program Chart has been updated with corrections. This was necessary as staff identified errors in the stat tracking formulas.

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	1,419		***3,981***
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***



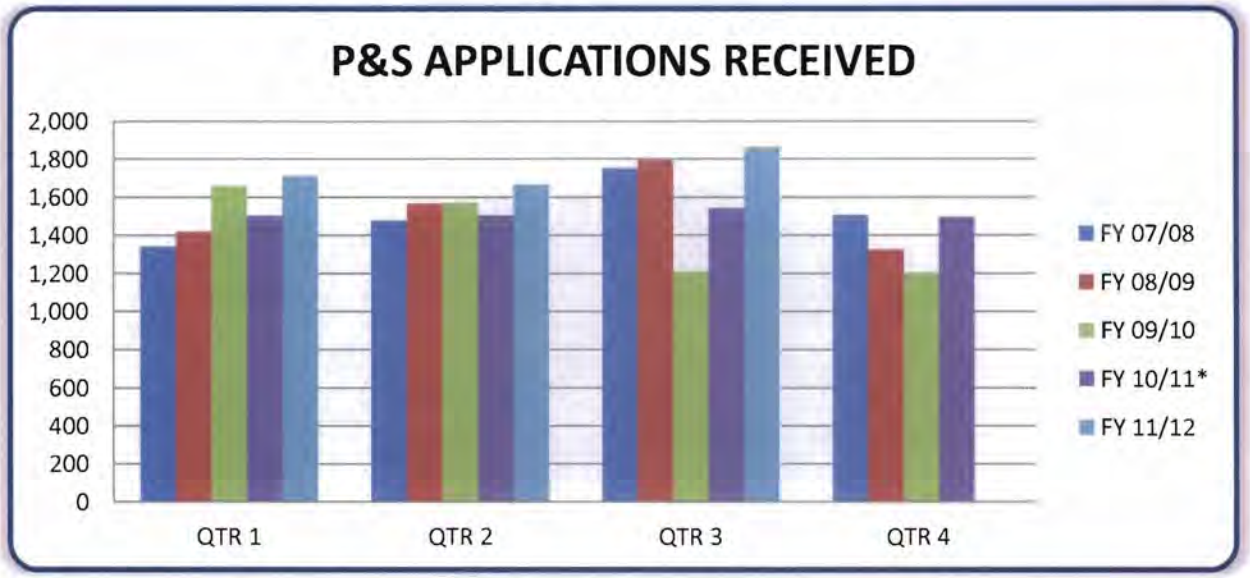


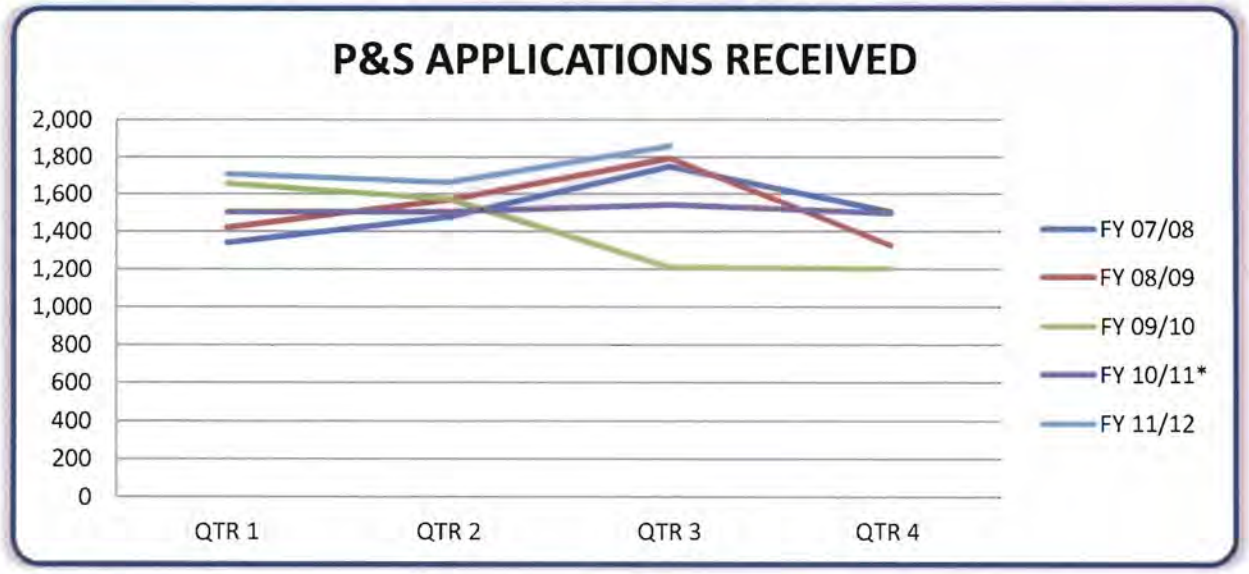
WORKLOAD REPORT
as of March 31, 2012

***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	1,862		***5,239***
FY 10/11*	1,503	1,505	1,543	1496	***6,047***
FY 09/10	1,658	1,573	1,211	1,203	***5,645***
FY 08/09	1,420	1,568	1,794	1,325	***6,107***
FY 07/08	1,341	1,478	1,751	1,506	***6,076***

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





WORKLOAD REPORT
as of March 31, 2012

Strategic Plan Goal 5: Organizational Effectiveness
Objective 5.1: Licensing Applications to be Reviewed Within 45 Days

	FY 11/12	Q1	Q2	Q3	*Q4*
# of Weeks 45 Day Initial Review Goal Not Met	***9***	2	6	1	
Number of Week Per Quarter / Toal Weeks	***39***	13	13	13	
Highest # of Days Initial Review Goal Exceeded	***N/A***	3	7	5	

INTERNATIONAL MEDICAL SCHOOL REVIEW
Per CCR Section 1314.1

COUNTRY	Medical School Name	Date Request Received	Letter Mailed to Medical School	Status of Application	CCR 1314.1(a)(1)	CCR 1314.1(a)(2)	Comments
Algeria	Universite Mouloud Mammeri de Tizi-Ouzou Faculty of Medicine	10/20/2011	3/14/2012	Pending		?	Letter sent on 3/14/12 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		Licensing Program verified medical school is owned and operated by the government, therefore, it is eligible for recognition pursuant to CCR 1314.1(a)(1).
Australia	Bond University Faculty of Health Sciences and Medicine	2/16/2012	4/4/2012	Pending	?	?	Letter sent on 4/4/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Australia	Queensland University (QU) - Australia U.S. Branch Campus	10/29/2010		Pending	?	?	Self-Assessment Report Received 01/17/2012 Staff needs to review Self-Assessment Report
Australia	University of Notre Dame Australia School of Medicine, Fremantle	2/16/2012	4/4/2012	Pending	?	?	Letter sent on 4/4/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Austria	Medical University of Innsbruck	6/2/2011	3/27/2012	Pending	?	?	Letter sent on 3/27/12 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	3/15/2012	Pending	?	?	Letter sent on 3/15/12 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	3/12/2012	Pending	?	?	Letter sent on 3/12/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Bangladesh	University of Dhaka, Zainul Haque Sikder Women's Medical College & Hospital	7/13/2010	3/12/2012	Pending	?	?	Letter sent on 3/12/12 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	Letter Mailed to Medical School	Status of Application	CCR 1314.1(a)(1)	CCR 1314.1(a)(2)	Comments
Brazil	Centro Universitario Serra dos Orgaos Faculdaded Unificadas (UNIFESO)	1/4/2012	3/12/2012	Pending	?	?	Letter sent on 3/12/12 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	9/21/2011 1/13/2012	Pending	?	?	Staff requested additional information from FMIT to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Brazil	Universidade Estacio de Sa (UNESA) Faculdade de Medicina	2/1/2012	3/27/2012	Pending	?		Letter sent on 3/27/12 to the medical school requesting information 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	3/9/2012	Pending	?	?	Letter sent on 3/9/12 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	6/28/2011	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	4/13/2012	Pending	?	?	Letter sent on 4/13/12 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	3/22/2012	Pending	?	?	Letter sent on 3/22/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
China	Anhui Medical University Faculty of Medicine	10/12/2011	3/20/2012	Pending	?	?	Letter sent on 3/20/12 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	3/8/2012	Pending	?	?	Letter sent on 3/8/12 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	3/22/2012	Pending	?	?	Letter sent on 3/22/12 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	3/26/20012	Pending	?	?	Letter sent on 3/26/12 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	Letter Mailed to Medical School	Status of Application	CCR 1314.1(a)(1)	CCR 1314.1(a)(2)	Comments
China	Shanghai Railway Medical University	7/6/2011	3/12/2012	Pending	?	?	Letter sent on 3/12/12 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	3/15/2012	Pending	?	?	Initial response from school reviewed. Letter sent on on 4/2/2012 to request additional information from TMU.
China	Tongji Medical College of Huazhong University of Science and Technology	8/31/2011	3/8/2012	Pending	?	?	Letter sent on 3/8/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
China	Xi'an Jiaotong University College of Medicine	6/21/2010	4/9/2012	Pending	?	?	Letter sent on 4/9/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
China	XinXiang Medical College	1/13/2012	3/30/2012	Pending	?	?	Letter sent on 3/30/12 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	3/12/2012	Pending		X	Additional information was requested from UNIBE on 3/12/2012 based on medical consultant's review of self-assessment report.
Ecuador	Universidad San Francisco de Quito Colegio de Ciencias de la Salud	12/19/2011	3/21/2012	Pending	?	?	Letter sent on 3/8/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Egypt	Benha Faculty of Medicine, Benha University	9/2/2011	3/22/2012	Pending	?	?	Letter sent on 3/22/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Egypt	University of Cairo Faculty of Medicine, Kasr Alainy Medical School	10/12/2011	4/4/2012	Pending	?	?	Letter sent on 4/2/12 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	3/27/2012	Pending	?	?	Letter sent on 3/27/12 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	Letter Mailed to Medical School	Status of Application	CCR 1314.1(a)(1)	CCR 1314.1(a)(2)	Comments
Georgia	Tbilisi Medical Institute 'Vita'	6/22/2011	4/11/2012	Pending	?	?	Letter sent on 4/11/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Greece	National and Kapodistrian University of Athens Faculty of Medicine	1/27/2012	3/30/2012	Pending	?	?	Letter sent on 3/30/12 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		Licensing Program verified medical school is owned and operated by the government, therefore, it is eligible for recognition pursuant to CCR 1314.1(a)(1).
India	Baba Farid University of Health Sciences, Government Medical College, Patiala	1/14/2011		Recognized	X		Licensing Program verified medical school is owned 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		Licensing Program verified medical school is owned 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	3/8/2012	Pending	?	?	Letter sent on 3/8/12 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		Licensing Program verified medical school is owned 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	8/30/2011	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	3/16/2012	Pending	?	?	Letter sent on 3/8/12 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		Licensing Program verified medical school is owned and operated by the government, therefore, it is eligible for recognition pursuant to CCR 1314.1(a)(1).
India	Maharashtra University of Health Sciences, Government Medical College Nagpur	9/14/2010		Recognized	X		Licensing Program verified medical school is owned and operated by the government, therefore, it is eligible for recognition pursuant to CCR 1314.1(a)(1).

COUNTRY	Medical School Name	Date Request Received	Letter Mailed to Medical School	Status of Application	CCR 1314.1(a)(1)	CCR 1314.1(a)(2)	Comments
India	Maharashtra University of Health Sciences, Lokmanya Tilak Municipal Medical College	8/26/2011	3/8/2012	Pending	?	?	Letter sent on 3/8/12 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		Licensing Program verified medical school is owned 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	3/12/2012	Pending	?	?	Letter sent on 3/12/12 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	3/12/2012	Pending	?	?	Letter sent to school on 3/12/2022 requesting additional information.
India	Mahatma Gandhi University, Malankara Orthodox Syrian Church Medical College	2/24/2011	3/16/2012	Pending	?	?	Letter sent on 3/16/12 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	3/20/2012	Pending	?	?	Letter sent on 3/20/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	NTR University of Health Sciences, Osmania Medical College	3/30/2012	4/11/2012	Pending	?	?	Letter sent on 4/11/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	NTR University of Health Sciences, P E S Institute of Medical Sciences and Research	6/21/2011	3/22/2012	Pending	?	?	Letter sent on 3/22/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	NTR University of Health Sciences, Sri Venkateswara Medical College, Vijayawada	2/7/2012	4/5/2012	Pending	?	?	Letter sent on 4/5/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Pondicherry University, Vinayaka Mission's Medical College	8/31/2011	4/11/2012	Pending	?	?	Letter sent on 4/11/12 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	Letter Mailed to Medical School	Status of Application	CCR 1314.1(a)(1)	CCR 1314.1(a)(2)	Comments
India	Rajasthan University of Health Sciences, Mahatma Gandhi Medical College and Hospital, Jaipur	3/16/2012	3/19/2012	Pending	?	?	Letter sent on 3/19/12 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	3/13/2012	Pending	?	?	Letter sent on 3/13/12 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, Vydehi Institute of Medical Sciences & Research Centre, Bangalore	1/31/2012	4/5/2012	Pending	?	?	Letter sent on 4/5/12 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	3/9/2012	Pending	?	?	Letter sent on 3/9/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Sikkim Manipal University of Health, Medical & Technoligical Sciences, Sikkim Manipal Institute of Medical Sciences	2/21/2012	3/9/2012	Pending	?	?	Letter sent on 3/9/12 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		Licensing Program verified medical school is owned 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	3/15/2012	Pending	?	?	Letter sent on 3/15/12 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		Licensing Program verified medical school is owned 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		Licensing Program verified medical school is owned and operated by the government, therefore, it is eligible for recognition pursuant to CCR 1314.1(a)(1).
India	Tilaka Manjhi Bhagalpur University, Jawaharlal Nehru Medical College	8/29/2011	4/5/2012	Pending	?	?	Letter sent on 4/5/12 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	Letter Mailed to Medical School	Status of Application	CCR 1314.1(a)(1)	CCR 1314.1(a)(2)	Comments
India	University of Kashmie, Jehlum Valley College of Medical Sciences	8/10/2011	3/20/2012	Pending	?	?	Letter sent on 3/20/12 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		Licensing Program verified medical school is owned and operated by the government, therefore, it is eligible for recognition pursuant to CCR 1314.1(a)(1).
India	Veer Narmad South Gujarat University, Government Medical College	1/5/2012		Recognized	X		Licensing Program verified medical school is owned 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	4/5/2012	Pending	?	?	Letter sent on 4/5/2012 to the medical school requesting information to determine eligibility for recogntion pursuant to CCR 1314.1(a)(1).
Iran	Ahvaz Jondishapour University of Medical Sciences	9/13/2011	3/8/2012	Pending	?	?	Letter sent on 3/8/12 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	3/26/2012	Pending	?	?	Letter sent on 3/26/12 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		Recognized	X		Licensing Program verified medical school is owned and operated by the government, therefore, it is eligible for recognition pursuant to CCR 1314.1(a)(1).
Iran	Shiraz University of Medical Sciences	9/12/2011	10/17/2011	Recognized	X		Licensing Program verified medical school is owned 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		Licensing Program verified medical school is owned 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	Letter Mailed to Medical School	Status of Application	CCR 1314.1(a)(1)	CCR 1314.1(a)(2)	Comments
Iraq	Al-Anbar University College of Medicine	10/19/2011	4/5/2012	Pending	?	?	Letter sent on 4/5/12 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	3/9/2012	Pending	?	?	Letter sent on 3/9/12 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 beginning of the English Language Program in 1996.
Italy	Universita degli Studi di Milano Bicocca Faculty of Medicine and Surgery	9/9/2011	3/13/2012	Pending	?	?	Letter sent on 3/13/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Japan	Faculty of Medicine, University of Miyazaki	10/6/2010	3/20/2012	Pending	?	?	Letter sent on 3/19/12 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)		4/4/2011	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	3/22/2012	Pending	?	?	Letter sent on 3/22/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Japan	Kyorin University School of Medicine	2/17/2012	3/13/2012	Pending	?	?	Letter sent on 3/13/12 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	4/12/2012	Pending	?	?	Letter sent on 4/12/12 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	Letter Mailed to Medical School	Status of Application	CCR 1314.1(a)(1)	CCR 1314.1(a)(2)	Comments
Kazakhstan	Karaganda State Medical Academy	8/25/2010	3/9/2012	Pending	?	?	Letter sent on 3/9/12 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	4/11/2012	Pending	?	?	Letter sent on 4/11/12 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	4/11/2012	Pending	?	?	Letter sent on 4/11/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Nepal	Kathmandu University, Manipal College of Medical Sciences	12/6/2010		Recognized	X		Licensing Program verified medical school is owned and operated by the government, therefore, it is eligible 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
Neves	Medical University of the Americas	3/19/2012		Pending		X	Staff needs to review Self-Assessment Report
Nigeria	Ladoke Akintola University of Technology College of Health Sciences	11/13/2010	3/13/2012	Pending	?	?	Letter sent on 3/13/12 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	3/26/2012	Pending	?	?	Letter sent on 3/26/12 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	5/11/2011	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	3/30/2012	Pending	?	?	Letter sent on 3/30/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Pakistan	Dow University of Health Sciences, Dow Medical College	2/7/2012	4/5/2012	Pending	?	?	Letter sent on 4/5/12 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	Letter Mailed to Medical School	Status of Application	CCR 1314.1(a)(1)	CCR 1314.1(a)(2)	Comments
Pakistan	Karachi Medical and Dental College, University of Karachi Faculty of Medicine	4/9/2012	4/10/2012	Pending	?		Letter sent on 4/10/12 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	1/14/2012	Recognized	X		Licensing Program verified medical school is owned and operated by the government, therefore, it is eligible for recognition pursuant to CCR 1314.1(a)(1).
Pakistan	University of Health Sciences Lahore, Nishtar Medical College and Hospital (NMCH)	9/1/2010	5/17/2011	Pending	?	?	Staff needs to request additional information from NMCH.
Pakistan	University of Health Sciences Lahore, Quaid-E-Azam Medical College	1/24/2012	3/20/2012	Pending	?	?	Letter sent on 3/20/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Poland	Medical University of Bialystok	1/4/2012	3/12/2012	Pending	?	?	Letter sent on 3/12/12 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		3/12/2012	Pending		X	Additional information was requested on 3/12/2012 based on medical consultant's review of self-assessment report.
Qatar	Weill Cornell Medical College in Qatar		6/14/2011	Recognized	X		WCMC - Q provided all of the necessary documents to verify eligibility for recognition pursuant to CCR 1314.1(a)(1).
Russia	Lomonsov Moscow University		11/10/2011	Recognized	X		Licensing Program verified medical school is owned and operated by the government, therefore, it is eligible for recognition pursuant to CCR 1314.1(a)(1).
Russia	Moscow State University of Medicine & Dentistry	3/20/2012	3/27/2012	Pending	?		Letter sent on 3/27/2012 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Russia	Novosibirsk State Medical Academy	2/7/2012	3/27/2012	Pending	?		Letter sent on 3/27/2012 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	Letter Mailed to Medical School	Status of Application	CCR 1314.1(a)(1)	CCR 1314.1(a)(2)	Comments
Russia	Yaroslavl State Medical Academy	5/10/2011	4/11/212	Pending	?	?	Letter sent on 4/11/2012 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	3/9/2012	Pending	?	?	Letter sent on 3/9/12 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	9/19/2011	Pending	?	?	Staff needs to request information from DNUS.
South Africa	Walter Sisulu University Faculty of Health Sciences	10/20/2011	4/5/2012	Pending	?	?	Letter sent on 4/5/12 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	3/9/2012	Recognized	X		Licensing Program verified medical school is owned and operated by the government; therefore, it is eligible for recognition pursuant to CCR 1314.1(a)(1).
South Korea	Dankook University College of Medicine	12/6/2010	3/9/2012	Pending	?	?	Letter sent on 3/9/12 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	4/30/2011	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	Inha University College of Medicine	2/29/2012	4/5/2012	Pending	?		Letter sent on 4/5/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
South Korea	Konkuk University College of Medicine	10/31/2011	4/5/2012	Pending	?	?	Letter sent on 4/5/12 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	4/12/2012	Pending	?	?	Letter sent on 4/12/12 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	Letter Mailed to Medical School	Status of Application	CCR 1314.1(a)(1)	CCR 1314.1(a)(2)	Comments
Taiwan	Fu Jen Catholic University School of Medicine	3/23/2011	3/26/2012	Pending	?	?	Letter sent on 3/26/12 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	M. Gorky Donetsk National Medical University	7/8/2011	4/9/2012	Pending	?	?	Letter sent on 4/9/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Ukraine	Odessa State Medical University	11/23/2010	3/9/2012	Pending	?	?	Letter sent on 3/9/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Venezuela	Universidad Central de Venezuela Escuela de Medicina Jose Marie Vargas		3/22/2012	Pending	?	?	Letter sent on 3/22/12 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		3/22/2012	Pending	?	?	Letter sent on 3/22/12 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	4/16/2012	Pending	?	?	Letter sent on 4/16/12 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	4/16/2012	Pending	?	?	Letter sent on 4/16/12 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:	April 13, 2012
ATTENTION:	Medical Board of California
SUBJECT:	Midwifery Advisory Council (MAC) Vacancies
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing
REQUESTED ACTION:	Reappoint Karen Ehrlich, L.M. to the MAC's vacant Licensed Midwife position.

STAFF RECOMMENDATION: Staff recommends that the Board accept this request to appoint to the Licensed Midwife position, Karen Ehrlich, L.M., to a three-year term with the MAC.

EXECUTIVE SUMMARY: Business and Professions Code section 2509 states that the Board shall create and appoint a Midwifery Advisory Council consisting of licensees of the board in good standing, who need not be members of the Board, and members of the public who have an interest in midwifery practice, including but not limited to, home births. At least one-half of the council members shall be California licensed midwives.

At its February 2-3, 2012, meeting, the Board determined that the public member positions on the MAC would be filled by: one California licensed physician practicing in the area of obstetrics/gynecology, one non-licensee of the Board, and one member of the Board. The Board also granted permission for the MAC to vote on and seat the selected members at its March 29, 2012 meeting, with the selected members subject to approval by the full Board at its next quarterly meeting.

On February 21, 2012, a Midwifery Advisory Council Member Interest Form was mailed to all California licensed midwives and individuals on the interested parties mailing list. An application was also posted on the Board's website. Three applications for the Ob-gyn position, three applications for the licensed midwife position and seven applications for the public member position were received. At the March 29, 2012, MAC meeting, applicants were given the opportunity to address the Council.

Karen Ehrlich has been a licensed midwife since 1996. She has been a member of the MAC since 2007, and served as Chairwoman from April 2010 through December 2011, and Vice Chairwoman in 2012. She continues to serve on the Midwifery Education Accreditation Council, and has done so since 2007. As a licensed midwife, Ms. Ehrlich is interested in continuing to serve on the MAC.

The MAC members voted to recommend to the full Board, reappointment of, Karen Ehrlich, L.M., to the MAC.

FISCAL CONSIDERATIONS: None.

PREVIOUS MBC AND/OR COUNCIL ACTION: Not applicable.

MEDICAL BOARD OF CALIFORNIA
Midwifery Program
Midwifery Advisory Council Member Interest Form

Expectations of Membership: *The Midwifery Advisory Council (MAC) members volunteer to serve and attend all MAC meetings for up to a three-year term. Duties and responsibilities include those specified by the Medical Board of California (Board) members, Board staff, or designees. This interest form has been developed to solicit volunteers who will serve on the Midwifery Advisory Council, which is an advisory council that shall make recommendations to the Medical Board of California on matters specified by the Board. The MAC represents the midwifery community and the organizations/associations that represent licensed midwives in the State of California. The Council also includes public member representatives who have an interest in midwifery, but are not licensed midwives. To be considered for appointment, please mail, e-mail, or fax your Interest Form* ***by March 15, 2012*** *to:*

Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
Attention: Midwifery Program
FAX: (916) 263-2487
Susan.Morrish@mbc.ca.gov

If you have any questions please contact Susan Morrish at (916) 263-2393.

Name: EHRLICH KAREN H.
(Please Print legibly - LAST, First, Middle Initial)

Address: [redacted] [redacted] [redacted] [redacted] [redacted]
Street *Suite/ Apartment #* *City* *State* *Zip Code*

Phone: [redacted] *Daytime* [redacted] ( ) _____ *Evening* [redacted] *FAX* [redacted]

E-Mail Address (if applicable): [redacted] @ [redacted]

Are you a California Licensed Midwife?: ☒ YES ☐ NO *(Check only one)* *License Number: LM #* 6

Are you a California Licensed Physician?: ☐ YES ☒ NO *(Check only one)* *License Number:* _____
If yes, are you currently practicing as an obstetrician/gynecologist? ☐ YES ☐ NO *(Check only one)*

Organization/Association being represented: Midwifery Advisory Council
(If volunteering as anon-licensee "public member" please insert the word "SELF – PUBLIC Interest")

Position within the Organization/Association: _____
(Board member, executive, or member)

Do you have a prepared Resume or List of Qualifications Available? ☒ Yes ☐ No
(Please attach Resume or List of Qualifications to this form)

What is your interest in midwifery practice and home births? I want to see Licensed Midwives able to provide high quality care that is within the terms of our license.
(Attach additional comments if more space is needed)

Karen H Ehrlich, LM
(Signature)

3/3/12
(Date)

DISCLOSURE: Providing this information is strictly voluntary. The personal information requested on this form is being collected for consideration of appointment as a member of the Midwifery Advisory Council. This information will be reviewed by the Board staff and members of the Board and/or Midwifery Committee. This form will be retained in the files of the Licensing Program. This position is voluntary and will require future time commitments. This form and attachments must be returned no later than March 15, 2012.

Karen H. Ehrlich, CPM, LM, MA [redacted] January 2012

Midwife, Childbirth Educator, Sexuality Educator

LICENSED MIDWIFE - State of California – since 1996
CERTIFIED PROFESSIONAL MIDWIFE- North American Registry of Midwives since 1996
REGISTERED MIDWIFE - North American Registry of Midwives – 1991 to 1996
CERTIFIED MIDWIFE - California Association of Midwives - 1988 to 1992

Professional Positions

MEDICAL BOARD OF CALIFORNIA

Midwifery Advisory Council – Charter Member 2007 to present
Chairwoman April 2010 through December 2011
Vice Chairwoman 2012
Division of Enforcement – Expert Consultant – 2010 to present

MIDWIFERY EDUCATION ACCREDITATION COUNCIL

Continuing Education Committee – 2007 to present

Work Experience

PRIVATE MIDWIFERY PRACTICE - 1976 to present

COMMUNITY EDUCATOR IN CHILDBIRTH AND MIDWIFERY - 1977 to present

Preceptor as needed – National Midwifery Institute – Sebastopol CA & Bristol VT
National College of Midwifery – Taos NM

Cabrillo College Extension – Perinatal Nursing - 2004

Cabrillo College and UC Santa Cruz - Early Childhood Education and Human Sexuality
Guest speaker – 1979 to present

Monterey Peninsula College, Monterey CA – Psychology of Women, Human Sexuality
Guest speaker ca 1995 to present

Sage Femme Midwifery School - instructor, 1987 to 1998

Education Program Associates, Campbell - Guest speaker in Alternative Modalities - 1988 to 1997

Planned Parenthood (Santa Cruz and Monterey) – 1976 to 1989
classes for sex education teachers; guest lectures and lecture series in many aspects of human sexuality and childbirth, presented in public and private elementary middle, junior high, high school, and college classes, and to adult groups of parents, business people, and service clubs

Community Hospital, Santa Cruz - 1978 - inservice classes for Birth Center nurses

Institute of Feminine Arts, Santa Cruz - 1977-1979 - workshops/classes for midwives and for students of midwifery

PERINATAL PROGRAM COORDINATOR & PRENATAL EDUCATOR- 1990 to 1994
Westside Community Health Center
1119 Pacific Avenue, Suite 200, Santa Cruz, CA 95060

COMMUNITY EDUCATION COORDINATOR - 1986-1989; EDUCATOR – 1976 to 1989
Planned Parenthood of Santa Cruz County
1119 Pacific Avenue, Santa Cruz 95060

CHILDBIRTH EDUCATOR – 1987 to 1988
Santa Cruz Medical Clinic 2025 Soquel Avenue, Santa Cruz 95062

CHILDBIRTH EDUCATOR, PRENATAL CARE PROVIDER – 1977 to 1979
Cedar Medical Clinic 540 Soquel Avenue, Santa Cruz 95062

CHILDBIRTH EDUCATOR – 1976 to 1982
YWCA
Cedar Medical Clinic
Santa Cruz County Adult Education
Private independent classes

Education

Master of Arts, Goddard College, Plainfield, Vermont – July, 2003
Health Arts and Sciences

Independent Study in Childbirth and Midwifery - 1973-present
Apprenticeship in Midwifery - 1975-1976

Bachelor of Science, Ithaca College, Ithaca, New York - 1968
Speech, English, and Secondary Education

Current Memberships

California Association of Midwives
Midwives Alliance of North America
National Association of Certified Professional Midwives
Midwifery Education Accreditation Council
Citizens for Midwifery
Coalition for Improving Maternity Services
Association for Pre and Perinatal Psychology and Health
Citizens for Health

Publications

"The Santa Cruz Birth Center Today" in *Birth and the Family Journal* Vol. 3, #3, Fall, 1976

Birth Song - 1979 - a book of poetry about birth

Midwife Means 'With Woman' - co-authored with Elizabeth Hallett, published by Midwives Childbirth Awareness Project/California Association of Midwives 1991

Life is a Sexually Transmitted Condition:The Sexuality of Labor and Birth, unpublished thesis, Goddard College, 2003

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	April 13, 2012
ATTENTION:	Medical Board of California
SUBJECT:	Midwifery Advisory Council (MAC) Vacancies
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing
REQUESTED ACTION:	Appoint James Byrne, M.D. to the MAC's vacant Ob-Gyn. Public Member position.

STAFF RECOMMENDATION: Staff recommends that the Board accept this request to appoint to a Public Member position, James Byrne, M.D. to a three-year term with the MAC.

EXECUTIVE SUMMARY: Business and Professions Code section 2509 states that the Board shall create and appoint a Midwifery Advisory Council consisting of licensees of the board in good standing, who need not be members of the Board, and members of the public who have an interest in midwifery practice, including, but not limited to, home births. At least one-half of the Council members shall be California licensed midwives.

At its February 2-3, 2012, meeting, the Board determined that the public member positions on the MAC would be filled by: one California licensed physician practicing in the area of obstetrics/gynecology, one non-licensee of the Board, and one member of the Board. The Board also granted permission for the MAC to vote on and seat the selected members at its March 29, 2012 meeting, with the selected members subject to approval by the full Board at its next quarterly meeting.

On February 21, 2012, a Midwifery Advisory Council Member Interest Form was mailed to all California licensed midwives and individuals on the interested parties mailing list. Three applications for the Ob-gyn position, three applications for the licensed midwife position and seven applications for the public member position were received. At the March 29, 2012, MAC meeting, applicants were provided an opportunity to address the Council.

Dr. James Byrne has been the Chief of Obstetrics and Maternal Fetal Medicine at the Santa Clara Valley Medical Center for the past eight years. In 2011, Dr. Byrne founded The Lucinda Health Foundation, a non-profit organization that seeks to improve maternal care delivery through several pathways, including a collaborative practice model for midwives and physicians. He is currently appointed on the American College of Obstetricians and Gynecologists, District IX, California, State Obstetrics Safety Committee. He is dedicated to improving maternal care and safety and has longstanding efforts in supporting midwifery.

The MAC members voted to recommend to the full Board, James Byrne, M.D., for appointment to the MAC.

FISCAL CONSIDERATIONS: None.

PREVIOUS MBC AND/OR COUNCIL ACTION: Not applicable.

MEDICAL BOARD OF CALIFORNIA
Midwifery Program
Midwifery Advisory Council Member Interest Form

Expectations of Membership: *The Midwifery Advisory Council (MAC) members volunteer to serve and attend all MAC meetings for up to a three-year term. Duties and responsibilities include those specified by the Medical Board of California (Board) members, Board staff, or designees. This interest form has been developed to solicit volunteers who will serve on the Midwifery Advisory Council, which is an advisory council that shall make recommendations to the Medical Board of California on matters specified by the Board. The MAC represents the midwifery community and the organizations/associations that represent licensed midwives in the State of California. The Council also includes public member representatives who have an interest in midwifery, but are not licensed midwives. To be considered for appointment, please mail, e-mail, or fax your Interest Form* ***by March 15, 2012*** *to:*

Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
Attention: Midwifery Program
FAX: (916) 263-2487
Susan.Morrish@mbc.ca.gov

If you have any questions please contact Susan Morrish at (916) 263-2393.

Name: BYRNE, JAMES DANIEL
(Please Print legibly - LAST, First, Middle Initial)

Address: [redacted]
Street *Suite/ Apartment #* *City* *State* *Zip Code*

Phone: [redacted] ([redacted]) ( ) N/A
Daytime *Evening* *FAX*

E-Mail Address (if applicable): [redacted]

Are you a California Licensed Midwife?: ☐ YES ☑ NO *(Check only one)* *License Number: LM #* _____

Are you a California Licensed Physician?: ☑ YES ☐ NO *(Check only one)* *License Number:* 674780
If yes, are you currently practicing as an obstetrician/gynecologist? ☑ YES ☐ NO *(Check only one)*

Organization/Association being represented: SANTA CLARA VALLEY MEDICAL CENTER
(If volunteering as anon-licensee "public member" please insert the word "SELF – PUBLIC Interest")

Position within the Organization/Association: CHAIR – OB/GYN
(Board member, executive, or member)

Do you have a prepared Resume or List of Qualifications Available? ☑ Yes ☐ No
(Please attach Resume or List of Qualifications to this form)

What is your interest in midwifery practice and home births? MY CAREER HAS BEEN
(Attach additional comments if more space is needed)
DEDICATED TO IMPROVING MATERNAL CARE AND SAFETY. AND THAT HAS INCLUDED LONG STANDING EFFORTS TO SUPPORT MIDWIFERY. SEE LETTER

JByrne 3/14/12
(Signature) *(Date)*

DISCLOSURE: Providing this information is strictly voluntary. The personal information requested on this form is being collected for consideration of appointment as a member of the Midwifery Advisory Council. This information will be reviewed by the Board staff and members of the Board and/or Midwifery Committee. This form will be retained in the files of the Licensing Program. This position is voluntary and will require future time commitments. This form and attachments must be returned no later than March 15, 2012.

JAMES DANIEL BYRNE, M.D.

CONTACT INFORMATION:
PHONE
EMAIL
MAIL

OVERVIEW OF EXPERTISE

Improving performance and safety. System, regional, and national obstetrics care quality improvement.

- Local: Developed and implemented new clinical and quality improvement systems for the largest public hospital birth center in California, including OB peer review, quality assessment, and system based improvement collaborations with multiple service lines.
- Regional/State: Role as leader and advisor for obstetrics care systems at a full spectrum of California hospitals, ranging from small rural centers to large university centers.
  - ACOG District IX State of California
    - Obstetrics Patient Safety Leadership Committee
  - California Maternal Quality Care Collaborative
    - Executive Committee
    - Contributing reviewer of both the Obstetrical Hemorrhage Toolkit and Eliminating Elective Delivery < 39 Weeks Toolkits that have been implemented nationally
  - March of Dimes
    - California Chapter Board of Directors
    - Chair of State Program Services Committee

  Consultant for Medical Board of California, UC Regents, and health systems.
- National: Recognized for large scale maternity care improvement and organizational change.
  - National Association of Public Hospitals
    - 2011 Chair of Advisory Committee- Perinatal Quality Initiative to Reduce Elective Deliveries in the Medicaid Population
    - 2010 Safety Net Award for implementing a regional program increasing OB care access and revenues
  - Former member of HCA Perinatal Safety Initiative physician advisory committee, a complex national collaborative to improve birth and newborn care at over 200 hospitals nationwide.

Leading design and implementation of several innovative regional maternity care programs.

- Government operated hospital system: New regional system of sub-specialty pregnancy clinics for a large safety-net health system. Annual visits increased 56% and revenues over 500%
- Public Private Partnership: New Maternal Fetal Medicine services at an urban not-for-profit hospital including Ultrasound and Diabetes in pregnancy care programs.
- Public Private Partnership: Designed and implemented an indigent care birth service at a rural hospital through a strategic partnership between multiple organizations.

Clinical Research: proven performance as site principle investigator including leading regulatory compliance, operations, and finances.

- 2011-current, National Institute of Child Health and Human Development Maternal Fetal Medicine Units Network. Stanford/SCVMC Collaboration. Site Principle Investigator
- 2004-current. Site Principle Investigator for multiple FDA-monitored, sponsored, multi-center trials.

CURRENT POSITIONS

2008 to Current **Santa Clara Valley Medical Center. San Jose, CA**
Chair Department of Obstetrics and Gynecology

- Leader of one of California's largest OB/Gyn Departments. Over 50 physicians and nurse practitioners at three hospitals with >120,000 annual clinic visits and >$30m in annual revenue.

2003 to Current **Santa Clara Valley Medical Center. San Jose, CA**
Chief of Obstetrics and Chief of Maternal-Fetal-Medicine

Medical Director for Obstetrics Service Areas

1. Labor and Delivery Triage/Ambulatory ~ *10,000 annual visits, more than many hospital ER's.*
2. Labor and Delivery *~4,500 annual births, California's largest public hospital birth center*

Medical Director for Maternal Fetal Medicine Service Areas

MFM- Services. MFM is crucial to supporting OB care systems and key to sustaining NICU and Pediatric specialty services.

1. Perinatal Ultrasound. *Four clinic sites with ~12,000 OB scans in 2010, one of the largest and most sophisticatedly coordinated OB Gyn Department level ultrasound systems in California. State AFP program approved referral center and AIUM accredited.*
2. PEP- Diabetes in Pregnancy Program. *One of largest such programs in State while also providing full OB care to our patients.*

CURRENT APPOINTMENTS

2003-Current Affiliated Clinical Associate Professor of Maternal Fetal Medicine and Obstetrics and Gynecology. Stanford University School of Medicine. Palo Alto, CA.
Scope: Regional/Local. Medical student education.

2010- Current March of Dimes California Chapter Board of Directors and Chair of State Program Services Committee
Scope: Statewide- over 500,000 annual births and State level MOD patient programs are then commonly adopted as the national MOD guidelines/projects.

2007-Current Executive Committee, California Maternal Quality Care Collaborative. Maternal Child and Adolescent Health Program, California Department of Public Health
Scope: Statewide- over 500,000 annual births. Group leads development of public policy and programs to monitor outcomes and improve safety for all births occurring in California.

2009-Current ACOG, District IX California State Obstetrics Safety Committee
Scope: Statewide ACOG group leads physician education and hospital safety.

2004-Current Medical Expert Reviewer. Executive Office of the Medical Board of California.
Scope: Statewide. Consultant for MBC investigations regarding OB care issues.

SIGNIFICANT PRIOR APPOINTMENTS

2006-2010 Perinatal Committee of the Expanded AFP Program, Prenatal Screening Section, Genetic Disease Branch, California Department of Health Services.
Scope: Statewide- ~ 350,000 annual pregnancies. Group leads revisions of the AFP program.

2004-2006 Fellow, California HealthCare Foundation (CHCF) Health Care Leadership Program.
Scope: Statewide. Competitive entry two-year fellowship to develop leadership and corporate skills needed to improve health care policy and delivery in California. Tuition and fees (~$50,000) sponsored by CHCF. Education administered by the UCSF Center for the Health Professions and the UCLA Anderson School of Management.

2004-2008 Expert Ultrasound Reviewer. American Institute of Ultrasound in Medicine.

Scope: National. Consultant for quality and regulatory standards case review of physicians and groups performing pregnancy related ultrasounds.

2002-2003 Charter Member of Physician Work Group: HCA National Perinatal Safety Initiative (formally Perinatal Risk Management Initiative). HCA Corporation, Nashville, TN.
Scope: National, 200,000 annual births. This multi-million dollar project developed and implemented patient safety programs including QI and evidence based medicine algorithms at 200 HCA hospitals nationwide, increased safety and decreasing professional liability claims.

RECENT HONORS AND RECOGNITION

2010 National Association of Public Hospitals Safety Net Award for 'Improving Access and Revenues: Applying Robust Process Improvement Models to Expand Regional Prenatal Services in a Safety-Net Healthcare System'

2005-2012 The Best Doctors in America®: Maternal Fetal Medicine

LICENSURE AND BOARD CERTIFICATION

1992-Current Licensed Physician California
2000 Maternal Fetal Medicine. Certificate #95-1250M
American Board of Obstetrics and Gynecology.
1998 Obstetrics and Gynecology. Certificate #95-1250
American Board of Obstetrics and Gynecology.

EDUCATION AND TRAINING

1995-1997 Maternal Fetal Medicine Fellowship
Women's and Children's Hospital
University of Southern California School of Medicine, Los Angeles, CA

1991-1995 Obstetrics and Gynecology Residency
Women's and Children's Hospital
University of Southern California School of Medicine, Los Angeles, CA

1987-1991 Doctorate of Medicine
Stritch School of Medicine, Loyola University Chicago, Chicago, IL

1982-1987 Bachelor of Arts Degree, Magna Cum Laude
California Lutheran University, Thousand Oaks, CA

HONORS AND AWARDS DURING TRAINING

1995 Outstanding Resident Teacher Award in Obstetrics.
University of Southern California School of Medicine
1995 Outstanding Resident Teacher Award in Gynecology.
University of Southern California School of Medicine
1995 Parke-Davis Scholar Award.
Association of Professors of Gynecology and Obstetrics
1994 CREOG Exam 99th%tile. Highest Score in USC Residency Program of 50 residents
1993 CREOG Exam 98th%-tile. Highest Score in USC Residency Program of 50 residents

Additional information regarding publications, presentations, and research available on request.

rev 06-2011

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	April 13, 2012
ATTENTION:	Medical Board of California
SUBJECT:	Midwifery Advisory Council (MAC) Vacancies
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing
REQUESTED ACTION:	Appoint Monique Webster to the MAC's vacant Public Member position.

STAFF RECOMMENDATION: Staff recommends that the Board accept this request to appoint to a Public Member position, Monique Webster to a three-year term with the MAC.

EXECUTIVE SUMMARY: Business and Professions Code section 2509 states that the Board shall create and appoint a Midwifery Advisory Council consisting of licensees of the board in good standing, who need not be members of the Board, and members of the public who have an interest in midwifery practice, including, but not limited to, home births. At least one-half of the Council members shall be California licensed midwives.

At its February 2-3, 2012, meeting, the Board determined that the public member positions on the MAC would be filled by: one California licensed physician practicing in the area of obstetrics/gynecology, one non-licensee of the Board, and one member of the Board. The Board also granted permission for the MAC to vote on and seat the selected members at its March 29, 2012 meeting, with the selected members subject to approval by the full Board at its next quarterly meeting.

On February 21, 2012, a Midwifery Advisory Council Member Interest Form was mailed to all California licensed midwives and individuals on the interested parties mailing list. Three applications for the Ob-gyn position, three applications for the licensed midwife position and seven applications for the public member position were received. Applicants were provided an opportunity to address the Council during the March 29, 2012, MAC meeting. Ms. Webster was unable to attend this meeting. However, based on her application and her desire to serve on the Council, members recommended Monique Webster's appointment.

Ms. Webster has a Master's degree in Public Health, with an emphasis on Maternal and Child Health. Her current position on the Berkeley Community Health Commission speaks of her continued interest in public health issues. Ms. Webster has volunteer experience as a postpartum doula in the San Francisco Bay area, and is currently planning a home birth with a midwife.

The MAC members voted to recommend to the full Board, Ms. Monique Webster, for appointment to the MAC.

FISCAL CONSIDERATIONS: None.

PREVIOUS MBC AND/OR COUNCIL ACTION: Not applicable.

MEDICAL BOARD OF CALIFORNIA
Midwifery Program
Midwifery Advisory Council Member Interest Form

Expectations of Membership: *The Midwifery Advisory Council (MAC) members volunteer to serve and attend all MAC meetings for up to a three-year term. Duties and responsibilities include those specified by the Medical Board of California (Board) members, Board staff, or designees. This interest form has been developed to solicit volunteers who will serve on the Midwifery Advisory Council, which is an advisory council that shall make recommendations to the Medical Board of California on matters specified by the Board. The MAC represents the midwifery community and the organizations/associations that represent licensed midwives in the State of California. The Council also includes public member representatives who have an interest in midwifery, but are not licensed midwives. To be considered for appointment, please mail, e-mail, or fax your Interest Form* ***by March 15, 2012*** *to:*

Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
Attention: Midwifery Program
FAX: (916) 263-2487
Susan.Morrish@mbc.ca.gov

If you have any questions please contact Susan Morrish at (916) 263-2393.

Name: WEBSTER, MONIQUE, M
(Please Print legibly - LAST, First, Middle Initial)

Address: [redacted] [redacted]
Street *Suite/ Apartment #* *City* *State* *Zip Code*

Phone: [redacted] [redacted] [redacted]
Daytime *Evening* *FAX*

E-Mail Address (if applicable): [redacted]

Are you a California Licensed Midwife?: ☐ YES ☑ NO *(Check only one)* *License Number: LM #* _____

Are you a California Licensed Physician?: ☐ YES ☑ NO *(Check only one)* *License Number:* _____
If yes, are you currently practicing as an obstetrician/gynecologist? ☐ YES ☐ NO *(Check only one)*

Organization/Association being represented: SELF - PUBLIC INTEREST
(If volunteering as non-licensee "public member" please insert the word "SELF – PUBLIC Interest")

Position within the Organization/Association: _____
(Board member, executive, or member)

Do you have a prepared Resume or List of Qualifications Available? ☑ Yes ☐ No
(Please attach Resume or List of Qualifications to this form)

What is your interest in midwifery practice and home births? SEE ATTACHED
(Attach additional comments if more space is needed)

_____

(Signature) 02/29/12 *(Date)*

DISCLOSURE: Providing this information is strictly voluntary. The personal information requested on this form is being collected for consideration of appointment as a member of the Midwifery Advisory Council. This information will be reviewed by the Board staff and members of the Board and/or Midwifery Committee. This form will be retained in the files of the Licensing Program. This position is voluntary and will require future time commitments. This form and attachments must be returned no later than March 15, 2012.

MONIQUE WEBSTER

[redacted]

Education

UNIVERSITY OF CALIFORNIA AT BERKELEY — Berkeley, CA
Master of Public Health, Maternal and Child Health Program, December 2005
Honors: Public Health Alumni Scholarship, 2004; University Fellowship, 2003-2004
Thesis Topic: DDT Levels and Length of Lactation in a Mexican Immigrant Population of Salinas, CA
Cumulative GPA: 3.83

UNIVERSITY OF CALIFORNIA AT DAVIS — Davis, CA
Bachelor of Science in Biology, Emphasis in Neurobiology, Physiology and Behavior, June 2002
Additional course work included upper-division economics, psychology, child development and anthropology
Upper-Division Cumulative GPA: 3.80

Experience

COMMISSIONER — Berkeley, CA
Community Health Commission, February 2010 to Present
Provide health planning, education, and informational service to the community. Review health proposals submitted by public and private agencies for funding. Advise the Mayor and City Council on public health issues.

HEALTH EDUCATOR — Berkeley, CA
Freelance, April 2007 to July 2011
Provide one-on-one support to private clients, including health education, personalized research and referrals to relevant community resources. Areas of interest include nutrition counseling, chronic conditions and health and wellness support.

BREAST CARE HEALTH EDUCATOR — San Francisco, CA
Kaiser Permanente, March 2006 to April 2007
Provided one-on-one support to newly diagnosed breast cancer patients. Advocated for patients, referred to relevant community resources, consulted with physicians and followed patients through treatment. Additional responsibilities included facilitating two support groups, maintaining patient materials and working with the breast care tracking system.

POSTPARTUM DOULA — San Francisco Bay Area, CA
Freelance, December 2004 to March 2006
Assessed needs of new families and provided physical and emotional support to new mothers, fathers and infants in their homes. Provided health education on a variety of parenting and infant care topics. Supported family choices and addressed parental concerns, basic breastfeeding difficulties, household organization and infant care. Provided appropriate referrals as necessary.

GRADUATE STUDENT RESEARCHER/ANALYST — San Francisco Bay Area, CA
UC Berkeley and UC San Francisco, January 2004 to February 2005
Researched and co-authored an article for the *Journal of Midwifery and Women's Health*. Using Epi Info, created study questionnaire and entered and analyzed data for one of three countries in a post-partum intervention trial of an anti-shock garment. Prepared reports and presentations, collaborated with other researchers and communicated with Nigerian healthcare providers.

GRADUATE STUDENT INSTRUCTOR Berkeley, CA

UC Berkeley, July 2003 to December 2004

In the graduate Public Health courses *International Maternal and Child Health* and *Qualitative Methods in Maternal and Child Health.*, activities included preparing materials for the course reader, coordinating guest speakers, grading papers and responding to student queries.

OUTREACH WORKER San Francisco, CA

Street Outreach Services/Americorps, September 2002 to August 2003

On an individual basis, assessed the healthcare needs of homeless people. Provided health education and referrals for further medical and social services. Distributed harm reduction materials, condoms, clothing, vitamins and hygiene supplies. Identified new populations for service delivery. Followed individuals in a case management capacity, including escorting clients to appointments and providing assistance with eligibility and application for public programs.

TEACHING ASSISTANT Davis, CA

UC Davis, January to April 2001; September to December 2001; April to June 2002

In the upper-division courses *Human Gross Anatomy*, *Personal Finance* and *Real Estate Economics*, with 250 to 400 students, responsibilities included writing and administering examinations, holding office hours, grading assignments and conducting review sessions.

HEALTH EDUCATOR Addis Ababa, Ethiopia

June to August in 1998 and 2000

Working with a culturally diverse population, planned and conducted health education classes on a variety of topics including family planning, HIV prevention and nutrition. Provided basic first aid

Publications

Weldon, R, Webster, M, Harley, K et al. Serum Persistent Organic Pollutants and Duration of Lactation among Mexican-American Women. *Journal of Environmental and Public Health.* 2010. doi:10.1155/2010/861757

Miller, S, Lester, F, Webster, M, & Cowan, B. Obstetric Fistula: A Preventable Tragedy. *Journal of Midwifery and Women's Health.* 2005;50(4):286-94.

Co-author, A Low Technology Obsterrical First Aid Device for Saving Mother's Lives: The Trial of the Anti-Shock Garment in Egypt, Nigeria, and Mexico, Global Forum for Health Research, Mexico City, Mexico. Nov. 16-20, 2004.

Skills and Activities

Certified Emergency Medical Technician
Current BLS/CPR/First Aid certification
Proficient in Microsoft Word, WordPerfect, PowerPoint, Excel, Access, SAS, STATA and Epi Info
Volunteer experience as a birth doula and mentor

Monique Webster

Response to question on interest in midwifery practice and home births

My interest in midwifery began when I volunteered as a birth doula at a birth center in Davis, where I was fortunate to work closely with several nurse-midwives. My passion only grew when I attended UC Berkeley for my Master's degree in Public Health with an emphasis in Maternal and Child Health. My current position on the Berkeley Community Health Commission speaks to my continued interest in broader public health issues, and my current pregnancy and plans for a homebirth with a midwife explains my deep interest in both midwifery and home birth.

Federation of STATE MEDICAL BOARDS

PROMOTING THE HIGHEST STANDARDS FOR MEDICAL LICENSURE AND PRACTICE

Protecting
Advocating
Serving

Protecting
Advocating
Serving

FSMB Update

Hedy L. Chang, FSMB Director
Humayun J. Chaudhry, DO, FACP, FSMB CEO & President

May 4, 2012
Medical Board of California

Federation of STATE MEDICAL BOARDS

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Greetings from the FSMB Board of Directors

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Federation of STATE MEDICAL BOARDS

What we'll cover today

FSMB: "New Directions"

Key Topics

- Vision & Mission
- Messages (Voice, Trust, People, Service)
- Structure
- Advocacy
- Education
- Data

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Protecting
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FSMB "New Directions"

FSMB is moving on many fronts to better serve you

- Vision & Mission
- Messages (Voice, Trust, People, Service)
- Structure

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FSMB Vision & Mission 2010-2015

Vision

The Federation of State Medical Boards is the leader in medical regulation, serving as an innovative catalyst for effective policy and standards.

Mission

FSMB leads by promoting excellence in medical practice, licensure, and regulation as the national resource and voice on behalf of state medical boards in their protection of the public.

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Federation of STATE & MEDICAL BOARDS

FSMB Messages to the Public

- FSMB is the **VOICE** of the nation's state medical boards
- The end product of this professional community is **TRUST** extending in many directions
- We are a community of **PEOPLE** dedicated to service and focused on two key goals
- At the heart of FSMB's work are three key elements of **SERVICE**

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How FSMB priorities are established

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How FSMB policy is made

- **Step 1:** Resolutions submitted to House of Delegates via state member boards or FSMB Board of Directors

- **Step 2:** Resolutions assigned to Reference Committees for consideration

- **Step 3:** Reference Committees recommend for or against; House members vote

- **Step 4:** House adopted policy sent to FSMB Board of Directors for implementation

- FSMB is formally mandated to create policy
- House must vote on all FSMB public policy positions

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FSMB Committee & Workgroup Structure

Committees Reporting to the House of Delegates	
Bylaws	Reference
Nominating	Rules

Committees & Workgroups Reporting to the Board of Directors	
Standing Committees: Audit, Editorial, Education, Ethics & Professionalism, and Finance	**Workgroups**: Define a Minimal Data Set, Examine Composite Action Index (CAI) and Board Metrics, Innovations in State Medical Licensure, International Collaboration, MOL on Non-Clinical Physicians, MOL Implementation, Office-Based Opioid Treatment, and Pain Policy
Special Committee on Physician Re-entry for Formerly Impaired Physicians	

Advisory	
Advisory Council of Board Executives	FCVS

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Protecting
Advocating
Serving

Advocacy

Significant upgrade to our capabilities

The creation of a new Washington, D.C. office and several new policy initiatives are aimed at serving better as your voice and partner

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FSMB Advocacy Network

- **More than 180 participants**
- **Summer Advocacy Meetings**
  - FSMB Members met with their U.S. Representative and/or Senator in districts across the U.S. to raise state medical board visibility and FSMB advocacy agenda
- **Continued "grassroots" efforts**
  - Raising awareness and communication within the regulatory community

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Advocacy Updates from Washington, D.C.

Launch of FSMB Advocacy Network News – August 2010

Our e-newsletter provides legislative tracking and news analysis about Congress, the White House, and federal agencies

Want to subscribe?

- Send an email request to lrobin@fsmb.org

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FSMB Support of State-based Licensure

- The U.S. medical regulatory structure limits physicians to practice only in the state(s) where they are licensed
- This provides optimal protection for patients by assuring physicians are qualified and fit to practice and provides the avenue for states and patients to address physician care that fails to meet an acceptable standard

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History of Portability

- 1995 – A centralized repository of physician core credentials created
- 1996 – Technology supports alternative licensure model to reduce burden of multi-state licensure process
- 2002 – Call for license application with model for expedited endorsement
- 2004 – Common Licensure Application Form (CLAF) established
- 2006 – HRSA contracts FSMB to design multi-state demonstration project
- 2007 – First of two 3-year HRSA license portability grants awarded to FSMB
- 2008 – CLAF evolves to Uniform Application for State Medical Licensure (UA)
- 2009 – NGA/FSMB-sponsored licensure meeting = FSMB refines focus
- 2010 – Second of two 3-year HRSA license portability grants awarded to FSMB
- 2011 – Adoption of FCVS and UA continues to expand

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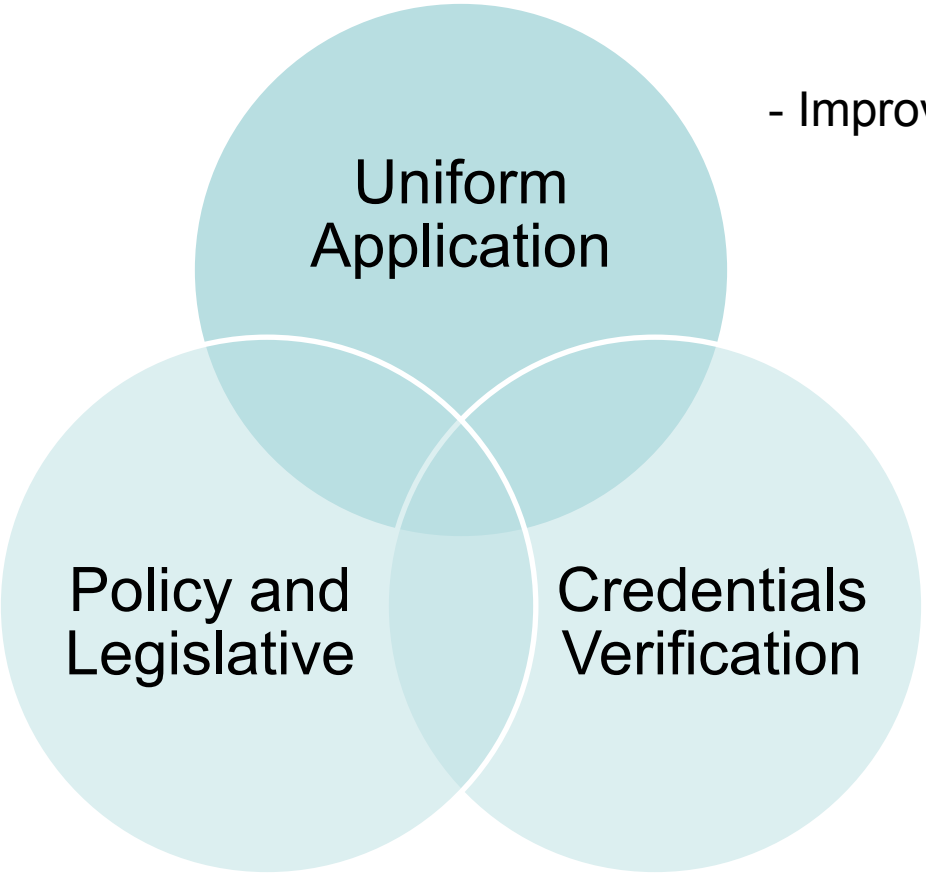
3 components of the portability initiative and areas of focus

- Improve the UA



- Develop a set of credentials, criteria and acceptable verification sources that could be adopted for an expedited licensure process

- Improve FCVS

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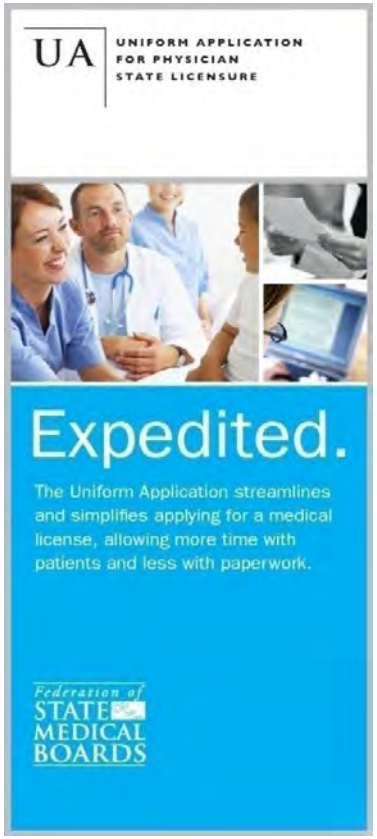
Significant Benefits

State Boards

- **Cost effective**
  - Grant funds and technical support
- **Simplified data retrieval process**
  - pdf, XML, web service
- **Paperless office environment**
  - Electronic forms
- **Licensing staff time**
  - Improved quality of data
- **Integrates with licensing software**

Physicians

- **Reduces redundancy in the application process**
- **Easy to use**
  - Smart fields, pre-population of data
- **Integration between FCVS and UA**
  - Data flows bi-directionally between the applications
  - 70% of the UA is pre-populated when FCVS is used
- **Secure data repository**



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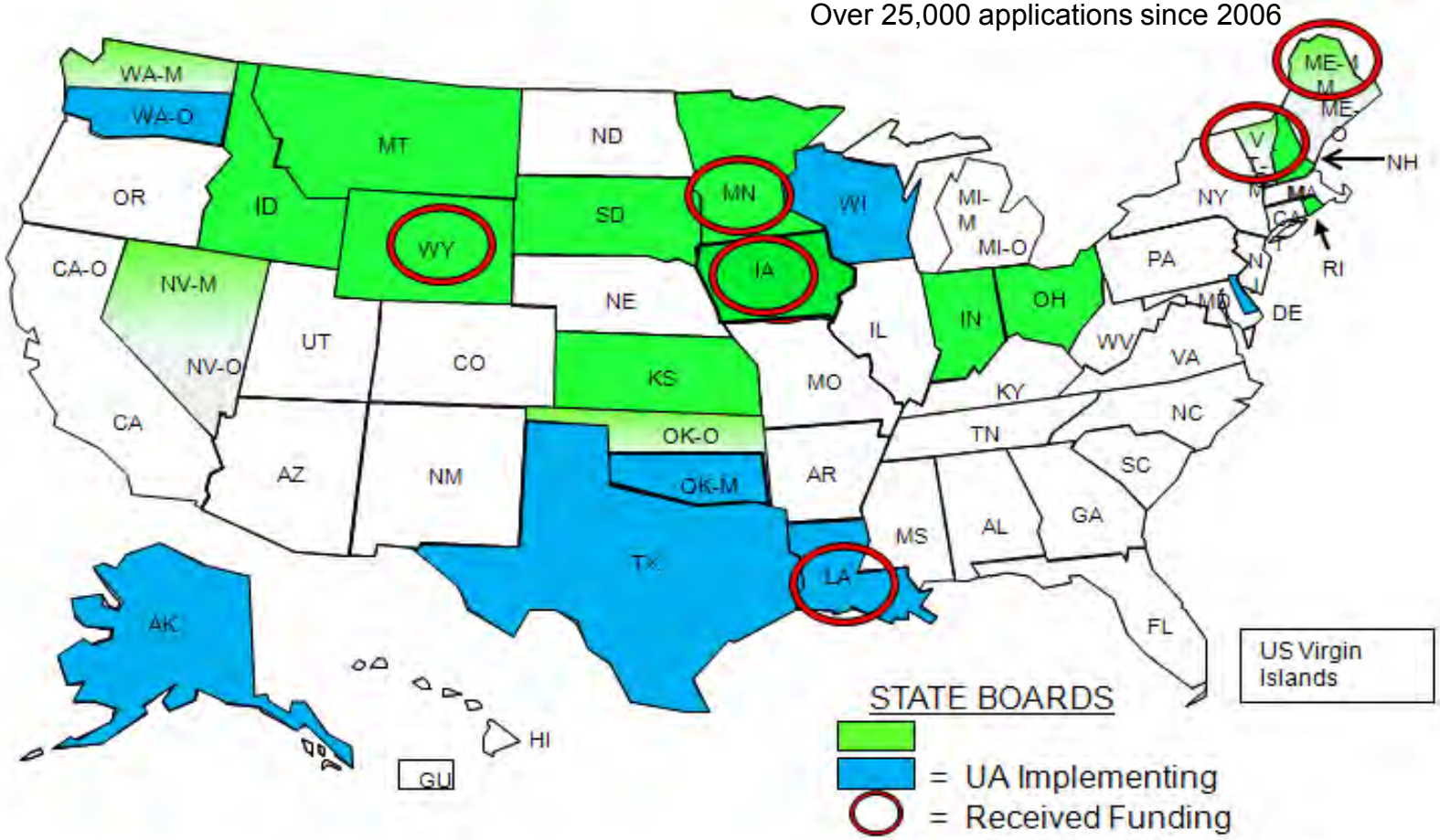
These states use the UA or are actively adopting the UA

16 SMBs using UA, 29 more considering/adopting it

Over 25,000 applications since 2006



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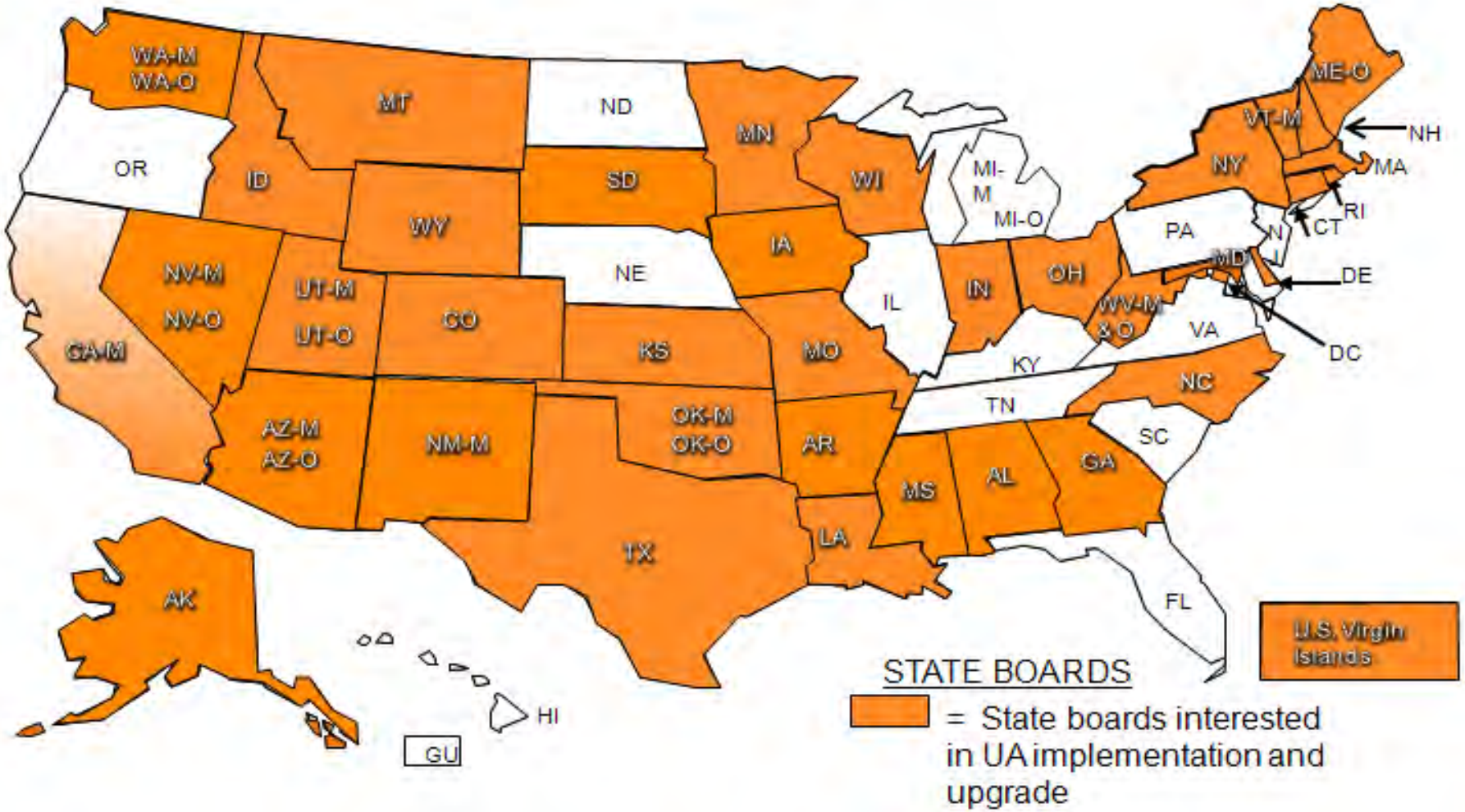
With overall interest growing significantly as 45 boards are now interested



FSMB House of Delegates' 2004 Policy Statement focus

"State medical boards have a responsibility to the public to ensure the ongoing competence of physicians seeking relicensure."

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What is Maintenance of Licensure (MOL)?

- **Process by which a licensed physician provides, as a condition of license renewal, evidence of participation in continuous professional development that**
  - Is practice-relevant
  - Is informed by objective data sources
  - Includes activities aimed at improving performance in practice
- **MOL Pilots are in development for 2012**

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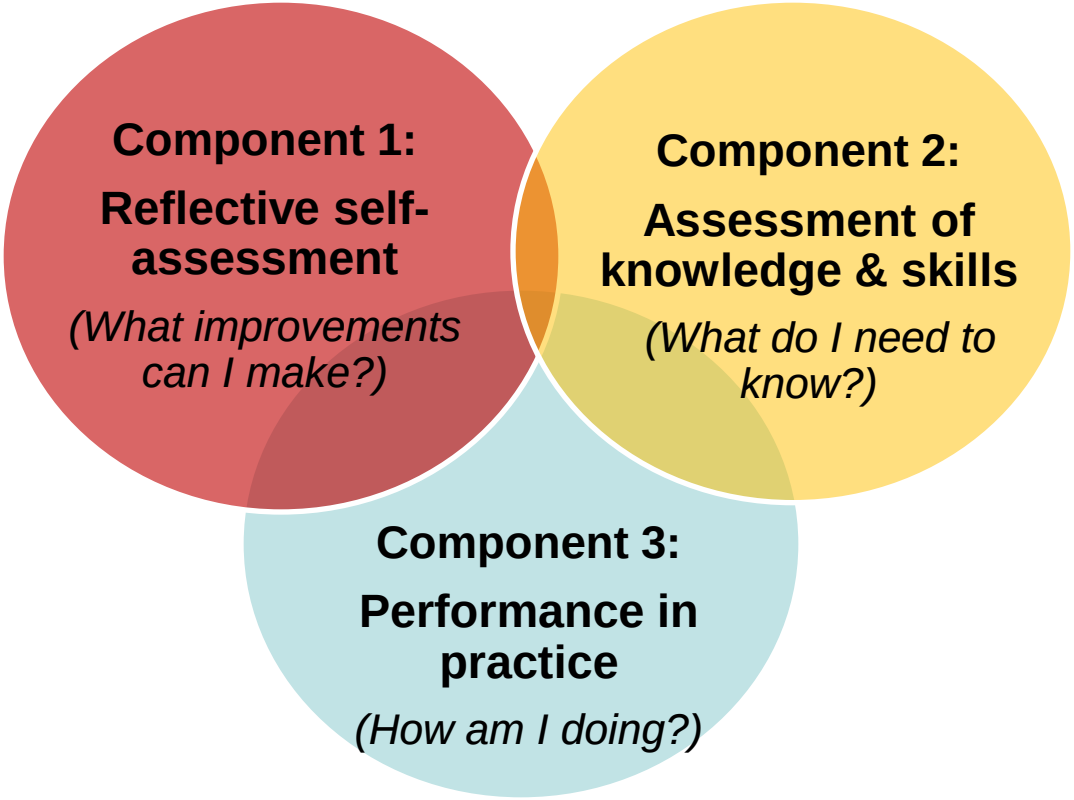
MOL Framework
(adopted by FSMB HOD in 2010)

3 major components of effective lifelong learning



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GOAL	STRATEGY (HOW)	OPTION/EXAMPLES
Reflective self-assessment	• External measures of knowledge and skills or performance benchmarks	Assessment tools: • Self-review tests – MOC and OCC – Home study – Web-based – Medical society simulations Professional development activities: •Literature review •CME in practice area
Assessment of knowledge and skills	• Structured, valid, practice relevant • Produce data to identify learning opportunities	• Practice-relevant MCQ exams (e.g., MOC/OCC) • Standardized patients • Computer-based case simulations • Patient and peer surveys • Procedural hospital privileging • Mentored/proctored observation of procedures • Others approved by state board
Performance in practice	• Incorporates data to assess performance in practice and guide improvement	• 360° evaluations • Patient reviews • Analysis of practice data • MOC/OCC Practice Improvement activity • AOA-BOS Clinical Assessment Program • CMS measures • Performance improvement CME & projects, e.g., SCIP, IHI. IPIP, HEDIS • Other performance projects

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Protecting
Advocating
Serving

Education

Supporting your mission of public protection
Our goal: Be the primary source for educational materials to help you keep up with best practices and trends in licensing and regulation

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Federation of STATE MEDICAL BOARDS

Education: What's New?

- **Expanded Annual Meeting**
  - Virtual sessions, "value-added" thematic content (2012 meeting: Celebrating Service, Partnership, Innovation and Leadership)
- **Improvements to *Journal of Medical Regulation***
  - Redesigned for better readability, expanded and improved content
- **"Responsible Opioid Prescribing"**

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Education Events

- **Annual Meeting**
  - Board Member Workshops
- **Annual Educational Series**
- **Board Attorney Workshops**
  - (Fall and Spring)
- **New Executives Orientation**
- **Monthly Roundtable**
- **Executive Institute Program***
- **Board Investigator Certification Program***

**Programs administered by AIM and supported by FSMB*

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Multiple Channels/Multiple Audiences

- **FSMB Annual Report**
- ***Journal of Medical Regulation***
- ***Newsline***
- ***FSMB eNews***
- **Website - www.fsmb.org**

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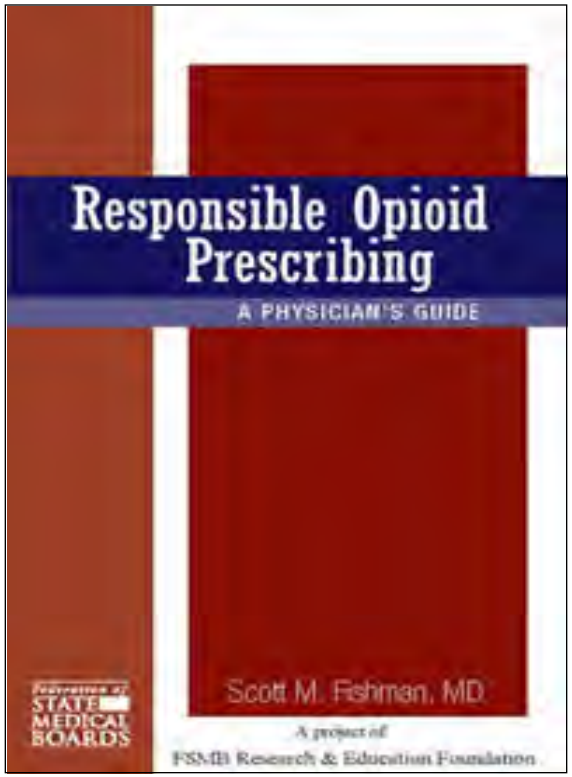
Educating Physicians About Opioid Use

- **"Responsible Opioid Prescribing: A Physician's Guide**
- **Written by Scott M. Fishman, M.D.**
- **Details:**
  - 162,000 hard copies distributed to physicians in 23 states
  - Eligible for 7.5 credits - AMA PRA Category 1
  - **2nd edition now available**



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Protecting
Advocating
Serving

Data

Data is at the core of what we do as an organization
We have the nation's most comprehensive repository of physician licensing and credentialing information, with data on more than 850,000 physicians –
Our data plays a key role in ensuring patient safety

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Federation Credentials Verification Service (FCVS)

- **Primary Source Verification:**
  - Identity
  - Medical Education (Domestic and/or ECFMG Certification)
  - Graduate Medical Education Training
  - Licensure Exam History
  - Board Action History
  - ABMS Board Certification
- **Low cost** (compared with other CVOs)
- **Authentic** (process, rigor and quality)
- **Security, storage and transmission of data**

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Federation Credentials Verification Service (FCVS)

- **Goal**
  - Create and maintain a high quality, permanent file of a medical professional's core credentials for use in licensure

- **Benefits**
  - Low cost (compared to other CVOs)
  - Decreases costs to physician and SMB
  - Reduces duplication of effort by physician and SMB
  - Discrepancies identified and summarized
  - Extensive data repository facilitates license portability

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FCVS is widely accepted

- **Primary Source Verification of Core Credentials**
- **Accepted by 64 of 69 Licensing Boards**
- **Over 140,000 M.D.s, D.O.s and P.A.s Enrolled**
- **Implementation of Fast Track in 2011**
  - Redesigned Work Groups
  - Improved Data Repository
  - Improved Communication with Boards and Physicians
- **NCQA Certification in Progress**

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FCVS and Your Board

- **Medical Board of California**
  - 1 of 64 accepting boards
  - In 2011, 827 FCVS profiles were created for the Medical Board of California
  - This represents about 2.8% of the total FCVS files completed in 2011

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FCVS Fast Track

- **Substantial upgrades**
  - Online platform that gives applicants much more control, efficiency and ease of use
  - Aligns FCVS staff with key customer groups
  - Fundamentally improved service
- **Establishes a portfolio**
  - Enhanced data and processing capabilities
  - Positions us to lead the way in credentialing
  - Building a portfolio is a time consuming process
- **Major transition**
  - Addressing adjustments and “fixes”
  - Customer migration
  - Natural continuous improvement
  - Remain committed to customer service

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Medical Board Participation in USMLE

- **Item Writing and Test Development**
- **Standard setting**
- **Governance committees**
- **Quality Assurance Program**
- **Special committees and projects**

Comprehensive Review of the USMLE (CRU) : Why Change?

Existing Step examinations are excellent but:

- Technology has advanced
- Medical education has evolved
- USMLE rate of change needs to adapt

Even existing assessments may benefit from reorganization and refinement to address observed unintended consequences

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Milestones Toward

2004

USMLE Composite Committee calls for in-depth review of program design, structure, format

2006-08

- Extensive information gathering process through surveys, webinars, focus groups, meetings
- Review & subsequent recommendations by the Committee to Evaluate the USMLE Program

2009

Approval by FSMB and NBME governance

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Ongoing Strategic Enhancements to USMLE

- Better support licensing decisions (supervised /independent practice)
- Reinforce prominence of foundational sciences
- Introduce additional measures related to competencies
- Reflect changes in information technology and usage
- Build on experience from Step 2 Clinical Skills (CS)

Comprehensive Review of USMLE

Committee to Evaluate the USMLE Program (CEUP) • Summary of the Final Report and Recommendations

EXECUTIVE SUMMARY

This document is a summary of the work and recommendations of the Committee to Evaluate the USMLE Program (CEUP), a committee constituted by the USMLE Composite Committee and comprising students, residents, clinicians, and members of the licensing, graduate, and undergraduate education communities. The goal of the committee was to determine if the mission and purpose of USMLE were effectively and efficiently supported by the current design, structure, and format of the USMLE. This process was to be guided, in part, by an analysis of information gathered from stakeholders, and was to result in recommendations to USMLE governance. The CEUP worked from 2006 to early 2008.

The USMLE examination program was designed in the late-1980s and introduced during the period 1992 to 1994. The program replaced the NBME Part Examination program and the Federation Licensing Examination (FLEX) program, which were the widely accepted medical licensing examination programs at that time. Since the introduction of USMLE, one major change in format/delivery and one major addition to the examination sequence have been implemented; these were, respectively, the transition from paper-based to computer delivery in 1999 and the introduction of a standardized patient examination in 2004. Except for these changes, and for the gradual evolution of content that occurred in response to shifts in medical practice and education, the overall structure and focus of the Step examinations have remained relatively unchanged.

To understand the rationale behind the recommendations described in this document, it is important to recognize and understand the nature of the framework that supports USMLE design, structure, and process. The values and priorities of the profession and the patients and society it serves should be reflected in the knowledge and skills tested within the licensing examination. When USMLE was first designed, early planners were alert to note that the structure of the Step examinations would reflect the knowledge and skills expected to have been acquired by students and residents as they move successfully through their training toward initial medical licensure. In recent years, educational leaders have more formally recognized and prioritized competencies that extend beyond the domains of medical science and clinical skills—competencies that are deemed important to the profession and the patients they serve but more difficult to assess using standard tools. At the same time, knowledge is expanding progressively, and the expectation that clinicians be able to draw on these fundamental insights in their approach to patients has become ever more critical. The desire to elevate the breadth and quality of assessment to meet the expectations of the broader profession and the public was a major theme in the committee's deliberations, and it has had a significant impact on the recommendations that resulted. The committee also acknowledged that any new or additional assessment tools implied by the recommendations must be rigorous, and should respect the balance between cost and value to the examinee and licensing authorities.

Adopted by FSMB House of Delegates in 2009

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Current USMLE Sequence Compared with Envisioned Final Structure

						Total
Current USMLE	Step 1	Step 2 CK	Step 2 CS	Step 3		
Current testing hours	*7*	*8*	*5*	*14**		*34*
Envisioned Change	Step 1	Step 2 CK	Step 2 CS	Step 3A	Step 3B	
Estimated testing hours			*5*	*6-8***	*6-8*	*34*

Time is divided over two days.* * Time may be divided over two days.*

NOTE: Naming convention TBD but anticipate retaining Step language.

Testing time remains 15 hours (Steps 1, 2 CK) and 14 hours (Step 3) respectively.

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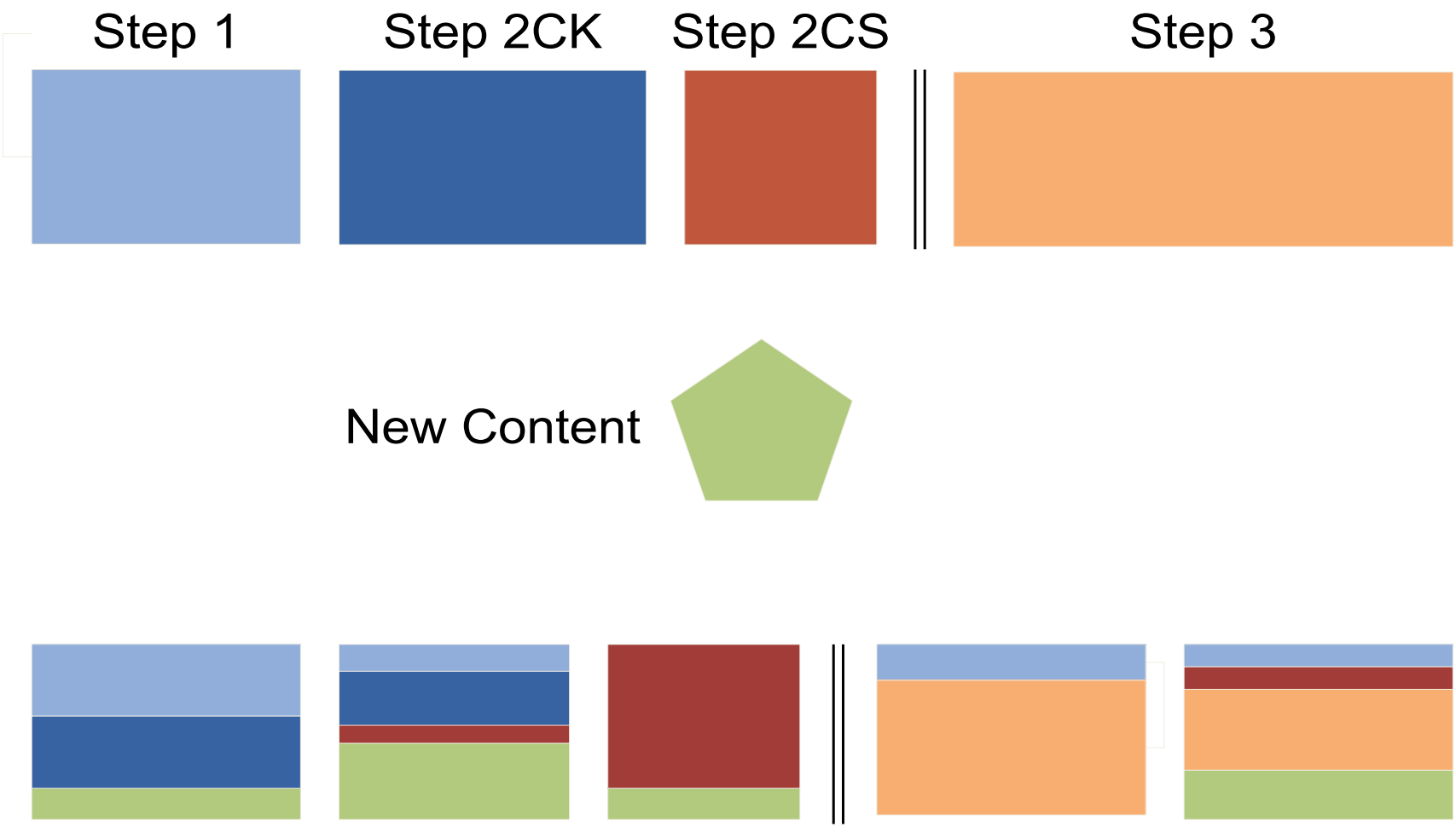
Current USMLE Sequence and Content



Envisioned Future Content

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SPEX

- **One-day multiple choice examination to evaluate general medical knowledge**
- **Enhanced in 2010**
  - Live items from USMLE Step 3 pool
  - More focus on tasks physicians do in practice (e.g., patient management/care items); less focus on mechanisms of disease
  - More descriptive performance reports provide better information about examinee strengths and weaknesses
- **Free take offer for state board member**

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Physician Data Center

- **Board Action Data Bank**
  - Collects & reports data on disciplinary actions taken against physicians and physician assistants by medical boards and other authorities
  - Querying – www.drdata.org
  - Annual Data Compilation Release
- **All Licensed Physicians Information**
  - Consolidated physician information
  - Disciplinary Alert – in 2011, 743 alerts were sent to the Medical Board of California
  - Public access – www.docinfo.org

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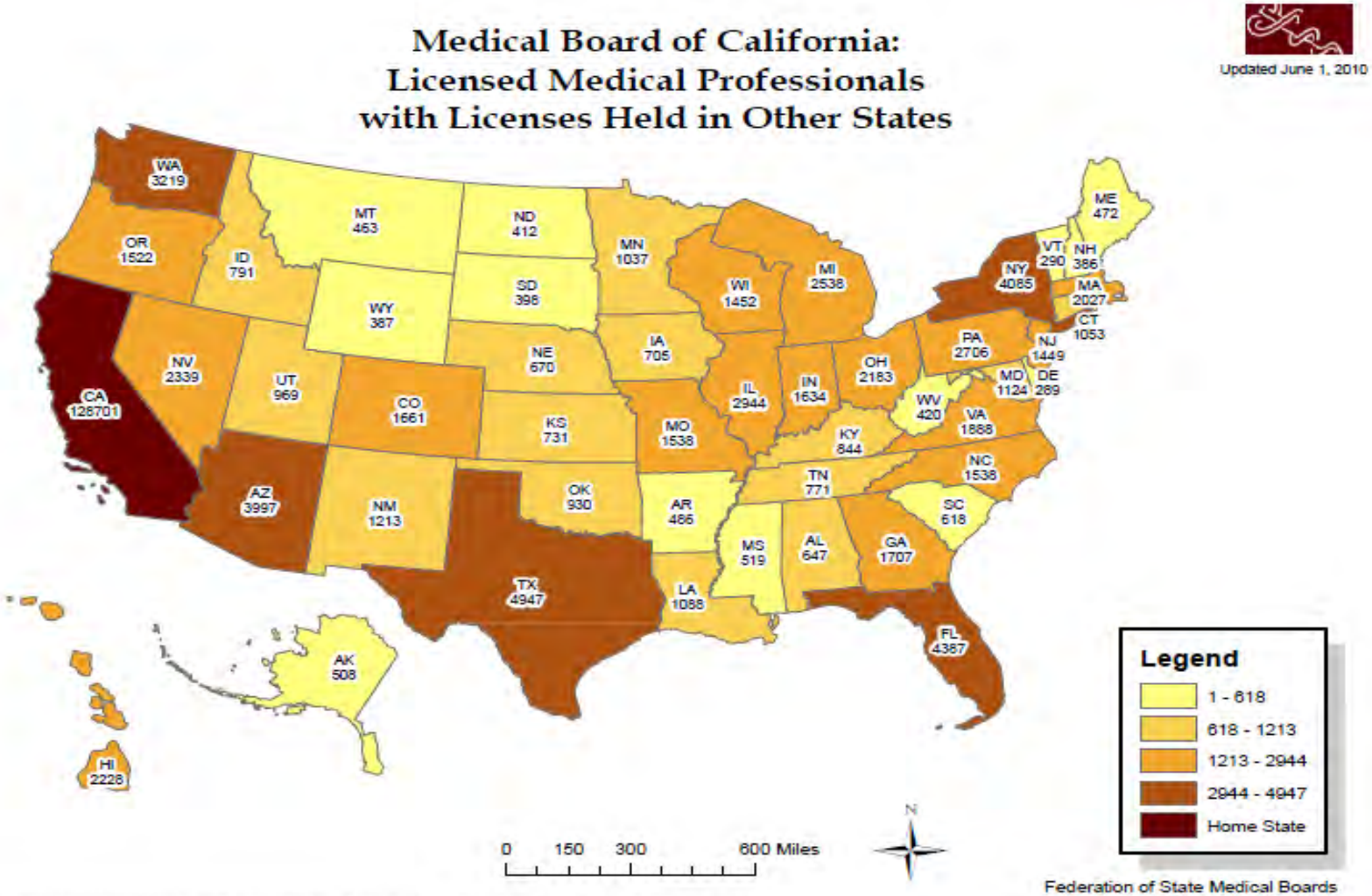
Medical Board of California: Licensed Medical Professionals with Licenses Held in Other States



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Federation of STATE MEDICAL BOARDS

Protecting
Advocating
Serving

Other FSMB Initiatives

- **FSMB Foundation**
- **FSMB Centennial**
- **Service Initiative**

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Federation of STATE MEDICAL BOARDS

Other Initiatives: What's New?

- **FSMB Foundation**
  - Renewed brand was launched in 2009, with new projects
    - Public Member Project
    - Violence Against Medical Boards Project
    - 2nd edition "Responsible Opioid Prescribing: A Physician's Guide" now available

FSMB FOUNDATION

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Federation of STATE MEDICAL BOARDS

California FSMB Leaders

- Charles Pinkham, MD
- FSMB President,1930-1931
- Expert on board disciplinary and administrative procedures
- Widely published in national journals including the Federation *Bulletin*
- One of the dominant figures in medical licensure during the first half of the 20th century along with Walter Bierring (Iowa), Herbert Platter (Ohio)

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California FSMB Leaders

- Louis Jones, MD
- FSMB President,1961-1962
- FSMB acquires its first national office during Jones' tenure
- President during FSMB's 50th anniversary
- In 1962, Jones thought in terms of assuring competence when he said *"…the challenge of the future in licensure is that of integrating total experience with multiple evaluations since fitness will change over time."*

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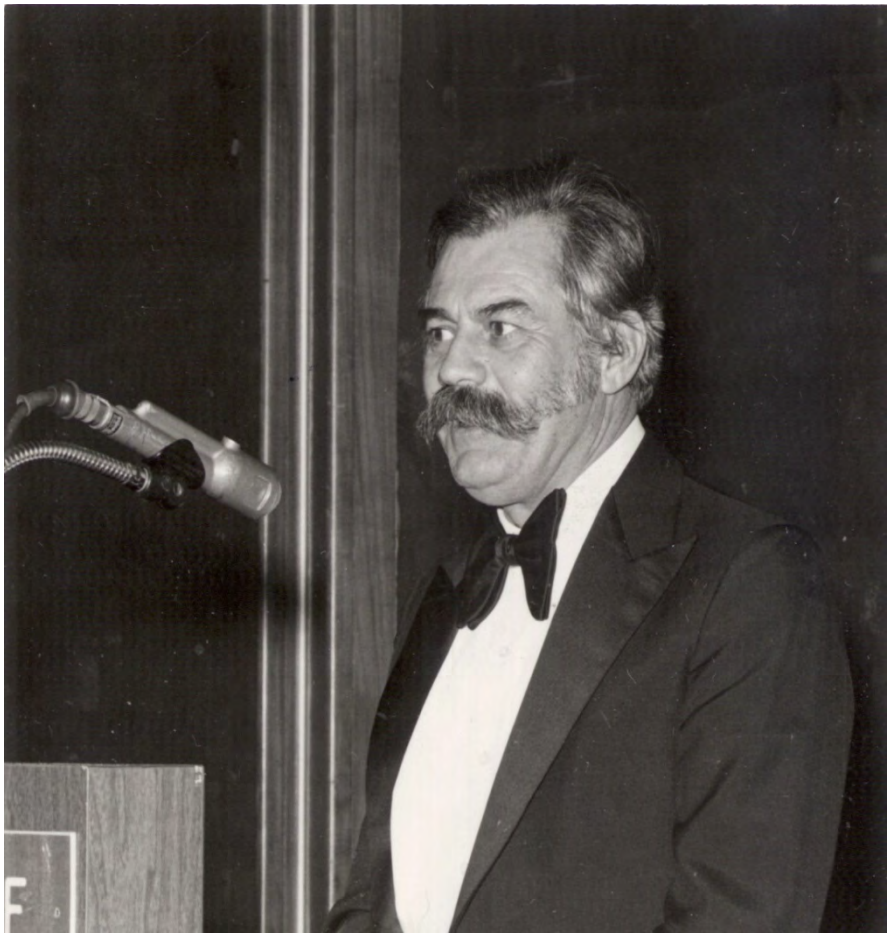

California FSMB Leaders

- Harold Wilkins, MD
- FSMB President,1977-1978
- Service on the FLEX Clinical Science Committee
- Editorial advisor to the *Federation Bulletin*
- Interested in scope of practice issues as evidenced by his service representing FSMB on the National Commission on Certification of Physician Assistants (NCCPA)

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California FSMB Leaders

- Alan Shumacher, MD
- FSMB President,1999-2000
- Established FSMB Special Committee on Physician Profiling in 1999
- Served FSMB on multiple USMLE committees, e.g., Composite Committee; Committee on Irregular Behavior

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Questions/Discussion/Contact Us

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Federation of STATE MEDICAL BOARDS

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
1ST QUARTER (Jan-Mar) 2012

SPECIALTY	Number of cases reviewed/sent to Experts	Number of Experts used and how often utilized	Active List Experts 4/1/12: 1,125↓
ADDICTION	6	**3 EXPERTS** 1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	15 ↓
ALLERGY & IMMUNOLOGY (A&I)			6
ANESTHESIOLOGY (Anes)	6	**6 EXPERTS** 6 LIST EXPERTS REVIEWED 1 CASE	80 ↓
COLON & RECTAL SURGERY (CRS)	1	**1 EXPERT** 1 LIST EXPERT	4
COMPLEMENTARY/ALTERNATIVE MEDICINE	7	**4 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 4 CASES*	26 ↓
	*INVOLVED CASE REVIEW, PREP&TESTIMONY, SUPPLEMENTAL WORK		
CORRECTIONAL MEDICINE			35 ↓
DERMATOLOGY (D)	4	**2 EXPERTS** 1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES	13 ↓
EMERGENCY (EM)	3	**3 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE	60 ↓
ETHICS			7 ↓
FAMILY (FM)	20	**12 EXPERTS** 5 LIST EXPERTS REVIEWED 1 CASE 6 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	97 ↓
HAND SURGERY			19
HOSPICE & PALLIATIVE MEDICINE			12
INTERNAL (General Internal Med)	24	**21 EXPERTS** 18 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES	226 ↓
Cardiovascular Disease (Cv)	6	**6 EXPERTS** 6 LIST EXPERTS REVIEWED 1 CASE	36 ↑
Endocrinology, Diabetes and Metabolism (EDM)	1	**1 EXPERT** 1 LIST EXPERT	8
Gastroenterology (Ge)	4	**2 EXPERTS** 2 LIST EXPERTS REVIEWED 2 CASES	20

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
1ST QUARTER (Jan-Mar) 2012

SPECIALTY	Number of cases reviewed/sent to Experts	Number of Experts used and how often utilized	Active List Experts 4/1/12: 1,125↓
Hematology (Hem)	1	**1 EXPERT** 1 LIST EXPERT	4
Infectious Disease (Inf)	1	**1 EXPERT** 1 LIST EXPERT	12
Medical Oncology (Onc)	1	**1 EXPERT** 1 LIST EXPERT	15
Nephrology (Nep)			12
Pulmonary Disease (Pul)			19
Rheumatology (Rhu)			7
MIDWIFE REVIEWER	2	**1 EXPERT** 1 LIST EXPERT REVIEWED 2 CASES	10
NEUROLOGICAL SURGERY (NS)	5	**5 EXPERTS** 5 LIST EXPERTS REVIEWED 1 CASE	11 ↑
NEUROLOGY (N)	1	**1 EXPERT** 1 LIST EXPERT	29
NEUROLOGY with Special Qualifications in Child Neurology (N/ChiN)			5
NUCLEAR MEDICINE (NuM)			5
OBSTETRICS & GYNECOLOGY (ObG)	15	**10 EXPERTS** 6 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 2 CASES	90 ↓
OPHTHALMOLOGY (Oph)	4	**2 EXPERTS** 1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES	37
ORTHOPAEDIC SURGERY (OrS)	5	**5 EXPERTS** 5 LIST EXPERTS REVIEWED 1 CASE	32 ↓
OTOLARYNGOLOGY (Oto)			28 ↑
PAIN MEDICINE (PM)	7	**5 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES	20 ↓

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
1ST QUARTER (Jan-Mar) 2012

SPECIALTY	Number of cases reviewed/sent to Experts	Number of Experts used and how often utilized	Active List Experts 4/1/12: 1,125↓
PATHOLOGY (Path)	1	**1 EXPERT** 1 LIST EXPERT	12
PEDIATRICS (Ped)			54 ↓
Pediatric Cardiology (Cd)	1	**1 EXPERT** 1 LIST EXPERT	6 ↓
Pediatric Emergency Medicine (PEM)			3
Pediatric Hematology-Oncology (HO)			4
Pediatric Nephrology (Ne)			2
Pediatric Pulmonology (Pul)			1
PHYSICAL MEDICINE & REHABILITATION (PMR)			10 ↓
PLASTIC SURGERY (PIS)	4	**4 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE	59 ↑
OCCUPATIONAL MEDICINE			9 ↓
PUBLIC HEALTH and GENERAL PREVENTIVE MED.			4 ↓
PSYCHIATRY (Psyc)	19	**14 EXPERTS** 9 LIST EXPERTS REVIEWED 1 CASE 5 LIST EXPERTS REVIEWED 2 CASES	102 ↓
RADIOLOGY (Rad)/ Diagnostic Radiology (Rad DR)			40
Radiation Oncology (Rad RO)			5
SLEEP MEDICINE (S)			10
SURGERY (S)	10	**5 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES	53 ↓
Pediatric Surgery (PdS)	1	**1 EXPERT** 1 LIST EXPERT	3
Vascular Surgery (VascS)	1	**1 EXPERT** 1 LIST EXPERT	14
THORACIC SURGERY (TS)			18 ↓

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
1ST QUARTER (Jan-Mar) 2012

SPECIALTY	Number of cases reviewed/sent to Experts	Number of Experts used and how often utilized	Active List Experts 4/1/12: 1,125↓
(MEDICAL) TOXICOLOGY			2 ↓
UROLOGY (U)	5	**3 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES	19

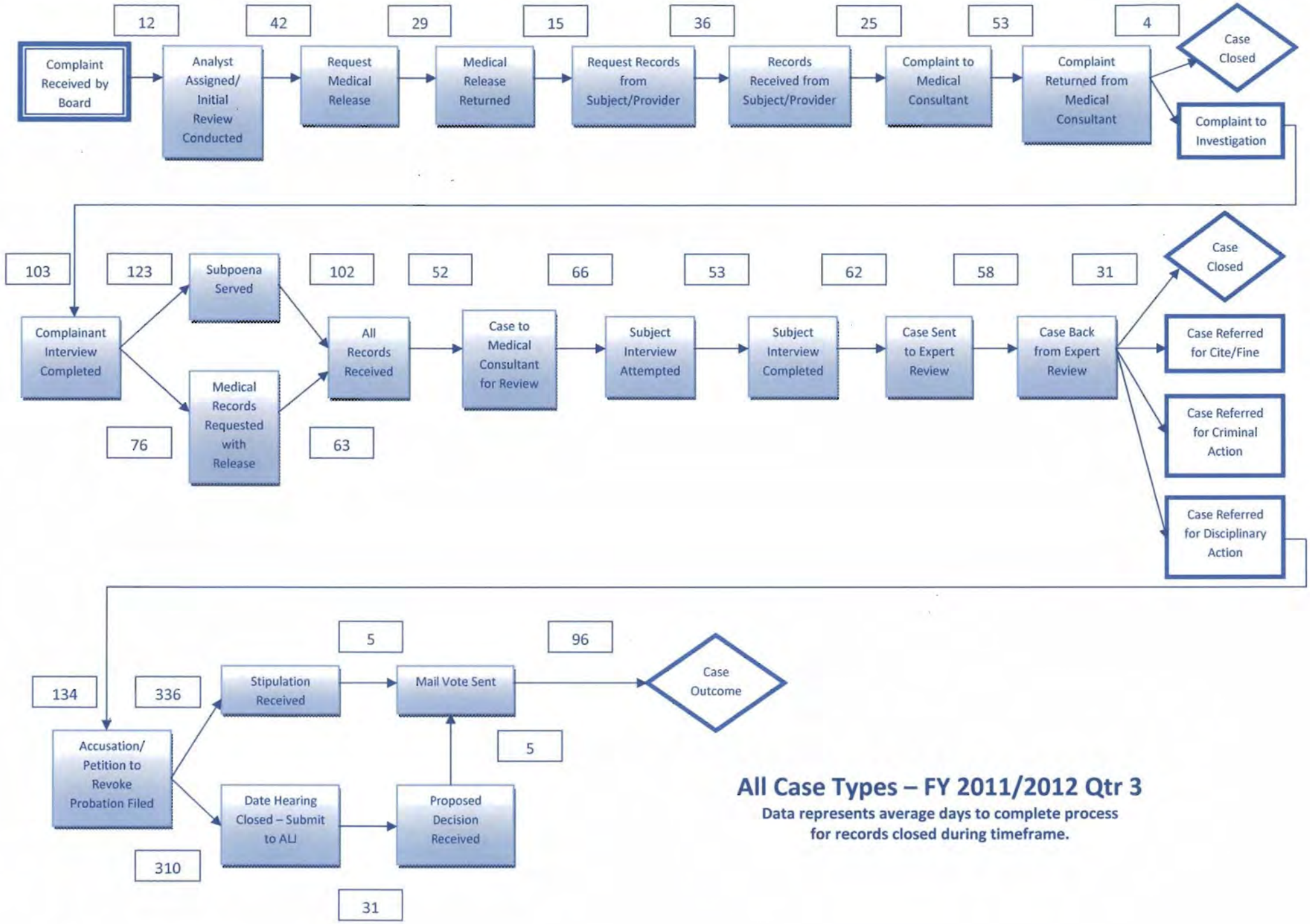
TOTAL EXPERTS UTILIZED (1ST QUARTER)	117
TOTAL CASES SENT TO EXPERTS (1ST QUARTER)	158
TOTAL ACTIVE LIST EXPERTS (AS OF 4/1/2012)	1,125

/susan (4/1/12)

Medical Board of California
Investigation Prosecution Timeframes*

	2005	2006		2007		2008		2009		2010		2011	Qtr 1 2012
	Prior to VE	All	VE	All	VE	All	VE	All	VE	All	VE	All	All
Calendar Day Age from Case Assigned to Case Closed Not Resulting in Prosecution													
Average	271	299	138	330	268	374	358	383	381	333	333	296	280
Median	252	285	134	304	269	335	324	346	346	298	297	273	246
Record Count	827	703	192	648	539	609	588	673	672	664	663	857	193
Calendar Day Age from Request to Suspension Order Granted													
Average	51	44	4	34	38	19	19	52	39	40	40	43	27
Median	17	3	2	22	23	10	10	23	23	1	1	17	13
Record Count	24	21	11	17	13	21	17	17	16	27	27	31	15
Calendar Day Age from Request to Receipt of Medical Records													
Average	58	53	37	59	57	63	58	73	73	64	64	67	55
Median	32	31	26	31	31	28	28	32	32	29	29	30	28
Record Count	475	376	228	264	259	256	252	243	243	257	257	246	36
Calendar Day Age from Request to Physician Interview Completed													
Average	48	51	43	52	50	63	63	52	52	46	46	52	52
Median	36	42	38	37	36	41	42	37	37	34	34	38	35
Record Count	597	453	172	406	371	473	466	696	696	582	582	729	143
Calendar Day Age from Request to Receipt of Expert Opinion													
Average	51	47	35	51	43	50	50	48	48	47	47	58	55
Median	41	35	31	36	35	39	38	36	35	37	37	39	44
Record Count	519	424	82	344	270	374	359	426	424	415	415	599	118
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	549
Median	525	504	120	523	339	541	486	575	569	616	616	533	516
Record Count	187	149	17	198	95	157	131	189	186	200	199	239	64
Calendar Day Age from Accusation Filed to Disciplinary Outcome**													
Average	608	602	85	576	188	561	243	473	339	426	340	425	471
Median	526	466	99	426	182	384	238	351	309	326	304	391	391
Record Count	212	195	3	226	29	203	80	198	145	171	156	190	58

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



All Case Types – FY 2011/2012 Qtr 3

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

MEDICAL BOARD OF CALIFORNIA
Enforcement Processing Timeframes
2012 Strategic Plan Objective 5.2

Enforcement Process	2008/2009		2009/2010		2010/2011		2011/2012 Qtr 1		2011/2012 Qtr 2		2011/2012 Qtr 3	
	# Cases[1]	AVG[2]	# Cases	AVG	# Cases	AVG	# Cases	AVG	# Cases	AVG	# Cases	AVG
Complaint	6426	75	6563	76	7008	74	1849	77	1592	88	1764	88
% of Complaints Below 50 days (Goal: 50-60%)	43%		41%		35%		45%		37%		40%	
Investigation	1100	349	1290	328	1411	312	417	279	391	280	348	276
Discipline												
AG Processing to Preparation of an Accusation	240	103	304	106	294	107	99	107	85	100	77	121
Other Stages of the Legal Process (e.g., after charges filed)	228	381	232	368	216	417	90	388	75	395	67	443

[1] Some cases closed were opened in a prior fiscal year. **(Footnote applies to all years provided on report)**

[2] Average time (calendar days) in processing complaints during the fiscal year, for all cases, from date of original receipt of the complaint, for each stage of discipline, through completion of judicial review. **(Footnote applies to all years provided on report)**

ENFORCEMENT TIMEFRAMES

as of 03/31/12

FISCAL YEARS	2006 - 2007		2007 - 2008		2008- 2009		2009 - 20010		2010 - 2011		2011 - 2012	
	AVERAGE	MEDIAN	AVERAGE	MEDIAN	AVERAGE	MEDIAN	AVERAGE	MEDIAN	AVERAGE	MEDIAN	AVERAGE	MEDIAN
COMPLAINT PROCESSING	54	49	61	49	75	63	76	63	74	77	85	68
INVESTIGATION	307	289	324	272	349	309	328	292	312	283	278	244
TOTAL MBC												
DAYS	361	338	385	321	424	372	404	355	386	360	363	312
YEARS	0.99	0.93	1.05	0.88	1.16	1.02	1.11	0.97	1.06	0.99	0.99	0.85
AG PREP FOR ACC	127	76	121	58	103	63	106	66	107	72	109	82
OTHER LEGAL	446	350	471	324	381	311	368	312	417	324	404	351
TOTAL AG												
DAYS	573	426	592	382	484	374	474	378	524	396	513	433
YEARS	1.57	1.17	1.62	1.05	1.33	1.02	1.30	1.04	1.44	1.08	1.41	1.19
TOTAL MBC & AG												
DAYS	934	764	977	703	908	746	878	733	910	756	876	745
YEARS	2.56	2.09	2.68	1.93	2.49	2.04	2.41	2.01	2.49	2.07	2.40	2.04

Years calculated using 365 days per year

Data source: MBC Annual Reports, except 2011-2012

POST ACCUSATION AVERAGE TIME FRAMES

Cases Opened Between January 1, 2009, and December 31, 2011

Setting Cases for Administrative Hearing 210 Days

Factors

- Availability of Respondent's Counsel
- Availability of Calendar Days at the Office of Administrative Hearings
- Availability of Expert Witnesses
- Amendments to Pleadings by MBC
- Lack of Uniformity by the Office of Administrative Hearings in Setting Cases for Hearing
- Availability of DAGs

→

Post Hearing Adminstrative Procedures 160 Days

Factors

- Administrative Law Judge has 30 Days to Prepare Proposed Decision After the Case is Submitted
- MBC has 100 Days to Issue Decision from the Date Case Submitted
- MBC Decision Becomes Final 30 days After Issued
- Reconsideration Procedures

→

Writs of Mandate 268 Days

Factors

- Respondent/Petitioner is the Moving Party and Selects Venue
- Transcript Preparation by the Office of Administrative Hearings
- Setting Case for Hearing in Superior Court
- Remand to the MBC for Further Proceedings
- Business and Professions Code Requires Hearing to be Set within 180 Days Absent Good Cause
- California Judicial Council Rules of Court Require Two Years Before MBC Can File a Motion to Dismiss for Petitioner's Failure to Bring Case to Hearing

RECOMMENDATIONS

- Request that the Office of Administrative Hearings Initiate the Hearings in Medical Board Cases Within 180 Days of Receiving the "Request to Set"

- Request that the Office of Administrative Hearings Adopt a Uniform Statewide Procedure for Setting Hearings in Medical Board Cases

- Adopt the State Bar Disciplinary Model and Create an In-House Panel of Administrative Law Judges

- Request that the Judicial Council Modify its Rules and Reduce to One Year the Waiting Period to File a Motion to Dismiss for Failure to Prosecute a Case

LEGISLATIVE PACKET

MEDICAL BOARD MEETING

May 4, 2012
Torrance, CA

MEDICAL BOARD OF CALIFORNIA
TRACKER – LEGISLATIVE BILL FILE
April 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 Consent	Sponsor	3/21/12
AB 1548	Carter	Cosmetic Surgery: Employment of Physicians	Assembly Consent	Support	3/22/12
AB 1621	Halderman	Physicians & Surgeons: Prostate Cancer	Senate B&P	Reco: Support	
AB 1896	Chesbro	Tribal Health Programs: Health Care Practitioners	Asm. 3rd Reading	Reco: No Position	3/27/12
AB 2561	Hernandez	Certified Surgical Tech.	Asm. Approps	Reco: Neutral	3/29/12
AB 2570	Hill	Licensees: Settlement Agreements	Asm. Approps	Reco: Support	
SB 352	Huff	Chiropractors	Assembly	Support if Amended	01/11/12
SB 924	Price, Walters & Steinberg	PTs: Direct Access: Professional Corporations	Asm. B&P	Oppose Unless Amended	01/26/12
SB 1095	Rubio	Pharmacy: Clinics	Sen. Approps, 4/30	Reco: Support	
SB 1274	Wolk	Healing Arts: Hospitals: Employment	Sen. Health	Reco: Support	04/09/12
SB 1338	Kehoe	Abortion	Sen. B&P, 4/26	Reco: No Position	4/9/12
SB 1416	Rubio	Medical Residency Training Program Grants	Sen. Health, 4/25	Reco: Support	4/16/12
SB 1483	Steinberg	Physician Health Program	Sen. Approps	Reco: Oppose Unless Amended	4/17/12
SB 1488	Yee	Traditional Chinese Medicine: Traumatologist Certification	Senate	Reco: No Position	
SB 1575	B&P Comm.	Omnibus – B&P Health	Sen. Approps	Sponsor	4/16/12
SCR 69	Pavley	Ca Autism Awareness Month	Assembly Consent	Reco: Support	4/16/12

Pink – Sponsored Bill, Blue – For Discussion, Green – No Discussion Needed

SPONSORED BILLS

AB 1533

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1533
Author: Mitchell
Bill Date: March 21, 2012, amended
Subject: UCLA IMG Pilot Program
Sponsor: Medical Board of California and University of California
Position: Sponsor/Support

STATUS OF BILL:

This bill is on the Assembly Consent Calendar.

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.

This bill was amended to require the report to be submitted on or before January 1, 2018, and to require the report to include data on the number of participants who practice in designated medically underserved areas.

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 March 21st amendments were taken at the request of the Assembly Republican Caucus. The amendments would require the report prepared by the UC to be submitted on or before January 1, 2018, and would also require the report to include data on the number of participants who practice in designated medically underserved areas. The Board and the UC have no concerns with these amendments.

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)
California Academy of Family Physicians
California State Rural Health Association
Los Angeles County Board of Supervisors
California Medical Association

OPPOSITION: None on file

POSITION: Sponsor/Support

AMENDED IN ASSEMBLY MARCH 21, 2012

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

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 amended, 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~~ *David Geffen* School of *Medicine 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~~ *on or before January 1, 2018*. 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

400 to 1,000 unlicensed Hispanic IMG physicians legally reside and work in ~~Southern~~ *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"~~ *"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

Angeles David Geffen School of Medicine's International Medical Graduate Pilot Program.

(b) Nothing in this chapter shall be construed to prohibit a foreign medical graduate from engaging in the practice of medicine when required as part of the pilot program authorized by this section.

(c) There is currently a preresidency training program at the University of California, Los Angeles David Geffen School of Medicine, Department of Family Medicine, hereafter referred to as UCLA, for selected international medical graduates (IMGs). Participation in the pilot program authorized by this section shall be at the option of UCLA. This section authorizes those IMGs, through the new pilot program authorized by this section, to receive, through the existing program, hands-on clinical instruction in the courses specified in subdivision (c) of Section 2089.5. The pilot program, as administered by UCLA, shall include all of the following elements:

(1) Each pilot program participant shall have done all of the following:

(A) Graduated from a medical school recognized by the Medical Board of California at the time of selection.

(B) Taken and passed the United States Medical Licensing Examination Steps 1 and 2 (Clinical Knowledge and Clinical Science).

(C) Submitted an application and materials to the Educational Commission for Foreign Medical Graduates.

(2) A pilot program participant shall receive all clinical instruction at health care facilities operated by the University of California, Los Angeles, or other approved ~~UCLA designated~~ *UCLA-designated* teaching sites, which shall be hospitals or clinics with either a signed formal affiliation agreement with UCLA or a signed letter of agreement.

(3) Participation of a trainee in clinical instruction offered by the pilot program shall not generally exceed 16 weeks. However, at the discretion of UCLA, an additional eight weeks of clinical instruction may be granted. In no event shall a participant receive more than 24 weeks of clinical instruction under the pilot program.

(4) The clinical instruction shall be supervised by licensed 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 postgraduate training should such a deficiency apply to that applicant.

(f) ~~After the pilot program has been operative for five years,~~ *On or before January 1, 2018,* 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, *the number of participants who practice in designated medically underserved areas,* 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

SB 1575

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1575
Author: Committee on Business, Professions, and Economic Development
Bill Date: April 16, 2012, amended
Subject: Omnibus
Sponsor: Committee, Medical Board, and other health boards
Position: Support MBC Provisions

STATUS OF BILL:

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

DESCRIPTION OF CURRENT LEGISLATION:

This bill is the vehicle by which omnibus legislation has been carried by the Senate Business, Professions and Economic Development Committee. This analysis will only include the relevant sections of the bill in the Business and Professions Code (BPC) that are sponsored by and impact the Medical Board of California (Board). The omnibus language would allow the Board to send renewal notices via e-mail; would clarify that the Board has enforcement jurisdiction over all licensees, including licensees with a non-practice license status; would establish a retired license status for licensed midwives; and would make other technical changes.

ANALYSIS:

BPC Sections 2021 & 2424 Renewal Notices – Ability to Send via E-Mail

These provisions allow the Board to send renewal notices via e-mail and require the Board to annually send an electronic notice to all licensees that have opted to receive correspondence via e-mail to confirm that the e-mail address on file with the Board is current.

The Board will be moving to a new information technology (IT) system, BreEZe, which 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., this bill would

allow the Board to send renewal notices via e-mail if requested by the physician and also include a process to ensure that the e-mail address on record is current.

BPC Section 2220 – Non Practice License Status, Authority to Impose Discipline

This provision would clarify that the Board has enforcement jurisdiction over all licensees, "including those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders."

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 lacks 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. This bill would make it clear that the Board does in fact have jurisdiction over all licensees.

BPC Section 2518 - Licensed Midwives – Retired Licensed Status

This provision would establish a retired license status for licensed midwives (LMs), similar to the retired license status for physicians.

A retired license status for licensed midwives appears to have been left out of the Licensed Midwifery Practice Act 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. This bill would establish the retired license status for LMs.

Additional Technical Changes:

- **Section 2064** - In 2005, the Medical Board requested a change in the omnibus bill to change Section 2064 from "...in an approved medical school or clinical training program...", to "...in an approved medical school ~~or~~ <u>and</u> training program". This amendment was asked for in error and the board should have not asked for this change.
- **Section 2184** – would 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.

- **Section 2516** – would change the term "infant" to "neonate" in subdivision (a)(3)(L) related to reporting requirements. According to the Midwifery Advisory Council, "neonate" is a more appropriate term to use for this reporting requirement than "infant", as it describes a newborn in the first 4 weeks of life.

FISCAL: None to MBC

SUPPORT: MBC (Sponsor/Support)

OPPOSITION: None on file

POSITION: Support MBC Provisions

AMENDED IN SENATE APRIL 16, 2012

SENATE BILL No. 1575

Introduced by Committee on Business, Professions and Economic Development (Senators Price (Chair), Corbett, Correa, Emmerson, Hernandez, Negrete McLeod, Strickland, Vargas, and Wyland)

March 12, 2012

An act to amend Sections *1934, 1950.5,* 2021, 2064, 2184, 2220, 2424, 2516, 2518, 2904.5, 3057.5, 3742, 3750, 3750.5, *4209, 4600, 4601, 4603.7, 4612,* 4980.04, 4980.34, 4980.398, 4980.399, *4980.43, 4980.44, 4980.48,* 4980.78, 4980.80, 4984.4, 4989.16, 4989.42, 4992.07, 4992.09, 4996.6, 4999.22, 4999.32, *4999.46,* 4999.57, 4999.58, 4999.59, *4999.62, 4999.76,* 4999.90, 4999.106, and 4999.120 of, to add ~~Section~~ *Sections* 144.5, *1902.2, 1942, 1958.1, and 4300.1* to *repeal Section 1909.5 of,* and to repeal and amend Section 4999.45 of, the Business and Professions Code, relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

SB 1575, as amended, Committee on Business, Professions and Economic Development. Professions and vocations.

Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs.

(1) Under existing law, specified professions and vocations boards are required to require an applicant to furnish to the board a full set of fingerprints in order to conduct a criminal history record check.

This bill would authorize such a board to request, and would require a local or state agency to provide, certified records of, among other things, all arrests and convictions needed by a board to complete an

applicant or licensee investigation. *By imposing additional duties on local agencies, the bill would impose a state-mandated local program.*

(2) Existing law, the Dental Practice Act, provides for the licensure and regulation of the practice of dentistry by the Dental Board of California within the Department of Consumer Affairs. Existing law establishes the Dental Hygiene Committee of California under the jurisdiction of the board and provides for the licensure and regulation of the practice of dental hygienists by the committee.

This bill would require dental hygienists, upon initial licensure and renewal, to report their employment status to the committee and would require that information to be posted on the committee's Internet Web site. This bill would also require an approval dental hygiene education program to register extramural dental facilities, as defined, with the committee.

Existing law provides that a dental hygienist may have his or her license suspended or revoked by the board for committing acts of unprofessional conduct, as defined.

This bill would include within the definition of unprofessional conduct the aiding or abetting of the unlicensed or unlawful practice of dental hygiene and knowingly failing to follow infection control guidelines, as specified.

Existing law authorizes the committee to deny an application for licensure or to revoke or suspend a license for specified reasons.

This bill would require the committee to deny a license or renewal of a license to any person who is required by law to register as a sex offender.

~~(2)~~

(3) Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Under existing law, the board issues a physician and surgeon's certificate to a licensed physician and surgeon. Existing law provides for the licensure and regulation of the practice of podiatric medicine by the California Board of Podiatric Medicine within the Medical Board of California.

Existing law requires the Medical Board of California and the California Board of Podiatric Medicine to provide written notification by certified mail to any physician and surgeon or podiatrist who does not renew his or her license within 60 days of expiration.

This bill would require the Medical Board of California and the California Board of Podiatric Medicine to provide that written

notification either by certified mail or by electronic mail if requested by the licensee. The bill would require the Medical Board of California to annually send an electronic notice to all licensees and applicants requesting confirmation that his or her electronic mail address is current.

Existing law authorizes the Medical Board of California to take action against all persons guilty of violating the Medical Practice Act. Existing law requires the Medical Board of California to enforce and administer various disciplinary provisions as to physician and surgeon certificate holders.

This bill would specify that those certificate holders include those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders.

~~(3)~~

(4) Existing law, the Licensed Midwifery Practice Act of 1993, provides for the licensure and regulation of the practice of licensed midwifery by the Medical Board of California. A violation of the act is a crime. Under existing law, these licenses are subject to biennial renewal that includes the payment of a specified fee and the completion of specified continuing education.

This bill would exempt a licensee from those renewal requirements if the licensee has applied to the board and has been issued a retired status license. The bill would prohibit the holder of a retired status license from engaging in the practice of midwifery. Because a violation of that prohibition would constitute a crime, the bill would impose a state-mandated local program.

~~(4)~~

(5) Existing law, the Psychology Licensing Law, provides for the licensure and regulation of psychologists by the Board of Psychology. Existing law provides that a licensed psychologist is a health care practitioner for purposes of specified telehealth provisions that concern the delivery of health care via information and communication technologies.

This bill would instead provide that a licensed psychologist is a health care provider subject to those telehealth provisions.

~~(5)~~

(6) Existing law, the Respiratory Care Practice Act, provides for the licensure and regulation of the practice of respiratory care by the Respiratory Care Board of California.

(1) The committee shall deny an application by the individual for licensure pursuant to this article.

(2) If the individual is licensed under this article, the committee shall promptly revoke the license of the individual. The committee shall not stay the revocation nor place the license on probation.

(3) The committee shall not reinstate or reissue the individual's licensure under this article. The committee shall not issue a stay of license denial and place the license on probation.

(b) This section shall not apply to any of the following:

(1) An individual who has been relieved under Section 290.5 of the Penal Code of his or her duty to register as a sex offender, or whose duty to register has otherwise been formally terminated under California law or the law of the jurisdiction that requires his or her registration as a sex offender.

(2) An individual who is required to register as a sex offender pursuant to Section 290 of the Penal Code solely because of a misdemeanor conviction under Section 314 of the Penal Code. However, nothing in this paragraph shall prohibit the committee from exercising its discretion to discipline a licensee under other provisions of state law based upon the licensee's conviction under Section 314 of the Penal Code.

(3) Any administrative adjudication proceeding under Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code that is fully adjudicated prior to January 1, 2013. A petition for reinstatement of a revoked or surrendered license shall be considered a new proceeding for purposes of this paragraph, and the prohibition against reinstating a license to an individual who is required to register as a sex offender shall be applicable.

~~SEC. 2.~~

SEC. 8. Section 2021 of the Business and Professions Code is amended to read:

2021. (a) If the board publishes a directory pursuant to Section 112, it may require persons licensed pursuant to this chapter to furnish any information as it may deem necessary to enable it to compile the directory.

(b) Each licensee shall report to the board each and every change of address within 30 days after each change, giving both the old and new address. If an address reported to the board at the time of application for licensure or subsequently is a post office box, the

applicant shall also provide the board with a street address. If another address is the licensee's address of record, he or she may request that the second address not be disclosed to the public.

(c) Each licensee shall report to the board each and every change of name within 30 days after each change, giving both the old and new names.

(d) The board shall annually send an electronic notice to each applicant and licensee who has chosen to receive correspondence via electronic mail that requests confirmation from the applicant or licensee that his or her electronic mail address is current. An applicant or licensee that does not confirm his or her electronic mail address shall receive correspondence at a mailing address provided pursuant to subdivision (b).

~~SEC. 3.~~

SEC. 9. Section 2064 of the Business and Professions Code is amended to read:

2064. Nothing in this chapter shall be construed to prevent a regularly matriculated student undertaking a course of professional instruction in an approved medical school, or to prevent a foreign medical student who is enrolled in an approved medical school or clinical training program in this state, or to prevent students enrolled in a program of supervised clinical training under the direction of an approved medical school pursuant to Section 2104, from engaging in the practice of medicine whenever and wherever prescribed as a part of his or her course of study.

~~SEC. 4.~~

SEC. 10. Section 2184 of the Business and Professions Code is amended to read:

2184. (a) Each applicant shall obtain on the written examination a passing score, established by the board pursuant to Section 2177.

(b) (1) Passing scores on each step of the United States Medical Licensing Examination shall be valid for a period of 10 years from the month of the examination for purposes of qualification for licensure in California.

(2) The period of validity provided for in paragraph (1) may be extended by the board for any of the following:

(A) For good cause.

(B) For time spent in a postgraduate training program, including, but not limited to, residency training, clinical training, fellowship

training, remedial or refresher training, or other training that is intended to maintain or improve medical skills.

(C) For an applicant who is a physician and surgeon in another state or a Canadian province who is currently and actively practicing medicine in that state or province.

(3) Upon expiration of the 10-year period plus any extension granted by the board under paragraph (2), the applicant shall pass the Special Purpose Examination of the Federation of State Medical Boards or a clinical competency written examination determined by the board to be equivalent.

~~SEC. 5.~~

SEC. 11. Section 2220 of the Business and Professions Code is amended to read:

2220. Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders, and the board shall have all the powers granted in this chapter for these purposes including, but not limited to:

(a) Investigating complaints from the public, from other licensees, from health care facilities, or from the board that a physician and surgeon may be guilty of unprofessional conduct. The board shall investigate the circumstances underlying a report received pursuant to Section 805 or 805.01 within 30 days to determine if an interim suspension order or temporary restraining order should be issued. The board shall otherwise provide timely disposition of the reports received pursuant to Section 805 and Section 805.01.

(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.

(c) Investigating the nature and causes of injuries from cases which shall be reported of a high number of judgments, settlements, or arbitration awards against a physician and surgeon.

~~SEC. 6.~~

SEC. 12. Section 2424 of the Business and Professions Code is amended to read:

2424. (a) The board or the California Board of Podiatric Medicine, as the case may be, shall notify in writing either by certified mail, return receipt requested, or by electronic mail if requested by the licensee, any physician and surgeon or any podiatrist who does not renew his or her license within 60 days from its date of expiration.

(b) Notwithstanding Section 163.5, any such licensee who does not renew his or her expired license within 90 days of its date of expiration shall pay all the following fees:

(1) The renewal fee in effect at the time of renewal.

(2) A penalty fee equal to 50 percent of the renewal fee.

(3) The delinquency fee required by Section 2435 or 2499.5, as the case may be.

(c) Notwithstanding any other provision of law, the renewal of any expired physician's and surgeon's or podiatrist's license within six months from its date of expiration shall be retroactive to the date of expiration of that license. The division or board, for good cause, may waive the 50 percent penalty fee and may extend retroactivity up to two years from the expiration date of any such license.

~~SEC. 7.~~

SEC. 13. Section 2516 of the Business and Professions Code is amended to read:

2516. (a) Each licensed midwife who assists, or supervises a student midwife in assisting, in childbirth that occurs in an out-of-hospital setting shall annually report to the Office of Statewide Health Planning and Development. The report shall be submitted no later than March 30, with the first report due in March 2008, for the prior calendar year, in a form specified by the board and shall contain all of the following:

(1) The midwife's name and license number.

(2) The calendar year being reported.

(3) The following information with regard to cases in California in which the midwife, or the student midwife supervised by the

1 midwife, assisted during the previous year when the intended place
2 of birth at the onset of care was an out-of-hospital setting:
3 (A) The total number of clients served as primary caregiver at
4 the onset of care.
5 (B) The total number of clients served with collaborative care
6 available through, or given by, a licensed physician and surgeon.
7 (C) The total number of clients served under the supervision of
8 a licensed physician and surgeon.
9 (D) The number by county of live births attended as primary
10 caregiver.
11 (E) The number, by county, of cases of fetal demise, infant
12 deaths, and maternal deaths attended as primary caregiver at the
13 discovery of the demise or death.
14 (F) The number of women whose primary care was transferred
15 to another health care practitioner during the antepartum period,
16 and the reason for each transfer.
17 (G) The number, reason, and outcome for each elective hospital
18 transfer during the intrapartum or postpartum period.
19 (H) The number, reason, and outcome for each urgent or
20 emergency transport of an expectant mother in the antepartum
21 period.
22 (I) The number, reason, and outcome for each urgent or
23 emergency transport of an infant or mother during the intrapartum
24 or immediate postpartum period.
25 (J) The number of planned out-of-hospital births at the onset of
26 labor and the number of births completed in an out-of-hospital
27 setting.
28 (K) The number of planned out-of-hospital births completed in
29 an out-of-hospital setting that were any of the following:
30 (i) Twin births.
31 (ii) Multiple births other than twin births.
32 (iii) Breech births.
33 (iv) Vaginal births after the performance of a cesarean section.
34 (L) A brief description of any complications resulting in the
35 morbidity or mortality of a mother or a neonate.
36 (M) Any other information prescribed by the board in
37 regulations.
38 (b) The Office of Statewide Health Planning and Development
39 shall maintain the confidentiality of the information submitted
40 pursuant to this section, and shall not permit any law enforcement

or regulatory agency to inspect or have copies made of the contents of any reports submitted pursuant to subdivision (a) for any purpose, including, but not limited to, investigations for licensing, certification, or regulatory purposes.

(c) The office shall report to the board, by April 30, those licensees who have met the requirements of subdivision (a) for that year.

(d) The board shall send a written notice of noncompliance to each licensee who fails to meet the reporting requirement of subdivision (a). Failure to comply with subdivision (a) will result in the midwife being unable to renew his or her license without first submitting the requisite data to the Office of Statewide Health Planning and Development for the year for which that data was missing or incomplete. The board shall not take any other action against the licensee for failure to comply with subdivision (a).

(e) The board, in consultation with the office and the Midwifery Advisory Council, shall devise a coding system related to data elements that require coding in order to assist in both effective reporting and the aggregation of data pursuant to subdivision (f). The office shall utilize this coding system in its processing of information collected for purposes of subdivision (f).

(f) The office shall report the aggregate information collected pursuant to this section to the board by July 30 of each year. The board shall include this information in its annual report to the Legislature.

(g) Notwithstanding any other provision of law, a violation of this section shall not be a crime.

~~SEC. 8.~~

SEC. 14. Section 2518 of the Business and Professions Code is amended to read:

2518. (a) Licenses issued pursuant to this article shall be renewable every two years upon payment of the fee prescribed by Section 2520 and submission of documentation that the licenseholder has completed 36 hours of continuing education in areas that fall within the scope of the practice of midwifery, as specified by the board.

(b) Each license not renewed shall expire, but may be reinstated within five years from the expiration upon payment of the prescribed fee and upon submission of proof of the applicant's qualifications as the board may require.

(c) A licensee is exempt from the payment of the renewal fee required by Section 2520 and the requirement for continuing education if the licensee has applied to the board for, and been issued, a retired status license. The holder of a retired status license may not engage in the practice of midwifery.

~~SEC. 9.~~

SEC. 15. Section 2904.5 of the Business and Professions Code is amended to read:

2904.5. A psychologist licensed under this chapter is a licentiate for purposes of paragraph (2) of subdivision (a) of Section 805, and thus is a health care provider subject to the provisions of Section 2290.5.

~~SEC. 10.~~

SEC. 16. Section 3057.5 of the Business and Professions Code is amended to read:

3057.5. Notwithstanding any other provision of this chapter, the board shall permit a graduate of a foreign university who meets all of the following requirements to take the examinations for a certificate of registration as an optometrist:

(a) Is over the age of 18 years.

(b) Is not subject to denial of a certificate under Section 480.

(c) Has a degree as a doctor of optometry issued by a university located outside of the United States.

~~SEC. 11.~~

SEC. 17. Section 3742 of the Business and Professions Code is amended to read:

3742. During the period of any clinical training, a student respiratory care practitioner shall be under the direct supervision of a person holding a valid, current, and unrestricted license issued under this chapter. "Under the direct supervision" means assigned to a respiratory care practitioner who is on duty and immediately available in the assigned patient care area.

~~SEC. 12.~~

SEC. 18. Section 3750 of the Business and Professions Code is amended to read:

3750. The board may order the denial, suspension, or revocation of, or the imposition of probationary conditions upon, a license issued under this chapter, for any of the following causes:

(a) Advertising in violation of Section 651 or Section 17500.

(b) Fraud in the procurement of any license under this chapter.

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

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

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.

(7) Licensed physician assistants.
(8) Licensed chiropractors.
(9) Licensed acupuncturists.
(10) Naturopathic doctors.
(11) Licensed physical therapists.
(12) Licensed occupational therapists.
(b) Podiatric medical corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.
(3) Registered nurses.
(4) Licensed optometrists.
(5) Licensed chiropractors.
(6) Licensed acupuncturists.
(7) Naturopathic doctors.
(8) Licensed physical therapists.
(9) Licensed occupational therapists.
(c) Psychological corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Registered nurses.
(4) Licensed optometrists.
(5) Licensed marriage and family therapists.
(6) Licensed clinical social workers.
(7) Licensed chiropractors.
(8) Licensed acupuncturists.
(9) Naturopathic doctors.
(d) Speech-language pathology corporation.
(1) Licensed audiologists.
(e) Audiology corporation.
(1) Licensed speech-language pathologists.
(f) Nursing corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Licensed psychologists.
(4) Licensed optometrists.
(5) Licensed marriage and family therapists.
(6) Licensed clinical social workers.
(7) Licensed physician assistants.
(8) Licensed chiropractors.
(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

AB 1548

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1548
Author: Carter
Bill Date: March 22, 2012, amended
Subject: Cosmetic Surgery: Employment of Physicians
Sponsor: American Society for Dermatologic Surgery and California Society of Dermatology and Dermatologic Surgery
Position: Support

STATUS OF BILL:

This bill is on the Assembly Consent Calendar.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would prohibit outpatient cosmetic surgery centers from violating the prohibition of the corporate practice of medicine. This bill defines "outpatient elective cosmetic medical procedures or treatments."

This bill was amended to specify that nothing in this bill shall be construed to alter or apply to arrangements currently authorized by law, including but not limited to, any entity operating a medical facility authorized to provide medical services under Section 1206 of the Health and Safety Code.

ANALYSIS:

The intent of this bill is to elevate the penalties of violating the corporate practice of medicine prohibition in order to prevent further offenses and to convince consumers with business models that violate this law to reconsider and revise their business practices.

This bill would enhance the penalty for corporations violating the prohibition of the corporate practice of medicine to a public offense punishable by imprisonment for up to five years and/or by a fine not exceeding $50,000. Current law states that this violation is punishable as a misdemeanor, a $1,200 fine, and imprisonment for up to 180 days.

This bill would define "outpatient elective cosmetic medical procedures or treatments" as medical procedures or treatments that are performed to alter or reshape normal structures of the body solely in order to improve appearance.

The March 21st amendments specify that nothing in this bill shall be construed to alter or apply to arrangements currently authorized by law, including but not limited to, any entity operating a medical facility authorized to provide medical services under Section 1206 of the Health and Safety Code; these amendments do not impact the Board's analysis or the Board's Support position.

The purpose of this bill is to elevate the penalties of violating the corporate practice of medicine prohibition in order to prevent further offenses, which will help to ensure consumer protection. The Board has previously supported similar legislation, such as AB 2566 (Carter) in 2010 that contained language that mirrors the language in this bill, and AB 252 (Carter) in 2009 that authorized the revocation of a physician's license for knowingly practicing with an organization that is in violation of the corporate practice of medicine. Both bills were vetoed for being "duplicative of existing law." In 2008 AB 2398 (Nakanishi) contained very similar provisions to AB 252 and was held in the Senate.

FISCAL: None to the Board

SUPPORT:
American Society for Dermatologic Surgery (Co-Sponsor)
CA Society of Dermatology and Dermatologic Surgery (Co-Sponsor)
American Academy of Dermatology Association
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Otolaryngology Head and Neck Surgery
American Medical Association
American Society of Ophthalmic Plastic & Reconstructive Surgery, Inc.
California Society of Plastic Surgeons
Medical Board of California

OPPOSITION: None on File

AMENDED IN ASSEMBLY MARCH 22, 2012

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 1548

Introduced by Assembly Member Carter
(Coauthors: Assembly Members Bill Berryhill and Hill)
(Coauthors: Senators Correa, Emmerson, Negrete McLeod, and Wyland)

January 25, 2012

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

LEGISLATIVE COUNSEL'S DIGEST

AB 1548, as amended, Carter. Practice of medicine: cosmetic surgery: employment of physicians and surgeons.

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

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

This bill, with respect to a business organization that provides outpatient elective cosmetic medical procedures or treatments, that is owned and operated in violation of the prohibition against employment of licensed physicians and surgeons and podiatrists, and that contracts with or employs these licensees to facilitate the offer or provision of procedures or treatments that may only be provided by these licensees,

would make that business organization guilty of a violation of the prohibition against knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit. *The bill would prohibit construing its provisions to alter or apply to any arrangements currently authorized by law.* Because the bill would expand a public offense, it would impose a state-mandated local program.

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

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

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

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

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

1 SECTION 1. The Legislature finds and declares that the
2 Medical Practice Act ~~restricts the employment of physicians and~~
3 ~~surgeons by a corporation or~~ *prohibits corporations and* other
4 artificial legal ~~entity~~ *entities from exercising professional rights,*
5 *privileges, or powers*, as described in Article 18 (commencing
6 with Section 2400) of Chapter 5 of Division 2 of the Business and
7 Professions Code, and that the prohibited conduct described in
8 Section 2417.5 of the Business and Professions Code, as added by
9 this act, is declaratory of existing law.
10 SEC. 2. Section 2417.5 is added to the Business and Professions
11 Code, to read:
12 2417.5. (a) A business organization that offers to provide, or
13 provides, outpatient elective cosmetic medical procedures or
14 treatments, that is owned or operated in violation of Section 2400,
15 and that contracts with, or otherwise employs, a physician and
16 surgeon to facilitate its offers to provide, or the provision of,
17 outpatient elective cosmetic medical procedures or treatments that
18 may be provided only by the holder of a valid physician's and
19 surgeon's certificate is guilty of violating paragraph (6) of
20 subdivision (a) of Section 550 of the Penal Code.
21 (b) For purposes of this section, "outpatient elective cosmetic
22 medical procedures or treatments" means medical procedures or

1 treatments that are performed to alter or reshape normal structures
2 of the body solely in order to improve appearance.
3 *(c) Nothing in this section shall be construed to alter or apply*
4 *to arrangements currently authorized by law, including, but not*
5 *limited to, any entity operating a medical facility or other business*
6 *authorized to provide medical services under Section 1206 of the*
7 *Health and Safety Code.*
8 SEC. 3. No reimbursement is required by this act pursuant to
9 Section 6 of Article XIII B of the California Constitution because
10 the only costs that may be incurred by a local agency or school
11 district will be incurred because this act creates a new crime or
12 infraction, eliminates a crime or infraction, or changes the penalty
13 for a crime or infraction, within the meaning of Section 17556 of
14 the Government Code, or changes the definition of a crime within
15 the meaning of Section 6 of Article XIII B of the California
16 Constitution.

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AB 1621

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1621
Author: Halderman
Bill Date: February 8, 2012, introduced
Subject: Physicians and Surgeons: Prostate Cancer
Sponsor: Author

STATUS OF BILL:

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

DESCRIPTION OF CURRENT LEGISLATION:

This bill would exempt physicians working on trauma cases from current law that requires physicians to provide specified information on prostate diagnostic procedures to patients who undergo an examination of the prostate gland.

ANALYSIS:

Existing law (Business and Professions Code Section 2248), the Grant H. Kenyon Prostate Cancer Detection Act, requires physicians that examine a patient's prostate gland during a physical examination to provide information to the patient about the availability of appropriate diagnostic procedures if any of the following conditions are present: the patient is over 50 years of age; the patient manifests clinical symptomatology; the patient is at an increased risk of prostate cancer; or the provision of the information is medically necessary, in the opinion of the physician. Physicians often meet this requirement by providing patients with the 59-page booklet published by the National Cancer Institute and available on the Medical Board's Web site. Existing law specifies that a violation of this provision constitutes unprofessional conduct.

Existing law also defines "trauma case" as any injured person who has been evaluated by prehospital personnel according to policies and procedures established by the local EMS agency and who has been found to require transportation to a trauma facility.

The author's office believes that providing the required prostate diagnostic procedure information is not appropriate in all settings. Physicians in trauma settings may need to perform prostate exams on patients who are unconscious or in critical condition to evaluate pelvic fracture and internal bleeding after major trauma. This bill would add an exemption to existing law to allow for trauma situations.

Emergency room doctors also contend that current law can be impractical in trauma situations, especially since the patients are often unconscious and can be transferred to another unit or facility before regaining consciousness. In addition, providing trauma patients with information on prostate cancer could be misleading and lead the patient to think he is at risk for prostate cancer, when the examination was performed for a different reason.

Board staff believes that the exemption to existing law proposed by this bill for trauma cases is a reasonable exemption. Especially due to the fact that the patients are unconscious in many cases and a "trauma case" that would be eligible for this exemption is already defined in existing law. Board staff suggests that the Board support this bill.

FISCAL: None

SUPPORT: California Chapter of the American College of Emergency Physicians
California Hospital Association
Northern CA Chapter of the American College of Surgeons
One individual

OPPOSITION: None on File

POSITION: Recommendation: Support

ASSEMBLY BILL No. 1621

Introduced by Assembly Member Halderman

February 8, 2012

An act to amend Section 2248 of the Business and Professions Code, relating to medicine.

LEGISLATIVE COUNSEL'S DIGEST

AB 1621, as introduced, Halderman. Physicians and surgeons: prostate cancer.

Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Existing law requires a physician and surgeon examining a patient's prostate gland during a physical examination to provide the patient with specified information if certain conditions are present.

This bill would exempt from this requirement a physician and surgeon working on a trauma case, defined as any injured person who has been evaluated by prehospital personnel according to policies and procedures established by the local EMS agency and who has been found to require transportation to a trauma facility.

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

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

1 SECTION 1. Section 2248 of the Business and Professions
2 Code is amended to read:
3 2248. This section shall be known as, and may be cited as, the
4 Grant H. Kenyon Prostate Cancer Detection Act.

(a) If a physician and surgeon, during a physical examination, examines a patient's prostate gland, the physician and surgeon shall provide information to the patient about the availability of appropriate diagnostic procedures, including, but not limited to, the prostate antigen (PSA) test, if any of the following conditions are present:

(1) The patient is over 50 years of age.

(2) The patient manifests clinical symptomatology.

(3) The patient is at an increased risk of prostate cancer.

(4) The provision of the information to the patient is medically necessary, in the opinion of the physician and surgeon.

(b) Violation of subdivision (a) constitutes unprofessional conduct and is not subject to Section 2314.

(c) This section shall not apply to a physician and surgeon working on a trauma case as defined in Section 1798.160 of the Health and Safety Code.

O

AB 1896

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1896
Author: Chesbro
Bill Date: March 27, 2012, amended
Subject: Tribal Health Programs: Health Care Practitioners
Sponsor: California Rural Indian Health Board (CRIHB)

STATUS OF BILL:

This bill is on the Assembly Third Reading File.

DESCRIPTION OF CURRENT LEGISLATION:

AB 1896 would align state law with the federal Patient Protection and Affordable Care Act (PPACA) and would exempt all health care practitioners employed by a tribal health program from California licensure, if they are licensed in another state.

BACKGROUND (Provided by CRIHB):

Federal Law

In the early 1970s, Congress passed the Indian Self Determination and Education Assistance Act that allowed Indian tribes and tribal organizations to acquire increased control over the management of federal programs that impact their resources and governments. These agreements are referred to as "638 compacts and contracts." Contracts and compacts are very similar. Self-Determination contracts are authorized under the 1975 Indian Self Determination and Education Assistance Act. Self-Governance compacts are made possible by 1994 amendments to the 1975 Indian Self Determination and Education Assistance Act.

Federal law, Public Law 111-148, enacted in 2010, provides the following: "Licensed health professionals employed by a tribal health program shall be exempt, if licensed in any state, from the licensing requirements of the state in which the tribal health program performs the services described in the contract or compact of the tribal health program under the Indian Self-Determination and Education Assistance Act (ISDEAA) (25 U.S.C. 450 et seq.)"

The Federal Government and Tribes have a unique legal relationship

The "trust relationship" between the U.S. and Tribes has long been recognized in the Constitution, statutes, regulations, case law, Presidential executive orders and agency policies, and the general course of dealings between Tribes and the Federal government. In its role, the U.S. provides a variety of services, including health care, to American Indians (AIs).

An Indian Tribe is a self-governing entity and is acknowledged as such by the U.S. In the case Cherokee Nation v. Georgia, Justice Marshall described tribes as "domestic dependent nations." This and other judicial descriptions recognize 1) the nationhood of Tribes and 2) the Federal government's trust role.

Delivery of Indian Health Care

The Indian Health Care Improvement Act (IHCIA), along with the Snyder Act of 1921, forms the statutory basis for the delivery of federally-funded health care and the direct delivery of care to AIs. Since its passage in 1976, the IHCIA has provided the programmatic and legal framework for carrying out the federal government's trust responsibility for Indian Health.

To accomplish this goal, the Federal Government created Indian Health Service (IHS), an agency within the Department of Health and Human Services (HHS), whose sole mission is to deliver health care to AIs. The IHS provides comprehensive health care services—using a public health model—to 1.9 million AIs residing in tribal communities located in 35 States.

Indian Health Service

Throughout the U.S., the IHS directly operates 31 hospitals, 52 health centers, 2 school health centers, and 31 health stations. In addition, Tribes and Tribal organizations, through contracts and compacts under the Indian Self-Determination and Education Assistance Act, operate almost 50% of the IHS system and provide health care in 15 hospitals, 256 health centers, 9 school health centers, and 282 health stations (including 166 Alaska Native village clinics). The IHS or Tribes/Tribal organizations also operate 11 regional youth substance abuse treatment centers and 2,241 units of staff quarters.

Authority of Tribal Health Programs to Hire Providers

Historically, Tribal Health Programs have experienced shortages in doctors, nurses and other providers. The Indian Health Service reports the vacancy rates range from 10% to 25% depending on the type of provider and this is primarily due to the remoteness of the Tribal Health clinics. California's 31 Tribal Health Programs operate 57 ambulatory clinics and have difficulty hiring and retaining providers to work in the facilities. These necessary safety net clinics serve over 130,000 American Indian patients and non-Indian Medi-Cal patients on an annual basis.

States and the New Federal Tribal Health Program Provider Provision

Maine, Arizona, Nebraska and are some of the first states to deal with the new Federal provision.

Maine
On July 15, 2010, Anthony Marple, MaineCare Services Director issued a letter regarding the provision. In the letter Director Marple states, "We have recently had inquiries about Maine physician licensing requirements from Indian Health Service Providers who come to practice in Maine... This letter is to confirm that IHS providers do not have to be licensed in the State of Maine so long as they are licensed in some other state or territory (including Puerto Rico)."

Arizona
Arizona is complying with the provision. Arizona's Department of Health Services and Health Care Cost Containment System have complied with the law through procedural rules.

Nebraska
Nebraska initially chose not to comply with the provision. In response, the Ponca Tribe filed a lawsuit against Nebraska officials that alleged they were ignoring the provision. In August of 2011, the tribe withdrew the lawsuit after state health officials and the Attorney General's Office reported they had reviewed the matter and decided the tribe's doctor, Rosa M. Huguet and the Fred LeRoy Health and Wellness Center in Omaha fell under federal jurisdiction.

ANALYSIS:

This bill would align California law with the federal law and would provide that an individual, who is licensed as a health care practitioner in any other state and is employed by a tribal health program, is exempt from any licensing requirement in California law governing the healing arts, including physician licensing requirements. This bill defines health care practitioner as any person who engages in acts that are the subject of licensure or regulation under the law of any other state. Federal law defines "tribal health program" as an Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded in whole or part, by the Indian Health Services (IHS) through, or in contract or compact with the IHS under the ISDEAA.

According to the sponsors, tribal clinics can see patients that are not associated with a tribe, and1/3 of the patients seen in tribal health clinics are non-Indian Medi-Cal patients. Currently, in order to receive Medi-Cal payments, the provider must be licensed in California. The purpose of AB 1896 is to align California law with the federal PPACA and to allow the tribal health programs to receive Medi-Cal payments for services provided by practitioners, even if they are not licensed in California, as allowed by federal law.

Board staff has met with CRIHB several times and has discussed the importance of protecting consumers and ensuring that all patients, including patients not associated with an Indian Tribe, have complaint resolution options available. According to the sponsors, the following are options available for all patients receiving services in tribal health programs:

- IHS, which among other avenues, offers a web-based patient safety adverse event reporting system called WebCident.

- Tribal Health Program Governing Boards have compliance services, established by the Boards of Directors of Tribal Health Programs. Compliance services include an anonymous hotline for complaints operated by the United Indian Health Service, an option to file a complaint, which may be investigated and if applicable, disciplinary or corrective action can be taken.

- The Federal Tort Claims Act, which allows parties claiming to have been injured by negligent actions of employees of the U.S. to file claims against the federal government. This encompasses negligent acts of Tribal contractors carrying out contracts, grants, or cooperative agreements.

- Licensing Boards in other states that issued the practitioner license.

Board staff will continue to work with CRIHB, the author's office, and other interested parties to ensure that if this bill is passed, it is implemented in a way that will ensure consumer protection for all patients served in tribal health programs.

FISCAL: None

SUPPORT: CRIHB (Sponsor)
CRIHB, Tribal Governments Consultation Committee

OPPOSITION: None on file

POSITION: Recommendation: No Position

AMENDED IN ASSEMBLY MARCH 27, 2012

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 1896

Introduced by Assembly Member Chesbro

February 22, 2012

An act to amend the heading of Article 10 (commencing with Section 710) of Chapter 1 of Division 2 of, and to add Section 719 to, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 1896, as amended, Chesbro. Tribal health programs: health care practitioners.

Under existing federal law, licensed health professionals employed by a tribal health program are required to be exempt, if licensed in any state, from the licensing requirements of the state in which the tribal health program performs specified services. A tribal health program is defined as an Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Indian Health Service.

Existing law provides for the licensure and regulation of health care practitioners by various healing arts boards *within the Department of Consumer Affairs*.

This bill would codify that federal requirement by specifying that a *person who is licensed as a* health care practitioner *in any other state and is* employed by a tribal health program is exempt from any state licensing requirement *with respect to acts authorized under the person's license* where the tribal health program performs specified services.

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

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

1 SECTION 1. The heading of Article 10 (commencing with
2 Section 710) of Chapter 1 of Division 2 of the Business and
3 Professions Code is amended to read:
4
5 Article 10. Federal Personnel and Tribal Health Programs
6
7 SEC. 2. Section 719 is added to the Business and Professions
8 Code, to read:
9 719. (a) A *person who is licensed as a* health care practitioner
10 *in any other state and is* employed by a tribal health program, as
11 defined in Section 1603 of Title 25 of the United States Code, shall
12 be exempt from any licensing requirement described in this division
13 *with respect to acts authorized under the person's license* where
14 the tribal health program performs the services described in the
15 contract or compact of the tribal health program under the Indian
16 Self-Determination and Education Assistance Act (25 U.S.C. Sec.
17 450 et seq.).
18 (b) For purposes of this section, "health care practitioner" means
19 any person who engages in acts that are the subject of licensure
20 or regulation under ~~this division or any initiative act referred to in~~
21 ~~this division~~ *the law of any other state.*

O

AB 2561

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2561
Author: Hernandez
Bill Date: As proposed to be amended
Subject: Certified Surgical Technologists
Sponsor: Association of Surgical Technologists
CA State Association of Surgical Technologists

STATUS OF BILL:

This bill is in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would define certified surgical technologist (CST) and would define surgical technology patient care. This bill would prohibit individuals from holding themselves out to be CSTs unless they meet specified requirements.

ANALYSIS:

This bill would amend definitions and title protection for certified surgical technologists into the Medical Practice Act. CSTs work under the supervision of a physician, similar to a medical assistant. This bill would not require the Medical Board of California (Board) to issue a license or registration for a CST.

This bill would provide title protection by prohibiting individuals from using the title "Certified Surgical Technologist" in California unless the individual: has successfully completed a nationally accredited educational program for surgical technologists, or a training program for surgical technology in the army, navy, air force, marine corps, or coast guard of the United States or in the United States Public Health Service; and holds and maintains certification as a surgical technologist by the National Board of Surgical Technology and Surgical Assisting or its successor, or another nationally accredited surgical technologist certification program. This bill would define "Certified Surgical Technologist" as a person who practices surgical technology, and who has successfully completed a nationally accredited educational program for surgical technologists and holds and maintains certification as a surgical technologist by any of the entities described above.

This bill would define "surgical technology" to mean surgical patient care as follows:

- Preparing the operating room for surgical procedures by ensuring that surgical equipment is functioning properly and safely.
- Preparing the operating room and the sterile field for surgical procedures by preparing sterile supplies, instruments, and equipment using sterile technique.

- Anticipating the needs of the surgical team based on knowledge of human anatomy and pathophysiology and how they relate to the surgical patient and the patient's surgical procedure.

- As directed in an operating room setting, performing the following tasks at the sterile field:
    - Passing supplies, equipment, or instruments.
    - Sponging or suctioning an operative site.
    - Preparing and cutting suture material.
    - Transferring and pouring irrigation fluids.
    - Transferring but not administering drugs within the sterile field.
    - Handling specimens.
    - Holding retractors and other instruments.
    - Applying electrocautery to clamps on bleeders.
    - Connecting drains to suction apparatus.
    - Applying dressings to closed wounds.
    - Assisting in counting sponges, needles, supplies, and instruments with the registered nurse circulator.
    - Cleaning and preparing instruments for sterilization on completion of the surgery.
    - Assisting the surgical team with cleaning of the operating room on completion of the surgery.

This bill would specify that it does not repeal, modify, or amend any existing law relating to the supervision of surgical technologists and it would not prohibit or limit any healing arts licensee described in this division from performing a task or function within the scope of the healing art licensee's license. This bill would also not apply to a registered nurse or an individual employed by a health care facility whose primary functions include the cleaning or sterilization of supplies, instruments, equipment, or operating rooms.

According to the findings and declarations included in this bill, the surgical technology profession has grown to meet the continuing demand for well-educated, highly skilled, and versatile individuals to work with physicians and surgeons and other skilled professionals to deliver the highest possible level of patient care. Surgical site infections have been found to be the second most common hospital-acquired infections in the United States; the purpose of this bill is to encourage the education, training, and utilization of surgical technologists in California, given their role in surgical settings in order to take specific steps to prevent surgical site infections. This bill does not raise any concerns for the Board; staff is suggesting the Board be neutral on this bill.

FISCAL: None

SUPPORT: Association of Surgical Technologists (Co-sponsor)
CA State Association of Surgical Technologists (Co-sponsor)

OPPOSITION: American Nurses Association – Opposed to licensure of surgical technologists

POSITION: Recommendation: Neutral

MOCK UP

BILL NUMBER: AB 2561 AMENDED BILL TEXT

AS PROPOSED TO BE AMENDED IN ASSEMBLY APRIL 24, 2012

AMENDED IN ASSEMBLY MARCH 29, 2012

INTRODUCED BY Assembly Member Roger Hernández

FEBRUARY 24, 2012

An act to amend Section 152 of the Business and Professions Code, relating to the Department of Consumer Affairs.

An act to add and repeal Article 25 (commencing with Section 2525.20) of Chapter 5 of Division 2 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 2561, as amended, Roger Hernández. The Department of Consumer Affairs. Certified surgical technologists.

Existing law provides for the licensure and regulation of healing arts licensees by boards within the Department of Consumer Affairs, including the licensure and regulation of physicians and surgeons by the Medical Board of California.

This bill would make it unlawful to use the title "certified surgical technologist" unless one meets certain educational requirements, and holds a certification issued by specified entities.

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

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The Legislature finds and declares the following:

(a) Surgical technologists are responsible for the environmental disinfection, safety, and efficiency of the operating room, and their knowledge and experience with aseptic surgical technique qualifies them for a role of importance in the surgical suite.

(b) The surgical technology profession has grown to meet the continuing demand for well-educated, highly skilled, and versatile individuals to work with physicians and surgeons and other skilled

professionals to deliver the highest possible level of patient care.

(c) As surgical site infections have been found to be the second most common hospital-acquired infections in the United States, a key purpose of this article is to encourage the education, training, and utilization of surgical technologists in California, given their role in surgical settings in order to take specific steps to prevent surgical site infections.

SEC. 2. Article 25 (commencing with Section 2525.20) is added to Chapter 5 of Division 2 of the Business and Professions Code, to read:

Article 25. Certified Surgical Technologists

2525.20. This article shall be known and cited as the Certified Surgical Technologist Act.

2525.22. As used in this article, the following definitions shall apply:

~~(a) "Committee" means the Certified Surgical Technologist Committee within the Medical Board of California.~~

~~(b)~~ (a) "Certified surgical technologist" means a person who practices surgical technology, and who has successfully completed a nationally accredited educational program for surgical technologists and holds and maintains certification as a surgical technologist by any of entities described in Section 2525.24.

~~(c)~~ (b) "Surgical technology" means surgical patient care as follows:

(1) Preparing the operating room for surgical procedures by ensuring that surgical equipment is functioning properly and safely.

(2) Preparing the operating room and the sterile field for surgical procedures by preparing sterile supplies, instruments, and equipment using sterile technique.

(3) Anticipating the needs of the surgical team based on knowledge of human anatomy and pathophysiology and how they relate to the surgical patient and the patient's surgical procedure.

(4) As directed in an operating room setting, performing the following tasks at the sterile field:

(A) Passing supplies, equipment, or instruments.

(B) Sponging or suctioning an operative site.

(C) Preparing and cutting suture material.

(D) Transferring and pouring irrigation fluids.

(E) Transferring but not administering drugs within the sterile field.

(F) Handling specimens.

(G) Holding retractors and other instruments.

(H) Applying electrocautery to clamps on bleeders.

(I) Connecting drains to suction apparatus.

(J) Applying dressings to closed wounds.

(K) Assisting in counting sponges, needles, supplies, and

instruments with the registered nurse circulator.
(L) Cleaning and preparing instruments for sterilization on completion of the surgery.
(M) Assisting the surgical team with cleaning of the operating room on completion of the surgery.

2525.24. (a) It shall be unlawful to use the title "certified surgical technologist" in this state unless a person (1) has successfully completed a nationally accredited educational program for surgical technologists, or a training program for surgical technology in the army, navy, air force, marine corps, or coast guard of the United States or in the United States Public Health Service, and (2) holds and maintains certification as a surgical technologist by the National Board of Surgical Technology and Surgical Assisting or its successor, or another nationally accredited surgical technologist certification program.

2525.26. This article does not repeal, modify, or amend any existing law relating to the supervision of surgical technologists, nor shall it be construed to do so.

2525.28. This article does not prohibit or limit any healing arts licensee described in this division from performing a task or function within the scope of the healing art licensee's license, nor shall it be construed as such.

2525.30. This article does not apply to any of the following:
(a) A registered nurse licensed pursuant to Chapter 6 (commencing with Section 2700) or a vocational nurse licensed pursuant to Chapter 6.5 (commencing with Section 2840).
(b) An individual employed by a health care facility whose primary functions include the cleaning or sterilization of supplies, instruments, equipment, or operating rooms.

AB 2570

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2570
Author: Hill
Bill Date: February 24, 2012, introduced
Subject: Licensees: Settlement Agreements
Sponsor: Author

STATUS OF BILL:

This bill is in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would prohibit a physician from including a "gag clause" provision in a civil settlement agreement, or one that prohibits the other party in the dispute from contacting, filing a complaint with, or cooperating with, the appropriate licensing board, or requiring the other party to withdraw a previously filed complaint. A violation of this provision would subject the licensee to disciplinary action.

ANALYSIS:

Current law in the Medical Practice Act (Section 2220.7) already prohibits a physician from including a "gag clause" in a civil settlement and subjects physicians to disciplinary action if they violate this provision of law. This bill would expand this prohibition to all boards, bureaus, and programs within the Department of Consumer Affairs. The language in this bill is identical to the language included in AB 446 (Negrete McLeod, 2005), which the Medical Board of California (Board) supported and AB 2260 (Negrete McLeod, Chapter 645, Statutes of 2006), which the Board sponsored, that among other things, prohibited a physician from including a "gag clause" provision in a civil settlement agreement.

Board staff believes this bill will ensure that consumers in California will not be coerced to waive their right to file a complaint as a condition of receiving civil settlement. This will help other boards under DCA to ensure that the appropriate administrative actions are taken and consumers are protected, regardless of the status of the civil settlement.

FISCAL: None

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Support

ASSEMBLY BILL No. 2570

Introduced by Assembly Member Hill
(Coauthor: Senator Correa)

February 24, 2012

An act to add Section 143.5 to the Business and Professions Code, relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

AB 2570, as introduced, Hill. Licensees: settlement agreements.

Existing law provides that it is a cause for suspension, disbarment, or other discipline for an attorney to agree or seek agreement that the professional misconduct or the terms of a settlement of a claim for professional misconduct are not to be reported to the disciplinary agency, or to agree or seek agreement that the plaintiff shall withdraw a disciplinary complaint or not cooperate with an investigation or prosecution conducted by the disciplinary agency.

This bill would prohibit a licensee who is regulated by the Department of Consumer Affairs or various boards, bureaus, or programs, or an entity or person acting as an authorized agent of a licensee, from including or permitting to be included a provision in an agreement to settle a civil dispute that prohibits the other party in that dispute from contacting, filing a complaint with, or cooperating with the department, board, bureau, or program, or that requires the other party to withdraw a complaint from the department, board, bureau, or program. A licensee in violation of these provisions would be subject to disciplinary action by the board, bureau, or program. The bill would also prohibit a board, bureau, or program from requiring its licensees in a disciplinary action that is based on a complaint or report that has been settled in a civil

action to pay additional moneys to the benefit of any plaintiff in the civil action.

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

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

1 SECTION 1. Section 143.5 is added to the Business and
2 Professions Code, to read:
3 143.5. (a) No licensee who is regulated by a board, bureau, or
4 program within the Department of Consumer Affairs, nor an entity
5 or person acting as an authorized agent of a licensee, shall include
6 or permit to be included a provision in an agreement to settle a
7 civil dispute, whether the agreement is made before or after the
8 commencement of a civil action, that prohibits the other party in
9 that dispute from contacting, filing a complaint with, or cooperating
10 with the department, board, bureau, or program or that requires
11 the other party to withdraw a complaint from the department,
12 board, bureau, or program. A provision of that nature is void as
13 against public policy, and any licensee who includes or permits to
14 be included a provision of that nature in a settlement agreement
15 is subject to disciplinary action by the board, bureau, or program.
16 (b) Any board, bureau, or program within the Department of
17 Consumer Affairs that takes disciplinary action against a licensee
18 or licensees based on a complaint or report that has also been the
19 subject of a civil action and that has been settled for monetary
20 damages providing for full and final satisfaction of the parties may
21 not require its licensee or licensees to pay any additional sums to
22 the benefit of any plaintiff in the civil action.
23 (c) As used in this section, "board" shall have the same meaning
24 as defined in Section 22, and "licensee" means a person who has
25 been granted a license, as that term is defined in Section 23.7.

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
Position: Support if Amended

STATUS OF BILL:

This bill is in the Assembly.

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. The Board will be supportive of 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:
California Medical Association
The Joint Council of Allergy, Asthma & Immunology
Capital Allergy & Respiratory Disease Center
Medical Board of California (if amended)
North Bay Allergy & Asthma Medical Associates
Allergy & Asthma Associates of Southern California

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

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.

O

SB 924

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 924
Author: Price, Walters, and Steinberg
Bill Date: January 26, 2012, amended
Subject: Physical Therapists: Direct Access to Services: Professional Corporations
Sponsor: California Physical Therapy Association
Position: Oppose Unless Amended

STATUS OF BILL:

This bill is in the Assembly Business, Professions & Consumer Protection Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would add licensed physical therapists, chiropractors, acupuncturists, naturopathic doctors, occupational therapists, marriage and family therapists, and clinical social workers, to the list of healing arts practitioners who may be shareholders, officers, directors, or professional employees of a medical or podiatry corporation.

This bill would allow a patient to directly access PT services, without being referred by a physician, provided that the treatment is within the scope of a PT as long as specified conditions are met. This bill would also require a PT to provide a patient that has directly accessed their PT services to provide a specified written notice, orally and in writing and signed by the patient, before performing PT services.

ANALYSIS:

This bill would add licensed physical therapists, chiropractors, acupuncturists, naturopathic doctors, occupational therapists, marriage and family therapists, and clinical social workers, to the list of healing arts practitioners who may be shareholders, officers, directors, or professional employees of a medical or podiatry corporation. This bill would also require medical or podiatry corporations to disclose to patients, orally and in writing, when initiating physical therapy (PT) treatment services, the patient may seek services form a PT provider of his or her choice who may not necessarily be employed by the medical or podiatry corporation; this requirement does not apply to medical corporations that contract with a health care service plan.

The Medical Board of California (the Board) has taken a support position on AB 783 (Hayashi), which 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. This bill would also add other health care practitioners who may be professional employees of a medical corporation.

This bill would also allow a patient to directly access PT services, without being referred by a physician, provided that the treatment is within the scope of a PT as long as the following conditions are met:

- If the PT has reason to believe the patient has signs or symptoms of a condition that requires treatment beyond the scope of practice of a PT, the PT shall refer the patient to a physician, an osteopathic physician, or to a dentist, podiatrist or chiropractor.
- The PT shall comply with advertising requirements (Business and Professions Code Section 650).
- The PT shall notify the patient's physician, with the patient's written authorization, that the PT is treating the patient.
- The PT shall not continue treating the patient beyond 30 business days (approximately 6 weeks) or 12 visits, whichever occurs first, without receiving a dated signature on the PTs plan of care from a licensed physician or osteopathic physician, indicating approval of the PT's plan of care. The bill would specify that approval of the plan of care shall include an appropriate examination by the licensed physician.

This bill would require a PT to provide to patients that have directly accessed their PT services to provide a specified written notice, orally and in writing, and signed by the patient, before performing PT services. The notice must be in at least 14-point type, on one page, and must state the following:

Direct Physical Therapy Treatment Services

You are receiving direct physical therapy treatment services from an individual who is not a physician and surgeon, but who is a physical therapist licensed by the Physical Therapy Board of California.

Under California law, you may continue to receive direct physical therapy treatment services for a period of 30 business days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, from a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California, a dated signature on the physical therapists plan of care indicating approval of the physical therapists plan of care.

If you have received direct physical therapy treatment services for a duration of 30 business days or 12 visits, whichever occurs first, from a

physical therapist, it may constitute unprofessional conduct for that physical therapist or another physical therapist to provide direct physical therapy treatment services without receiving from a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California a dated signature on the physical therapists plan of care, indicating approval of the physical therapist's plan of care.

This bill changes the scope of practice of a PT by allowing that practitioner to treat patients without a referral from a physician. The Board has taken an oppose position in the past on bills that allowed for direct patient access to PT services. This bill does limit the amount of time a patient can receive PT services before being seen by a physician to 30 business days or 12 visits, whichever occurs first. This bill also requires that a notice be given to the patient, orally and in writing, and be signed by the patient.

The Board is opposed to this bill unless it is amended to remove the provisions that allow for direct patient access to PT services. The Board feels that expanding the scope of practice for PT's by allowing them to see patients directly, without having the patients first seen by a physician, puts patients at risk. A patient's condition cannot be accurately determined without first being examined by a physician, as PTs are not trained to make these comprehensive assessments and diagnoses. As such, the Board believes this bill would compromise patient care and consumer protection, and is opposed unless it is amended to remove the provisions that allow for direct patient access to PT services.

FISCAL: None to the Board

SUPPORT:
(Previous Version)
California Physical Therapy Association (Sponsor)
California Advocates for Nursing Home Reform
California Senior Legislature
Numerous Individuals

OPPOSITION:
(Previous Version)
California Association of Joint Powers Authorities
California Chiropractic Association
California Medical Association
California Orthopaedic Association
California Society of Anesthesiologists

AMENDED IN SENATE JANUARY 26, 2012

AMENDED IN SENATE MAY 24, 2011

AMENDED IN SENATE MAY 9, 2011

AMENDED IN SENATE MARCH 30, 2011

SENATE BILL No. 924

Introduced by ~~Senator~~ *Senators Price,* Walters, *and Steinberg*
~~(Coauthors: Senators Emmerson, Runner, and Strickland)~~
~~(Coauthors: Assembly Members Bill Berryhill, Chesbro, Knight, Morrell, Norby, and Silva)~~

February 18, 2011

An act to amend ~~Section 2660~~ *Sections 2406 and 2690* of, and to add ~~Section~~ *Sections 2406.5,* 2620.1, *and 2694.5* to, the Business and Professions Code, *and to amend Section 13401.5 of the Corporations Code,* relating to ~~physical therapists~~ *healing arts.*

LEGISLATIVE COUNSEL'S DIGEST

SB 924, as amended, ~~Walters~~ *Price.* Physical therapists: direct access to ~~services.~~ *services: professional corporations.*

~~Existing~~

(1) Existing law, the Physical Therapy Practice Act, creates the Physical Therapy Board of California and makes it responsible for the licensure and regulation of physical therapists. The act defines the term "physical therapy" for its purposes and makes it a crime to violate any of its provisions. ~~The act authorizes the board to suspend, revoke, or impose probationary conditions on a license, certificate, or approval issued under the act for unprofessional conduct, as specified.~~

This bill would specify that patients may access physical therapy treatment directly, and would, in those circumstances, require a physical

therapist to refer his or her patient to another specified healing arts practitioner if the physical therapist has reason to believe the patient has a condition requiring treatment or services beyond that scope of practice, ~~to disclose to the patient any financial interest he or she has in treating the patient,~~ and, with the patient's written authorization, to notify the patient's physician and surgeon, if any, that the physical therapist is treating the patient. The bill would prohibit a physical therapist from treating a patient beyond ~~a 30-day period~~ *30 business days or 12 visits, whichever occurs first*, unless the ~~patient has obtained a diagnosis from a physician and surgeon~~ *physical therapist receives a specified authorization from a person with a physician and surgeon's certificate. The bill would require a physical therapist, prior to the initiation of treatment services, to provide a patient with a specified notice concerning the limitations on the direct treatment services.* ~~The bill would provide that failure to comply with these provisions constitutes unprofessional conduct subject to disciplinary action by the board.~~

(2) 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, 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 provide that specified healing arts licensees may be shareholders, officers, directors, or professional employees of a physical therapy corporation. The bill would require, except as specified, that a medical corporation, podiatry corporation, and physical therapy corporation provide patients with a specified disclosure notifying them that they may seek physical therapy treatment services from any physical therapy provider. The bill would also make conforming changes to related provisions.

Because the bill would specify additional requirements under the Physical Therapy Practice Act, the violation of which would be a crime, it would impose a state-mandated local program.

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

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

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

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

1 SECTION 1. The Legislature finds and declares that an
2 individual's access to early intervention to physical therapy
3 treatment may decrease the duration of a disability, reduce pain,
4 and lead to a quicker recovery.
5 *SEC. 2. Section 2406 of the Business and Professions Code is*
6 *amended to read:*
7 2406. A medical corporation or podiatry corporation is a
8 corporation ~~which~~ *that* is authorized to render professional services,
9 as defined in Sections 13401 and 13401.5 of the Corporations
10 Code, so long as that corporation and its shareholders, officers,
11 directors, and employees rendering professional services who are
12 physicians *and surgeons*, psychologists, registered nurses,
13 optometrists, podiatrists, *chiropractors, acupuncturists,*
14 *naturopathic doctors, physical therapists, occupational therapists,*
15 or, in the case of a medical corporation only, physician assistants,
16 *marriage and family therapists, or clinical social workers,* are in
17 compliance with the Moscone-Knox Professional Corporation Act,
18 the provisions of this article, and all other statutes and regulations
19 now or hereafter enacted or adopted pertaining to the corporation
20 and the conduct of its affairs.
21 With respect to a medical corporation or podiatry corporation,
22 the governmental agency referred to in the Moscone-Knox
23 Professional Corporation Act is the ~~Division of Licensing~~ *board.*
24 *SEC. 3. Section 2406.5 is added to the Business and Professions*
25 *Code, to read:*
26 *2406.5. (a) A medical corporation or podiatry corporation*
27 *that is authorized to render professional services, as defined in*
28 *Sections 13401 and 13401.5 of the Corporations Code, shall*
29 *disclose to its patients, orally and in writing, when initiating any*
30 *physical therapy treatment services, that the patient may seek*
31 *physical therapy treatment services from a physical therapy*
32 *provider of his or her choice who may not necessarily be employed*
33 *by the medical or podiatry corporation.*
34 *(b) This disclosure requirement shall not apply to any medical*
35 *corporation that contracts with a health care service plan with a*

license issued pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) if the licensed health care service plan is also exempt from federal taxation pursuant to Section 501(c)(3) of the Internal Revenue Code.

~~SEC. 2.~~

SEC. 4. Section 2620.1 is added to the Business and Professions Code, to read:

2620.1. (a) In addition to receiving wellness and evaluation services from a physical therapist, a person may initiate physical therapy treatment directly from a licensed physical therapist provided that the treatment is within the scope of practice of physical therapists, as defined in Section 2620, and that all the following conditions are met:

(1) If, at any time, the physical therapist has reason to believe that the patient has signs or symptoms of a condition that requires treatment beyond the scope of practice of a physical therapist, the physical therapist shall refer the patient to a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California or to a person licensed to practice dentistry, podiatric medicine, or chiropractic.

(2) The physical therapist shall ~~disclose to the patient any financial interest he or she has in treating the patient and shall~~ comply with Article 6 (commencing with Section 650) of Chapter 1 of Division 2.

(3) With the patient's written authorization, the physical therapist shall notify the patient's physician and surgeon, if any, that the physical therapist is treating the patient.

(4) With respect to a patient initiating physical therapy treatment services directly from a physical therapist, the physical therapist shall not continue treating that patient beyond 30 business days or 12 visits, whichever occurs first, without receiving, from a person holding a physician and surgeon's certificate from the Medical Board of California or the Osteopathic Medical Board of California, a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care. Approval of the physical therapist's plan of care shall include an appropriate patient examination by the person holding a physician and surgeon's certificate from the Medical Board of California

or the Osteopathic Medical Board of California. For purposes of this paragraph, "business day" means any calendar day except Saturday, Sunday, or the following business holidays: New Year's Day, Washington's Birthday, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, and Christmas Day.

(b) The conditions in paragraphs (1), (2), ~~and~~ (3), *and (4)* of subdivision (a) do not apply to a physical therapist when providing evaluation or wellness physical therapy services to a patient as described in subdivision (a) of Section 2620 *or treatment provided upon referral or diagnosis by a physician and surgeon, podiatrist, dentist, chiropractor, or other appropriate health care provider acting within his or her scope of practice. Nothing in this subdivision shall be construed to alter the disclosure requirements of Section 2406.5.*

(c) Nothing in this section shall be construed to expand or modify the scope of practice for physical therapists set forth in Section 2620, including the prohibition on a physical therapist diagnosing a disease.

(d) Nothing in this section shall be construed to require a health care service plan, insurer, *workers' compensation insurance plan,* or any other person or entity, including, but not limited to, a state program or state employer, to provide coverage for direct access to treatment by a physical therapist.

~~(e) A physical therapist shall not continue treating a patient beyond a 30-day period, unless the patient has obtained a diagnosis by a physician and surgeon.~~

(e) When a person initiates physical therapy treatment services directly pursuant to this section, the physical therapist shall not perform physical therapy treatment services without first providing the following written notice, orally and in writing, on one page, in at least 14-point type, and obtaining a patient signature on the notice:

Direct Physical Therapy Treatment Services

You are receiving direct physical therapy treatment services from an individual who is not a physician and surgeon, but who is a physical therapist licensed by the Physical Therapy Board of California.

Under California law, you may continue to receive direct physical therapy treatment services for a period of 30 business days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, from a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California, a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care.

If you have received direct physical therapy treatment services for a duration of 30 business days or 12 visits, whichever occurs first, from a physical therapist, it may constitute unprofessional conduct for that physical therapist or for another physical therapist to provide direct physical therapy treatment services without receiving from a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California a dated signature on the physical therapist's plan of care, indicating approval of the physical therapist's plan of care.

_____

[Patient's Signature/Date]

~~SEC. 3. Section 2660 of the Business and Professions Code is amended to read:~~

~~2660. The board may, after the conduct of appropriate proceedings under the Administrative Procedure Act, suspend for not more than 12 months, or revoke, or impose probationary conditions upon any license, certificate, or approval issued under this chapter for unprofessional conduct that includes, but is not limited to, one or any combination of the following causes:~~

~~(a) Advertising in violation of Section 17500.~~

~~(b) Fraud in the procurement of any license under this chapter.~~

~~(c) Procuring or aiding or offering to procure or aid in criminal abortion.~~

~~(d) Conviction of a crime that substantially relates to the qualifications, functions, or duties of a physical therapist or physical therapist assistant. The record of conviction or a certified copy thereof shall be conclusive evidence of that conviction.~~

~~(e) Habitual intemperance.~~

~~(f) Addiction to the excessive use of any habit-forming drug.~~

~~(g) Gross negligence in his or her practice as a physical therapist or physical therapist assistant.~~

~~(h) Conviction of a violation of any of the provisions of this chapter or of the Medical Practice Act, or violating, or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter or of the Medical Practice Act.~~

~~(i) The aiding or abetting of any person to violate this chapter or any regulations duly adopted under this chapter.~~

~~(j) The aiding or abetting of any person to engage in the unlawful practice of physical therapy.~~

~~(k) The commission of any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, or duties of a physical therapist or physical therapist assistant.~~

~~(*l*) Except for good cause, the knowing failure to protect patients by failing to follow infection control guidelines of the board, thereby risking transmission of blood-borne infectious diseases from licensee to patient, from patient to patient, and from patient to licensee. In administering this subdivision, the board shall consider referencing the standards, regulations, and guidelines of the State Department of Public Health developed pursuant to Section 1250.11 of the Health and Safety Code and the standards, regulations, and guidelines pursuant to the California Occupational Safety and Health Act of 1973 (Part 1 (commencing with Section 6300) of Division 5 of the Labor Code) for preventing the transmission of HIV, hepatitis B, and other blood-borne pathogens in health care settings. As necessary, the board shall consult with the Medical Board of California, the California Board of Podiatric Medicine, the Dental Board of California, the Board of Registered Nursing, and the Board of Vocational Nursing and Psychiatric Technicians of the State of California, to encourage appropriate consistency in the implementation of this subdivision.~~

~~The board shall seek to ensure that licensees are informed of the responsibility of licensees and others to follow infection control guidelines, and of the most recent scientifically recognized safeguards for minimizing the risk of transmission of blood-borne infectious diseases.~~

~~(m) The commission of verbal abuse or sexual harassment.~~

~~(n) Failure to comply with the provisions of Section 2620.1.~~

SEC. 5. Section 2690 of the Business and Professions Code is amended to read:

2690. A physical therapy corporation is a corporation that is authorized to render professional services, as defined in ~~Section~~ *Sections* 13401 *and 13401.5* of the Corporations Code, so long as that corporation and its shareholders, officers, directors, and employees rendering professional services who are physical therapists, *physicians and surgeons, podiatrists, acupuncturists, naturopathic doctors, occupational therapists, speech-language pathologists, audiologists, registered nurses, psychologists, and physician assistants* are in compliance with the Moscone-Knox Professional Corporation Act, this article, and all other statutes and regulations now or hereafter enacted or adopted pertaining to the corporation and the conduct of its affairs.

With respect to a physical therapy corporation, the governmental agency referred to in the Moscone-Knox Professional Corporation Act is the ~~Physical Therapy Board of California~~ *board.*

SEC. 6. Section 2694.5 is added to the Business and Professions Code, to read:

2694.5. A physical therapy corporation that is authorized to render professional services, as defined in Sections 13401 and 13401.5 of the Corporations Code, shall disclose to its patients, orally and in writing, when initiating any physical therapy treatment services, that the patient may seek physical therapy treatment services from a physical therapy provider of his or her choice who may not necessarily be employed by the physical therapy corporation.

SEC. 7. Section 13401.5 of the Corporations Code is amended to read:

13401.5. Notwithstanding subdivision (d) of Section 13401 and any other provision of law, the following licensed persons may be shareholders, officers, directors, or professional employees of the professional corporations designated in this section so long as the sum of all shares owned by those licensed persons does not exceed 49 percent of the total number of shares of the professional corporation so designated herein, and so long as the number of those licensed persons owning shares in the professional corporation so designated herein does not exceed the number of persons licensed by the governmental agency regulating the designated professional corporation:

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

(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Licensed psychologists.
(4) Licensed optometrists.
(5) Licensed marriage and family therapists.
(6) Licensed clinical social workers.
(7) Licensed physician assistants.
(8) Licensed chiropractors.
(9) Licensed acupuncturists.
(10) Naturopathic doctors.
(11) Licensed professional clinical counselors.
(g) Marriage and family therapist corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.
(3) Licensed clinical social workers.
(4) Registered nurses.
(5) Licensed chiropractors.
(6) Licensed acupuncturists.
(7) Naturopathic doctors.
(8) Licensed professional clinical counselors.
(h) Licensed clinical social worker corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.
(3) Licensed marriage and family therapists.
(4) Registered nurses.
(5) Licensed chiropractors.
(6) Licensed acupuncturists.
(7) Naturopathic doctors.
(8) Licensed professional clinical counselors.
(i) Physician assistants corporation.
(1) Licensed physicians and surgeons.
(2) Registered nurses.
(3) Licensed acupuncturists.
(4) Naturopathic doctors.
(j) Optometric corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Licensed psychologists.
(4) Registered nurses.
(5) Licensed chiropractors.

(6) Licensed acupuncturists.
(7) Naturopathic doctors.
(k) Chiropractic 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 acupuncturists.
(9) Naturopathic doctors.
(10) Licensed professional clinical counselors.
(*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.
(11) Licensed professional clinical counselors.
(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 and family therapists.
(10) Licensed clinical social workers.
(11) Licensed optometrists.
(12) Licensed professional clinical counselors.
(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.
(o) Professional clinical counselor corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.
(3) Licensed clinical social workers.
(4) Licensed marriage and family therapists.
(5) Registered nurses.
(6) Licensed chiropractors.
(7) Licensed acupuncturists.
(8) Naturopathic doctors.
(p) Physical therapy corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Licensed acupuncturists.
(4) Naturopathic doctors.
(5) Licensed occupational therapists.
(6) Licensed speech-language pathologists.
(7) Licensed audiologists.
(8) Registered nurses.
(9) Licensed psychologists.
(10) Licensed physician assistants.
~~SEC. 4.~~

SEC. 8. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O

SB 1065

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1095
Author: Rubio
Bill Date: February 16, 2012, introduced
Subject: California Outpatient Pharmacy Safety and Improvement Act
Sponsor: California Ambulatory Surgery Association (CASA)

STATUS OF BILL:

This bill is in Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would expand the type of clinics that may be issued a limited license by the Board of Pharmacy to include specified outpatient settings and Medicare certified ambulatory surgical centers. The license issued by the Board of Pharmacy allows these clinics to purchase drugs at wholesale for administration or dispensing to clinic patients for pain and nausea under the direction of a physician.

ANALYSIS:

Currently, one of the requirements for a clinic to be issued a license by the Board of Pharmacy is state licensure as a surgical clinic by the California Department of Public Health (CDPH). However, a ruling issued several years ago (*Capen v. Shewry: 155 Cal.App.4th 378*) prohibited CDPH from issuing licenses to any outpatient setting or surgical center with any percentage of physician ownership. This ruling required surgery centers owned by physicians to instead be accredited; and therefore were not eligible to obtain a license from the Pharmacy Board to purchase drugs at wholesale for administration or dispensing to clinic patients. According to the author, this is problematic because 90% of surgery centers have some percentage of physician ownership. Currently, physicians working in accredited surgery centers are each individually required to acquire and maintain on-hand a myriad of medications to dispense at the point of care, instead of the surgery center being able to purchase medication at wholesale and safely store the medication in a centralized location in the surgery center.

This bill will resolve an unintended consequence created by the 2007 court decision that prohibited CDPH from licensing surgical centers with any percentage of physician ownership. This bill would allow accredited and certified surgery centers to obtain a license from the Pharmacy Board, which will permit accredited surgery centers to purchase medication at wholesale and safely store the medication in a centralized location in the surgery center. Board staff is suggesting that the Board support this bill.

FISCAL: None

SUPPORT: CASA (Sponsor)
Numerous Surgical Centers

OPPOSITION: None on file

POSITION: Recommendation: Support

MOCK UP

BILL NUMBER: AB 2561 AMENDED BILL TEXT

AS PROPOSED TO BE AMENDED IN ASSEMBLY APRIL 24, 2012

AMENDED IN ASSEMBLY MARCH 29, 2012

INTRODUCED BY Assembly Member Roger Hernández

FEBRUARY 24, 2012

An act to amend Section 152 of the Business and Professions Code, relating to the Department of Consumer Affairs.

An act to add and repeal Article 25 (commencing with Section 2525.20) of Chapter 5 of Division 2 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 2561, as amended, Roger Hernández. The Department of Consumer Affairs. Certified surgical technologists.

Existing law provides for the licensure and regulation of healing arts licensees by boards within the Department of Consumer Affairs, including the licensure and regulation of physicians and surgeons by the Medical Board of California.

This bill would make it unlawful to use the title "certified surgical technologist" unless one meets certain educational requirements, and holds a certification issued by specified entities.

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

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The Legislature finds and declares the following:

(a) Surgical technologists are responsible for the environmental disinfection, safety, and efficiency of the operating room, and their knowledge and experience with aseptic surgical technique qualifies them for a role of importance in the surgical suite.

(b) The surgical technology profession has grown to meet the continuing demand for well-educated, highly skilled, and versatile individuals to work with physicians and surgeons and other skilled

professionals to deliver the highest possible level of patient care.

(c) As surgical site infections have been found to be the second most common hospital-acquired infections in the United States, a key purpose of this article is to encourage the education, training, and utilization of surgical technologists in California, given their role in surgical settings in order to take specific steps to prevent surgical site infections.

SEC. 2. Article 25 (commencing with Section 2525.20) is added to Chapter 5 of Division 2 of the Business and Professions Code, to read:

Article 25. Certified Surgical Technologists

2525.20. This article shall be known and cited as the Certified Surgical Technologist Act.

2525.22. As used in this article, the following definitions shall apply:

~~(a) "Committee" means the Certified Surgical Technologist Committee within the Medical Board of California.~~

~~(b)~~ (a) "Certified surgical technologist" means a person who practices surgical technology, and who has successfully completed a nationally accredited educational program for surgical technologists and holds and maintains certification as a surgical technologist by any of entities described in Section 2525.24.

~~(c)~~ (b) "Surgical technology" means surgical patient care as follows:

(1) Preparing the operating room for surgical procedures by ensuring that surgical equipment is functioning properly and safely.

(2) Preparing the operating room and the sterile field for surgical procedures by preparing sterile supplies, instruments, and equipment using sterile technique.

(3) Anticipating the needs of the surgical team based on knowledge of human anatomy and pathophysiology and how they relate to the surgical patient and the patient's surgical procedure.

(4) As directed in an operating room setting, performing the following tasks at the sterile field:

(A) Passing supplies, equipment, or instruments.

(B) Sponging or suctioning an operative site.

(C) Preparing and cutting suture material.

(D) Transferring and pouring irrigation fluids.

(E) Transferring but not administering drugs within the sterile field.

(F) Handling specimens.

(G) Holding retractors and other instruments.

(H) Applying electrocautery to clamps on bleeders.

(I) Connecting drains to suction apparatus.

(J) Applying dressings to closed wounds.

(K) Assisting in counting sponges, needles, supplies, and

instruments with the registered nurse circulator.

(L) Cleaning and preparing instruments for sterilization on completion of the surgery.

(M) Assisting the surgical team with cleaning of the operating room on completion of the surgery.

2525.24. (a) It shall be unlawful to use the title "certified surgical technologist" in this state unless a person (1) has successfully completed a nationally accredited educational program for surgical technologists, or a training program for surgical technology in the army, navy, air force, marine corps, or coast guard of the United States or in the United States Public Health Service, and (2) holds and maintains certification as a surgical technologist by the National Board of Surgical Technology and Surgical Assisting or its successor, or another nationally accredited surgical technologist certification program.

2525.26. This article does not repeal, modify, or amend any existing law relating to the supervision of surgical technologists, nor shall it be construed to do so.

2525.28. This article does not prohibit or limit any healing arts licensee described in this division from performing a task or function within the scope of the healing art licensee's license, nor shall it be construed as such.

2525.30. This article does not apply to any of the following:

(a) A registered nurse licensed pursuant to Chapter 6 (commencing with Section 2700) or a vocational nurse licensed pursuant to Chapter 6.5 (commencing with Section 2840).

(b) An individual employed by a health care facility whose primary functions include the cleaning or sterilization of supplies, instruments, equipment, or operating rooms.

SENATE BILL No. 1095

Introduced by Senator Rubio

February 16, 2012

An act to amend Sections 4190 and 4195 of, and to amend the heading of Article 14 (commencing with Section 4190) of Chapter 9 of Division 2 of, the Business and Professions Code, relating to pharmacy.

LEGISLATIVE COUNSEL'S DIGEST

SB 1095, as introduced, Rubio. Pharmacy: clinics.

Existing law, the Pharmacy Law, provides for the licensure and regulation of the practice of pharmacy by the California State Board of Pharmacy and makes a knowing violation of its provisions a crime. Existing law authorizes a surgical clinic, as defined, that is licensed by the board to purchase drugs at wholesale for administration or dispensing, under the direction of a physician and surgeon, to patients registered for care at the surgical clinic. Existing law prohibits a surgical clinic from operating without a license issued by the board. Existing law requires these surgical clinics to comply with various regulatory requirements and to maintain specified records. Existing law authorizes the board to inspect a surgical clinic at any time in order to determine whether a surgical clinic is operating in compliance with certain requirements.

This bill would expand these provisions to additionally authorize an outpatient setting or an ambulatory surgical center, as specified, to purchase drugs at wholesale for administration or dispensing, subject to the requirements applicable to surgical clinics. The bill would delete the requirement that a surgical clinic be licensed by the board but would require the clinics described above to be licensed in order to receive the benefits of these provisions. The bill would specify that the board is authorized to inspect only a clinic that is licensed by the board.

Because a knowing violation of these requirements by outpatient settings and ambulatory surgical centers would be a crime, the bill would impose a state-mandated local program.

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

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

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

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

1 SECTION 1. This act shall be known and may be cited as the
2 California Outpatient Pharmacy Patient Safety and Improvement
3 Act.
4 SEC. 2. The heading of Article 14 (commencing with Section
5 4190) of Chapter 9 of Division 2 of the Business and Professions
6 Code is amended to read:
7
8 Article 14. ~~Surgical~~ Clinics
9
10 SEC. 3. Section 4190 of the Business and Professions Code is
11 amended to read:
12 4190. *(a) For the purposes of this article, "clinic" means a*
13 *surgical clinic licensed pursuant to paragraph (1) of subdivision*
14 *(b) of Section 1204 of the Health and Safety Code, an outpatient*
15 *setting accredited by an accreditation agency, as defined in Section*
16 *1248 of the Health and Safety Code, or an ambulatory surgical*
17 *center certified to participate in the Medicare Program under Title*
18 *XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et*
19 *seq.).*
20 ~~(a)~~
21 *(b)* Notwithstanding any provision of this chapter, a ~~surgical~~
22 ~~clinic, as defined in paragraph (1) of subdivision (b) of Section~~
23 ~~1204 of the Health and Safety Code~~ *clinic* may purchase drugs at
24 wholesale for administration or dispensing, under the direction of
25 a physician *and surgeon*, to patients registered for care at the clinic,
26 as provided in subdivision ~~(b)~~ *(c)*. The clinic shall keep records of
27 the kind and amounts of drugs purchased, administered, and

dispensed, and the records shall be available and maintained for a minimum of three years for inspection by all properly authorized personnel.

~~(b)~~

(c) The drug distribution service of a ~~surgical~~ clinic shall be limited to the use of drugs for administration to the patients of the ~~surgical~~ clinic and to the dispensing of drugs for the control of pain and nausea for patients of the clinic. Drugs shall not be dispensed in an amount greater than that required to meet the patient's needs for 72 hours. Drugs for administration shall be those drugs directly applied, whether by injection, inhalation, ingestion, or any other means, to the body of a patient for his or her immediate needs.

~~(c)~~

(d) No ~~surgical~~ clinic shall ~~operate without a license issued by the board nor shall it~~ be entitled to the benefits of this section until it has obtained a license from the board. A separate license shall be required for each clinic location. A clinic *licensed by the board* shall notify the board of any change in the clinic's address on a form furnished by the board.

~~(d) Any~~

(e) If a clinic is licensed by the board, any proposed change in ownership or beneficial interest in the licensee shall be reported to the board, on a form to be furnished by the board, at least 30 days prior to the execution of any agreement to purchase, sell, exchange, gift or otherwise transfer any ownership or beneficial interest or prior to any transfer of ownership or beneficial interest, whichever occurs earlier.

(f) Nothing in this section shall limit the ability of a physician and surgeon or a group medical practice to prescribe, dispense, administer, or furnish drugs at a clinic as provided in Sections 2241.5, 2242, and 4170.

SEC. 4. Section 4195 of the Business and Professions Code is amended to read:

4195. The board shall have the authority to inspect a clinic *that is licensed pursuant to this article* at any time in order to determine whether ~~a~~ *the* clinic is, or is not, operating in compliance with this article and all other provisions of the law.

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because

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

O

SB 1274

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1274
Author: Wolk
Bill Date: April 9, 2012, amended
Subject: Hospitals: Employment
Sponsor: Shriners Hospital for Children

STATUS OF BILL:

This bill is in Senate Health Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow Shriners Hospital for Children (Shriners) to continue to employ physicians, and will allow the hospital to bill insurers for the services rendered to patients with insurance coverage.

ANALYSIS:

Current law (commonly referred to as the "Corporate Practice of Medicine" - B&P Code section 2400) generally prohibits corporations or other entities that are not controlled by physicians from practicing medicine, to ensure that lay persons are not controlling or influencing the professional judgment and practice of medicine by physicians.

Shriners has provided high quality sub-specialty care to children with neuromusculoskeletal conditions, burn injuries and other special health care needs without regard to payment for services, since 1923. There are two Shriners hospitals in California, one in Sacramento and one in Los Angeles, which serve 34,000 children in California each year.

Shriners has always directly employed physicians because they are exempted from the ban on the corporate practice of medicine (CPM), as they are a charitable institution that does not charge for medical professional services. The Shriners Endowment Fund has fully supported the operations of Shriners hospitals since its inception. However, the Endowment Fund has incurred a significant decrease in value and Shriners has continued to serve children and their families through deficit spending, which is not sustainable. This bill would allow Shriners to bill insurers for services provided to patients who have insurance coverage, and still allow Shriners to directly employ physicians.

This bill is drafted in a way that would only apply to the two Shriners Hospitals in California, by requiring the hospital to be owned and operated by a licensed charitable organization that offers only pediatric subspecialty care, and that prior to January 1, 2013, must have employed physicians on an annual basis and must not have charged for professional services rendered to patients. This bill requires Shriners Hospital to meet the following conditions:

- The hospital does not increase the number of salaried licensees by more than five physicians and surgeons or podiatrists each year.
- The hospital does not expand its scope of services beyond pediatric subspecialty care.
- The hospital accepts each patient needing service, regardless of his or her ability to pay, including whether the patient has any form of health insurance.
- The medical staff concur by an affirmative vote that the physician's and surgeon's employment is in the best interest of the communities served by the hospital.
- The hospital does not interfere with, control, or otherwise direct the physician's and surgeon's professional judgment in a manner prohibited by existing law.

This bill will narrowly expand the CPM exemption to allow Shriners to recoup some patient care costs from insurance companies, which will allow Shriners to stay in operation, without having to limit services to the 34,000 children they serve each year in California. Board staff is suggesting a support position on this bill.

FISCAL: None

SUPPORT: Shriners Hospital for Children (Sponsor)

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN SENATE APRIL 9, 2012

SENATE BILL No. 1274

Introduced by Senator Wolk

February 23, 2012

An act to amend Section 2401 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 1274, as amended, Wolk. Healing arts: hospitals: employment.

Existing law, the Medical Practice Act, restricts the employment of licensed physicians and surgeons and podiatrists by a corporation or other artificial legal entity, subject to specified exemptions.

This bill would authorize a hospital that is owned and operated by a licensed charitable organization, that offers only pediatric subspecialty care, that, prior to January 1, 2013, employed licensees on a salary basis, and that has not charged for professional services rendered to patients, to charge for services rendered to patients, provided certain conditions are met, including, but not limited to, that the hospital does not increase the number of salaried licensees by more than 5 each year ~~and~~, that the hospital accepts each patient regardless of his or her ability to pay, *and that the medical staff concur by an affirmative vote that the physician and surgeon's employment meets a specified standard.*

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

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

1 SECTION 1. Section 2401 of the Business and Professions
2 Code is amended to read:

2401. (a) Notwithstanding Section 2400, a clinic operated primarily for the purpose of medical education by a public or private nonprofit university medical school, which is approved by the Division of Licensing or the Osteopathic Medical Board of California, may charge for professional services rendered to teaching patients by licensees who hold academic appointments on the faculty of the university, if the charges are approved by the physician and surgeon in whose name the charges are made.

(b) Notwithstanding Section 2400, a clinic operated under subdivision (p) of Section 1206 of the Health and Safety Code may employ licensees and charge for professional services rendered by those licensees. However, the clinic shall not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 or any other provision of law.

(c) Notwithstanding Section 2400, a narcotic treatment program operated under Section 11876 of the Health and Safety Code and regulated by the State Department of Alcohol and Drug Programs, may employ licensees and charge for professional services rendered by those licensees. However, the narcotic treatment program shall not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 or any other provision of law.

(d) Notwithstanding Section 2400, a hospital owned and operated by a health care district pursuant to Division 23 (commencing with Section 32000) of the Health and Safety Code may employ a licensee pursuant to Section 2401.1, and may charge for professional services rendered by the licensee, if the physician and surgeon in whose name the charges are made approves the charges. However, the hospital shall not interfere with, control, or otherwise direct the physician and surgeon's professional judgment in a manner prohibited by Section 2400 or any other provision of law.

(e) Notwithstanding Section 2400, a hospital that is owned and operated by a licensed charitable organization, that offers only pediatric subspecialty care, that, prior to January 1, 2013, employed licensees on a salary basis, and that has not charged for professional services rendered to patients may, commencing January 1, 2013, charge for services rendered to patients, provided the following conditions are met:

(1) The hospital does not increase the number of salaried licensees by more than five physicians and surgeons or podiatrists each year.

(2) The hospital does not expand its scope of services beyond pediatric subspecialty care.

(3) The hospital accepts each patient needing its scope of services regardless of his or her ability to pay, including whether the patient has any form of health insurance.

(4) The medical staff concur by an affirmative vote that the physician and surgeon's employment is in the best interest of the communities served by the hospital.

(5) The hospital does not interfere with, control, or otherwise direct the physician and surgeon's professional judgment in a manner prohibited by Section 2400 or any other provision of law.

O

SB 1338

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1338
Author: Kehoe
Bill Date: April 9, 2012, amended
Subject: Abortion
Sponsor: ACCESS Women's Health Justice
American Civil Liberties Union of California
NARAL Pro-Choice California
Planned Parenthood Affiliates of California

STATUS OF BILL:

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

DESCRIPTION OF CURRENT LEGISLATION:

This bill would eliminate the distinction in existing law between "surgical" and "nonsurgical" abortions and would allow physician assistants (PAs), nurse practitioners (NPs), and certified nurse-midwives (CNMs) to perform the functions necessary for an abortion by medication or aspiration techniques, if specified training is completed. This bill would sunset the authorization of PAs, NPs and CNMs to perform abortions by medication or aspiration techniques and the associated training requirements on January 1, 2015. After January 1, 2015, this bill would allow only those PAs, NPs, and CNMs who have completed the specified training to continue to perform aspiration abortions.

ANALYSIS:

According to the author, this bill seeks to codify the Health Workforce Pilot Project (HWPP) #171, coordinated through the Office of Statewide Health Planning and Development (OSHPD) and sponsored by the Advancing New Standards in Reproductive Health (ANSIRH) program at the University of California, San Francisco (UCSF). This pilot project has been approved since March 31, 2007, and will end on September 31, 2012. The purpose of the pilot project is to evaluate the safety, effectiveness and acceptability of NPs, CNMs, and PAs in providing aspiration abortions, and to evaluate the implementation of a standardized, competency based curriculum in provision of aspiration abortion care.

As part of the pilot, 41 NPs, CNMs and PAs were trained to be competent in aspiration abortion care. Clinicians participated in a comprehensive didactic and supervised clinical training program, which included a written exam and competency-based evaluation process. Trainee competency was evaluated daily and at the end of training on confidence, procedural performance, patient care, communication /interpersonal skills, professionalism, practice-based learning, and clinical knowledge.

This bill would also require PAs, NPs, and CNMs to complete the training required as a part of this pilot project before they are allowed to perform abortions by medication or aspiration techniques.

STATISTICS of the HWPP Pilot Project (#171) - Taken from the fact sheet:

Patient sample selection, enrollment and consent:

- 7,585 first-trimester aspiration abortion procedures were completed by NPs/CNMs/PAs and 6,195 procedures were completed by physicians, for a total of 13,780 abortion procedures.

- 13,876 patients agreed to participate in HWPP #171 and less than 20% (n=2,469) of study patients declined having a NP/CNM/PA perform their abortion procedure.

Abortion-related complications summary:

- A complication is identified at the time of the procedure (immediate) or after the procedure (delayed) and classified as either major (defined by the DCSMC as "complications requiring abortion-related surgeries, transfusion or hospitalization") or minor.

- Overall abortion-related complication rate: 1.3% of all procedures (178 of 13,780) have abortion-related complication diagnoses; this falls well below the expected rate of 5% for total complication diagnoses. No deaths have been reported during the study period at any of the clinic sites.

- Group-specific abortion-related complication rate: 1.5% for NPs, CNMs, and PAs (115 out of 7,585), and 1.0% for physicians (63 out of 6,195); this variation in complication rates between the two groups is within an acceptable clinical margin of difference.

- 97% (173 out of 178) of abortion-related complications have been minor and completely resolved without adverse outcomes; 5 cases have been classified as major complications and were successfully managed and resolved with appropriate treatment.

- The most common type of minor abortion-related complication diagnoses reported for both provider groups were incomplete abortion, hematometra, failed abortion, and symptomatic intrauterine material. Major abortion-related complications include incomplete abortion, infection, and uterine perforation.

- For both provider groups, less than 0.5% of the minor abortion-related complications were immediate and the remaining were delayed (n=142) with 1.2% in the clinician group and 0.8% in the physician group.

According to the sponsors, this bill is needed to assure that women in California have access to early abortion by aspiration technique. The sponsors state that many low-income and underserved

women do not have sufficient access to aspiration abortion because many counties in California lack an abortion provider, which requires women to travel a significant distance for care. The sponsors believe that increasing the number of providers for aspiration abortions will increase the ability of women to receive safe reproductive health care from providers in their community.

The California Nurses Association (CNA) believes that this bill is unnecessary because first trimester aspiration abortions require the performance of functions that are within the current legal authority of advanced practice clinicians. They also believe this bill is premature because the results of HWPP #171 have not been completed, published and subject to peer review.

Legislative counsel issued an opinion on April 6, 2012 that existing law does not authorize a NP, CNM, or PA to perform an aspiration abortion. Counsel made the conclusion that an aspiration abortion is a surgical abortion and as such, may only be performed by a licensed physician and surgeon.

FISCAL: None

SUPPORT: ACCESS Women's Health Justice (sponsor); American Civil Liberties Union of California (Sponsor); NARAL Pro-Choice California (sponsor); Planned Parenthood Affiliates of California (sponsor); ACT for Women and Girls; American Nurses Association of California; **California Academy of Family Physicians**; California Academy of Physician Assistants; California Association of Nurse Practitioners; California Latinas for Reproductive Justice; **California Medical Association**; California Nurse-Midwives Association; Law Students for Reproductive Justice; Maternal and Child Health Access; National Asian Pacific American Women's Forum; National Center for Youth Law; **Physicians for Reproductive Choice in Health**; Planned Parenthood Action Fund, Inc. of Santa Barbara, Ventura and San Luis Obispo Counties, Inc.; Planned Parenthood Advocacy Project Los Angeles County; Planned Parenthood Mar Monet; Planned Parenthood of Pasadena and San Gabriel Valley, Inc.; Planned Parenthood Shasta Pacific Action Fund; Santa Cruz Mujeres Women's Health Center; Service Employees International Union; Women's Community Clinic; and Numerous Individuals.

OPPOSITION: California Catholic Conference
California Nurses Association

POSITION: Recommendation: No Position

AMENDED IN SENATE APRIL 9, 2012

AMENDED IN SENATE MARCH 26, 2012

SENATE BILL No. 1338

Introduced by Senator Kehoe
(Principal coauthor: Senator Steinberg)
(Principal coauthors: Assembly Members Atkins, John A. Pérez, and Skinner)
(Coauthors: Senators Alquist, De León, DeSaulnier, Evans, Hancock, Leno, Lieu, Liu, and Wolk)
(Coauthors: Assembly Members Ammiano, Blumenfield, Brownley, Butler, Lara, and Williams)

February 24, 2012

An act to amend, *repeal, and add* Section 2253 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 1338, as amended, Kehoe. Abortion.

Existing law makes it a public offense, punishable by a fine not exceeding $10,000 or imprisonment, or both, for a person to perform or assist in performing a surgical abortion if the person does not have a valid license to practice as a physician and surgeon, or to assist in performing a surgical abortion without a valid license or certificate obtained in accordance with some other provision of law that authorizes him or her to perform the functions necessary to assist in performing a surgical abortion. Existing law also makes it a public offense, punishable by a fine not exceeding $10,000 or imprisonment, or both, for a person to perform or assist in performing a nonsurgical abortion if the person does not have a valid license to practice as a physician and surgeon or does not have a valid license or certificate obtained in accordance with

some other provision of law authorizing him or her to perform or assist in performing the functions necessary for a nonsurgical abortion. Under existing law, nonsurgical abortion includes termination of pregnancy through the use of pharmacological agents.

Existing law, the Nursing Practice Act, provides for the licensure and regulation of registered nurses, including nurse practitioners and certified nurse-midwives, by the Board of Registered Nursing. Existing law, the Physician Assistant Practice Act, provides for the licensure and regulation of physician assistants by the Physician Assistant Committee of the Medical Board of California.

This bill would make it a public offense, punishable by a fine not exceeding $10,000 or imprisonment, or both, for a person to perform ~~or assist in performing~~ an abortion if the person does not have a valid license to practice as a physician and surgeon, or to assist in performing an abortion without a valid license or certificate obtained in accordance with ~~some other provision of~~ law authorizing him or her to perform the functions necessary to assist in performing an abortion, except as specified. The bill would also make it a public offense, punishable by a fine not exceeding $10,000 or imprisonment, or both, for a person to perform ~~or assist in performing~~ an abortion by medication or aspiration techniques without a valid license to practice as a physician and surgeon or without a license or certificate ~~obtained in accordance with some other provision of law, including, but not limited to, the Nursing Practice Act or the Physician Assistant Practice Act,~~ *to practice as a nurse practitioner, a certified nurse-midwife, or a physician assistant* authorizing him or her to perform ~~or assist in performing~~ the functions necessary for an abortion by medication or aspiration techniques. *The bill would also, until January 1, 2015, require a nurse practitioner, certified nurse-midwife, or physician assistant to complete specified training in order to perform an abortion by aspiration techniques, but would indefinitely authorize a nurse practitioner, certified nurse-midwife, or physician assistant who completed a specified training program and achieved clinical competency to continue to perform abortions by aspiration techniques.* The bill would delete the description of what a nonsurgical abortion includes. ~~The bill~~ *and* would make ~~other~~ technical, nonsubstantive changes.

Because the bill would change the definition of crimes, the bill would impose a state-mandated local program.

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

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

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

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

1 SECTION 1. Section 2253 of the Business and Professions
2 Code is amended to read:
3 2253. (a) Failure to comply with the Reproductive Privacy
4 Act (Article 2.5 (commencing with Section 123460) of Chapter 2
5 of Part 2 of Division 106 of the Health and Safety Code) in
6 performing, assisting, procuring or aiding, abetting, attempting,
7 agreeing, or offering to procure an illegal abortion constitutes
8 unprofessional conduct.
9 (b) (1) Except as provided in paragraph (2), a person is subject
10 to Section 2052 if he or she performs ~~or assists in performing~~ an
11 abortion, and at the time of so doing, does not have a valid,
12 unrevoked, and unsuspended license to practice as a physician and
13 surgeon as provided in this chapter, or if he or she assists in
14 performing an abortion and does not have a valid, unrevoked, and
15 unsuspended license or certificate obtained in accordance with
16 ~~some other provision of~~ law that authorizes him or her to perform
17 the functions necessary to assist in performing an abortion.
18 (2) A person is subject to Section 2052 if he or she performs ~~or~~
19 ~~assists in performing~~ an abortion by medication or aspiration
20 techniques, and at the time of so doing, does not have a valid,
21 unrevoked, and unsuspended license to practice as a physician and
22 surgeon as provided in this chapter, or does not have a valid,
23 unrevoked, and unsuspended license or certificate ~~obtained in~~
24 ~~accordance with some other provision of law, including, but not~~
25 ~~limited to, the Nursing Practice Act (Chapter 6 (commencing with~~
26 ~~Section 2700)) or the Physician Assistant Practice Act (Chapter~~
27 ~~7.7 (commencing with Section 3500))~~, *to practice as a nurse*
28 *practitioner, a certified nurse-midwife, or a physician assistant*
29 that authorizes him or her to perform ~~or assist in performing~~ the

1 functions necessary for an abortion by medication or aspiration
2 techniques, *subject to subdivision (c).*
3 *(c) For purposes of paragraph (2) of subdivision (b), both of*
4 *the following shall apply:*
5 *(1) In order to perform an abortion by aspiration techniques,*
6 *a person with a license or certificate to practice as a nurse*
7 *practitioner or a certified nurse-midwife shall complete training*
8 *recognized by the Board of Registered Nursing. The training*
9 *protocols established by Health Care Workforce Pilot Project*
10 *(HWPP) No. 171 through the Office of Statewide Health Planning*
11 *and Development shall be considered as recognized by the board*
12 *and deemed to satisfy this requirement. A nurse practitioner or*
13 *certified nurse-midwife who has completed training and achieved*
14 *clinical competency through HWPP No. 171 shall be authorized*
15 *to continue to perform abortions by aspiration techniques.*
16 *(2) In order to receive authority from his or her supervising*
17 *physician and surgeon to perform an abortion by aspiration*
18 *techniques, a physician assistant shall complete training either*
19 *through training programs approved by the Physician Assistant*
20 *Committee pursuant to Section 3513 or by training to perform*
21 *medical services which augment his or her current areas of*
22 *competency pursuant to Section 1399.543 of Title 16 of the*
23 *California Code of Regulations. The training protocols established*
24 *by HWPP No. 171 shall be deemed to meet the standards of the*
25 *Physician Assistant Committee. A physician assistant who has*
26 *completed training and achieved clinical competency through*
27 *HWPP No. 171 shall be authorized to continue to perform*
28 *abortions by aspiration techniques.*
29 *(d) This section shall remain in effect only until January 1, 2015,*
30 *and as of that date is repealed, unless a later enacted statute, that*
31 *is enacted before January 1, 2015, deletes or extends that date.*
32 *SEC. 2. Section 2253 is added to the Business and Professions*
33 *Code, to read:*
34 *2253. (a) Failure to comply with the Reproductive Privacy*
35 *Act (Article 2.5 (commencing with Section 123460) of Chapter 2*
36 *of Part 2 of Division 106 of the Health and Safety Code) in*
37 *performing, assisting, procuring or aiding, abetting, attempting,*
38 *agreeing, or offering to procure an illegal abortion constitutes*
39 *unprofessional conduct.*

(b) (1) Except as provided in paragraph (2), a person is subject to Section 2052 if he or she performs an abortion, and at the time of so doing, does not have a valid, unrevoked, and unsuspended license to practice as a physician and surgeon as provided in this chapter, or if he or she assists in performing an abortion and does not have a valid, unrevoked, and unsuspended license or certificate obtained in accordance with law that authorizes him or her to perform the functions necessary to assist in performing an abortion.

(2) A person is subject to Section 2052 if he or she performs an abortion by medication or aspiration techniques, and at the time of so doing, does not have a valid, unrevoked, and unsuspended license to practice as a physician and surgeon as provided in this chapter, or does not have a valid, unrevoked, and unsuspended license or certificate to practice as a nurse practitioner, a certified nurse-midwife, or a physician assistant that authorizes him or her to perform the functions necessary for an abortion by medication or aspiration techniques. A nurse practitioner, certified nurse-midwife, or physician assistant who has completed training and achieved clinical competency through Health Care Workforce Pilot Project (HWPP) No. 171 through the Office of Statewide Health Planning and Development shall be authorized to continue to perform abortions by aspiration techniques.

(c) This section shall become operative on January 1, 2015.

~~SEC. 2.~~

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

O

SB 1416

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1416
Author: Rubio and Hernandez
Bill Date: April 16, 2012, amended
Subject: Medical Residency Training Program Grants
Sponsor: Author

STATUS OF BILL:

This bill is in Senate Health Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would establish a grant program in the Office of Statewide Health Planning and Development (OSHPD) to be used to fund grants to medical residency training programs for the creation of additional residency positions. The grant program would be funded by donations from private individuals or entities, and the funds are required to be appropriated by the Legislature.

ANALYSIS:

This bill would allow for private funding to be used to fund grants to be used to create more medical residency training positions. This bill may help to create more medical residency slots using private funding and may help to address physician shortages, which is especially important as provisions of health care reform take effect in 2014, and as California prepares to provide health services to substantial numbers of new patients. This bill is also consistent with the mission of the Medical Board of promoting access to care. Board staff is recommending a support position on this bill.

FISCAL: None

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN SENATE APRIL 16, 2012

SENATE BILL No. 1416

Introduced by ~~Senator~~ *Senators* Rubio *and Hernandez*

February 24, 2012

An act *to add Article 4 (commencing with Section 128310) to Chapter 4 of Part 3 of Division 107 of the Health and Safety Code,* relating to ~~public postsecondary education.~~ *health care.*

LEGISLATIVE COUNSEL'S DIGEST

SB 1416, as amended, Rubio. ~~Public postsecondary education: construction of new medical school.~~ *Medical residency training program grants: grants.*

Existing law, the Song-Brown Family Physician Training Act, declares the intent of the Legislature to increase the number of students and residents receiving quality education and training in the specialty of family practice and as primary care physician's assistants and primary care nurse practitioners. Existing law establishes, for this purpose, a state medical contract program with accredited medical schools, programs that train primary care physician's assistants, programs that train primary care nurse practitioners, registered nurses, hospitals, and other health care delivery systems.

Existing law establishes the California Healthcare Workforce Policy Commission and requires the commission to, among other things, identify specific areas of the state where unmet priority needs for primary care family physicians and registered nurses exist, establish standards for family practice training programs, family practice residency programs, primary care physician assistants programs, and programs that train primary care nurse practitioners, and review and make recommendations to the Director of the Office of Statewide Health

Planning and Development concerning the funding of those programs that are submitted to the Health Professions Development Program for participation in the state medical contract program.

The bill would create the Graduate Medical Education Trust Fund in the State Treasury and would require that moneys in the fund be used by the Office of Statewide Health Planning and Development, upon appropriation by the Legislature, to fund grants to medical residency training programs for the creation of additional residency positions, which would be funded at the same rate as residency positions funded through the Medicare Program.

~~Existing law establishes the system of public postsecondary education in this state, consisting of 3 segments: the University of California, the California State University, and the California Community Colleges. Existing law provides that the University of California has exclusive jurisdiction in public higher education over instruction in the profession of law and over graduate instruction in the professions of medicine, dentistry, and veterinary medicine.~~

~~This bill would express the intent of the Legislature to enact legislation that would provide for the establishment and construction of a new medical school in this state.~~

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

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

1 *SECTION 1. Article 4 (commencing with Section 128310) is*
2 *added to Chapter 4 of Part 3 of Division 107 of the Health and*
3 *Safety Code, to read:*
4
5 *Article 4. Medical Residency Training Program Grants*
6
7 *128310. (a) The Graduate Medical Education Trust Fund is*
8 *hereby created in the State Treasury.*
9 *(b) Moneys in the fund shall, upon appropriation by the*
10 *Legislature, be used by the office solely for the purposes specified*
11 *in this section.*
12 *(c) Notwithstanding Section 16305.7 of the Government Code,*
13 *all interest earned on the moneys that have been deposited into*
14 *the fund shall be retained in the fund and used for purposes*
15 *consistent with the fund.*

1 *(d) The fund shall consist of all of the following:*
2 *(1) All private moneys donated by private individuals or entities*
3 *to the commission for deposit into the fund.*
4 *(2) Any amounts appropriated to the fund by the Legislature.*
5 *(3) Any interest that accrues on amounts in the fund.*
6 *(e) Moneys in the fund shall be used by the office to fund grants*
7 *to medical residency training programs for the creation of*
8 *additional residency positions. Additional residency positions*
9 *funded pursuant to this section shall be funded at the same rate*
10 *as residency positions funded through the Medicare Program.*
11 *(f) For purposes of this section, "office" means the Office of*
12 *Statewide Health Planning and Development.*
13 ~~SECTION 1. It is the intent of the Legislature to enact~~
14 ~~legislation that would provide for the establishment and~~
15 ~~construction of a new medical school in this state.~~

O

SB 1483

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1483
Author: Steinberg
Bill Date: April 17, 2012, amended
Subject: Physicians and Surgeons: Physician Health Program
Sponsor: California Medical Association
California Hospital Association
California Psychiatric Association
California Society of Addiction Medicine

STATUS OF BILL:

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

DESCRIPTION OF CURRENT LEGISLATION:

This bill would create the Physician Health Awareness, and Monitoring Quality Act of 2012. This bill would establish the Physician Health Program (PHP), which would be administered by the Physician Health, Recovery, and Monitoring Oversight Committee (Committee), also created by this bill. This bill would require the Department of Consumer Affairs (DCA) to select a contractor to implement the PHP, and the Committee would serve as the evaluation body of the PHP. The PHP would provide for confidential participation by physicians who have a qualifying illness and are not on probation with the Medical Board of California (Board). The PHP would refer physicians (participants) to monitoring programs though written agreements and monitor the compliance of the participants with that agreement. The bill would require the Committee to report to DCA on the outcome of the PHP and the bill would require regular audits of the PHP.

ANALYSIS:

This bill would define "physician and surgeon" as a holder of a valid physician and surgeon's certificate. For the purposes of participating in the PHP, it also would include students enrolled in medical schools approved or recognized by the Board, graduates of medical schools enrolled in medical specialty residency training programs approved or recognized by the Board, or physicians and surgeons seeking reinstatement of a license from the Board.

Including students and graduates enrolled in residency training programs could expand the PHP to include individuals that do not reside in California or may even include individuals attending international medical schools. In addition, if a student or graduate enrolled in residency training, who is participating in the PHP

doesn't comply with the written agreement, that individual may not yet be licensed by the Board, and there is no mechanism in the bill to alert the Board when a student or graduate in a residency program is not compliant and could be a danger to patients in the future.

This bill would define "qualifying illness" to mean alcohol or substance abuse, a mental disorder, or another health condition that a clinical evaluation determines can be monitored and treated with private clinical and monitoring programs. The definition for "impairment" also includes this terminology.

Including "another health condition" in the definition of qualifying illness is too broad. It is not clear what other health condition could be monitored and treated with private and clinical monitoring programs.

This bill would define "Physician Health Program" in part as the vendors, providers, or entities that contract with the committee. This bill would prohibit the PHP from offering or providing treatment services to physicians.

This bill would create the PHP and require the PHP to do all of the following:

- Be available to all physicians and surgeons.
- Promote awareness among members of the medical community on the recognition of health issues that could interfere with safe practice.
- Educate the medical community on the benefits of and options available for early intervention to address those health issues.
- Refer physicians and surgeons to monitoring programs certified by the program by executing a written agreement with the participant and monitoring the compliance of the participant with that agreement.
- Provide for the confidential participation by physicians and surgeons who have a qualifying illness and that are not on probation with the Board.

Promoting awareness and education is a positive step, but could be done through other avenues, such as the Board's Newsletter. The bill requires the PHP to refer physicians to monitoring programs certified by the PHP; however, this bill does not include a requirement or a process for the PHP to certify monitoring programs. Most importantly, this bill does not identify a funding mechanism for the PHP program. Because the provisions of this bill are being amended into the Medical Practice Act, it would appear to make the Board a responsible party for implementing and overseeing the PHP, but the Board is clearly not named to do this. In addition, it appears to possibly make the Board responsible for funding this bill with moneys from the Board's contingent fund. This is a major concern for the Board and the Board was previously opposed to bills that would have created similar programs were funded by moneys in the Board's contingent fund without any oversight or control of the expenditures.

This bill would create the Physician Health, Awareness, and Monitoring Quality Oversight Committee that would be allowed to take any reasonable administrative actions to carry out the responsibilities of this bill, including hiring staff and entering into contracts with vendors or others. The Committee would consist of 14 members; 12 members would be appointed by the Governor and would consist of the following:

- Eight physician members that have education, training, and experience in the identification and treatment of substance use or mental disorders, or both. The physician appointments are as follows:
    - Two members recommended by a statewide association representing psychiatrists with at least 3,000 members.
    - Two members recommended by a statewide association representing addiction medicine specialists with at least 300 members.
    - Three members recommended by a statewide association representing physician from all specialties, modes of practice, and practice settings with at least 25,000 members.
    - One member recommended by a statewide hospital association representing at least 400 hospitals.
- Four members of the public that have experience in a field related to mental illness, or alcohol or substance abuse, or both, as specified.

One member would be appointed by the Speaker of the Assembly, and one member would be appointed by the Senate Committee on Rules. This bill would require members of the Committee to serve without compensation and would serve for a term of four years, unless specified differently in the bill. The Committee would be subject to the Bagley-Keene Open Meeting Act and the California Public Records Act.

The Committee would be required to adopt rules that would include, but not be limited to, criteria for acceptance of participants into the PHP and refusal to accept a person as a participant, and assigning the costs of participation and the associated financial responsibilities of participants.

This bill does not assign a state agency to have jurisdiction over the PHP or the Committee. It seems that this bill intends the Committee to act as the body that has jurisdiction over the PHP program, as the PHP would report to the Committee, and the Committee would only have to report statistics to DCA, but DCA would not have oversight authority or the ability to direct the Committee or the PHP. In addition, there is no funding mechanism identified to fund any portion of the Committee, including the staff that this bill would authorize the Committee to hire and the contracts that this Committee would be executing, nor costs associated with the meetings of this Committee.

This bill would require DCA to select a contractor for the PHP program for a five year term, termed a "program vendor". This bill would require the Committee to serve as the evaluation body for procurement. This bill would specify criteria for the program vendor selected through the contracting process, who would be responsible for running the PHP program. This criteria would require the program vendor to monitor the monitoring entities that participants have retained for mentoring treatment, and provide ongoing services to physicians that resume practice. The program vendor would also be required to have a system in place to promptly report physicians that are unable to practice safely to the Board, when, contrary to agreements with the PHP, they continue to practice unsafely. The system would be required to ensure absolute confidentiality in the communication to the enforcement division of the Board, and would not be allowed to provide information to any other individual or entity, unless authorized by the physician.

Again, this bill does not identify a funding mechanism for the contract that DCA would be required to execute, although it might be a no cost contract. Although the bill charges DCA with selecting a contract, this bill would still require the Committee to serve as the evaluation body for procurement. For the reporting of physicians to the Board, in order to clarify that the PHP has a system in place to report physicians to the Board, the language should instead say that if the requirements in this bill are violated, then the physician would be reported to the Board. Lastly, it is also unclear what kind of "ongoing services" the program vendor would be providing to physicians that resume practice, as the PHP is not allowed by this bill to provide treatment services.

The contract with the Program Vendor for the PHP would require the PHP to do the following:

- Report annually to the Committee on the statistics of the PHP, as specified.
- Submit to periodic audits and inspections, as specified. The audits would be required to be published, given to the Legislature, and posted on the Committee's Web site. The Committee would be required to biennially contract to perform an audit of the PHP, as specified. This bill would not allow General Fund monies to be used for this purpose.
- The Committee would be required to report statistics to DCA, and DCA would be required to report this information to the Legislature, as specified.

Again, this bill does not include a funding mechanism for the statistics report or the audit that the Committee would be required to contract out for; this bill only specifies that General Fund monies cannot be used for the audit.

This bill would require a physician to enter into an individual agreement with the PHP as a condition of participation. The agreement would be required to include the following:

- A jointly agreed-upon plan and mandatory conditions and procedures to monitor compliance with the program, including, but not limited to, an agreement to cease practice.
- Compliance with the terms and conditions of treatment and monitoring.
- Limitations on practice.
- Conditions and terms for return to practice.
- Criteria for program completion.
- Criteria for termination of the participant from the program.
- If a participant retains the service of a private monitoring entity, the participant must agree to authorize the program to receive reports from the private monitoring entity and to request information from the private monitoring entity regarding the participant's treatment status.

This bill would specify that agreements with participants would not be disclosed to the Board or Committee if the participant did not enroll in PHP as a condition of probation or as a result of an action by the Board and if the participant is in compliance with the conditions and procedures in the agreement. This bill would require the PHP to immediately report the name of the participant to the Committee when it learns the participant is failing to meet the requirements of the program, if the participant's impairment is not substantially alleviated through treatment, if the participant withdraws or is terminated from PHP prior to completion, or if the participant is unable to practice medicine with reasonable skill and safety. This bill would require the Committee to refer the matter to the Board within two business days of receiving a report from the PHP.

The major issues of concern with this bill are that it is currently located in the Medical Practice Act, it does not identify a state agency to have oversight of the Committee and the PHP, and there is no funding source identified. Although the Board is not specifically named in this bill, it would appear to make the Board a responsible party for implementing and overseeing the PHP. In addition, it appears to possibly make the Board responsible for funding this bill with moneys from the Board's contingent fund. This is a major concern for the Board and the Board was previously opposed to bills that would have created similar programs were funded by moneys in the Board's contingent fund without any oversight or control of the expenditures. According to the author's office, this bill is a work in progress, and many of the issues pointed out in this analysis will be fixed as the bill goes through the process.

Board staff is suggesting an Oppose Unless Amended position on this bill. The major amendments would be to move the provisions of this bill out of the Medical Practice Act and into the general code sections to make this a DCA oversight function and to identify a funding source that is not the Board's contingent fund or a cost to all licensees.

FISCAL: Unknown, as a funding source is not identified in this bill.

SUPPORT: California Medical Association (Co-Sponsor)
California Hospital Association (Co-Sponsor)
California Psychiatric Association (Co-Sponsor)
California Society of Addiction Medicine (Co-sponsor)

OPPOSITION: None on file

POSITION: Recommendation: Oppose Unless Amended

AMENDED IN SENATE APRIL 17, 2012

SENATE BILL No. 1483

Introduced by Senator Steinberg

February 24, 2012

An act to ~~amend Section 2842~~ *add Article 14 (commencing with Section 2340) to Chapter 5 of Division 2* of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 1483, as amended, Steinberg. ~~Vocational nursing.~~ *Physicians and surgeons.*

Existing law provides for the licensing and regulation of physicians and surgeons by the Medical Board of California.

This bill would create the Physician Health Program, administered by the Physician Health, Recovery, and Monitoring Oversight Committee, with 14 members to be appointed as specified. The purpose of the program would be to promote awareness and education relative to physician and surgeon health issues, including impairment due to alcohol or substance abuse, mental disorders, or other health conditions that could affect the safe practice of medicine. The bill would provide for referral by the program of physicians and surgeons, as defined, to certified monitoring programs on a voluntary basis, governed by a written agreement between the participant and the program. The bill would require the Department of Consumer Affairs to select a contractor to implement the program, with the committee serving as the evaluation body for submitted proposals. The bill would require the committee to report to the department on the outcome of the program and would require regular audits of the program. The bill would enact other related provisions.

~~Existing law, the Vocational Nursing Practice Act, provides for the licensure and regulation of the practice of vocational nursing by the Board of Vocational Nursing and Psychiatric Technicians of the State of California. The board is comprised of 11 members, including one member who is a licensed vocational nurse or registered nurse with specified experience as a teacher or administrator in an accredited school of vocational nursing.~~

~~This bill would instead require that experience to have been obtained in a board-approved school of vocational nursing. The bill would make other technical, nonsubstantive changes.~~

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

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

1 *SECTION 1. The Legislature finds and declares all of the*
2 *following:*
3 *(a) (1) It is in every patient's interest to have physicians and*
4 *surgeons that are healthy and well.*
5 *(2) Physicians and surgeons may have health conditions that*
6 *interfere with their ability to practice medicine safely.*
7 *(3) In such cases, the most effective long-term protection for*
8 *patients is early intervention to address health issues that have*
9 *the potential to interfere with the safe practice of physicians and*
10 *surgeons.*
11 *(b) While the Legislature recognizes that physicians and*
12 *surgeons have a number of options for obtaining treatment, it is*
13 *the intent of the Legislature in enacting this act to promote*
14 *awareness among members of the medical community about health*
15 *issues that could interfere with safe practice, to promote awareness*
16 *that private early intervention options are available, to provide*
17 *resources and referrals to ensure physicians and surgeons are*
18 *better able to choose high quality private interventions that meet*
19 *their specific needs, and to provide a separate mechanism for*
20 *monitoring treatment.*
21 *SEC. 2. Article 14 (commencing with Section 2340) is added*
22 *to Chapter 5 of Division 2 of the Business and Professions Code,*
23 *to read:*

Article 14. Physician Health, Awareness, and Monitoring Quality

2340. This article shall be known and may be cited as the Physician Health, Awareness, and Monitoring Quality Act of 2012.

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

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

(b) "Committee" means the Physician Health, Awareness, and Monitoring Quality Oversight Committee established pursuant to Section 2343.

(c) "Department" means the Department of Consumer Affairs.

(d) "Impairment" means the inability to practice medicine with reasonable skill and safety to patients by reason of alcohol or substance abuse, a mental disorder, or another health condition as determined by a clinical evaluation in individual circumstances.

(e) "Participant" means a physician and surgeon enrolled in the program pursuant to an agreement entered into as provided in Section 2346.

(f) "Physician Health Program" or "program" means the program defined in Section 2342 and includes vendors, providers, or entities that contract with the committee pursuant to this article. The program itself shall not offer or provide treatment services to physicians and surgeons.

(g) "Physician and surgeon" means a holder of a valid physician and surgeon's certificate. For the purposes of participating in the program under this article, "physician and surgeon" shall also mean a student enrolled in a medical school approved or recognized by the board, a graduate of a medical school enrolled in a medical specialty residency training program approved or recognized by the board, or a physician and surgeon seeking reinstatement of a license from the board.

(h) "Qualifying illness" means alcohol or substance abuse, a mental disorder, or another health condition that a clinical evaluation determines can be monitored and treated with private clinical and monitoring programs.

2342. The Physician Health Program shall do all of the following:

(a) Be available to all physicians and surgeons, as defined in subdivision (g) of Section 2341.

(b) Promote awareness among members of the medical community on the recognition of health issues that could interfere with safe practice.

(c) Educate the medical community on the benefits of and options available for early intervention to address those health issues.

(d) Refer physicians and surgeons to monitoring programs certified by the program by executing a written agreement with the participant and monitoring the compliance of the participant with that agreement.

(e) Provide for the confidential participation by physicians and surgeons who have a qualifying illness and that are not on probation with the board.

2343. (a) (1) There is hereby established the Physician Health, Awareness, and Monitoring Quality Oversight Committee that shall have the duties and responsibilities set forth in this article. The committee may take any reasonable administrative actions to carry out the responsibilities and duties set forth in this article, including, but not limited to, hiring staff and entering into contracts.

(2) The committee shall be formed no later than ____.

(3) The committee composition shall be as follows:

(A) All of the members under this subparagraph shall be appointed by the Governor and licensed in this state as physicians and surgeons with education, training, and experience in the identification and treatment of substance use or mental disorders, or both.

(i) Two members recommended by a statewide association representing psychiatrists with at least 3,000 members.

(ii) Two members recommended by a statewide association representing addiction medicine specialists with at least 300 members.

(iii) Three members recommended by a statewide association representing physician and surgeons from all specialties, modes of practice, and practice settings with at least 25,000 members.

(iv) One member recommended by a statewide hospital association representing at least 400 hospitals.

(v) For the purpose of the initial composition of the committee, one member appointed under clause (i) shall be appointed for a two-year term and the other member for a three-year term; one

member appointed under clause (ii) shall be appointed for a two-year term and the other member for a three-year term; one member appointed under clause (iii) shall be appointed for a two-year term, one member for a shall be appointed for three-year term, and one member shall be appointed for a four-year term; and the member appointed under clause (iv) shall be appointed for a four-year term.

(B) All members appointed under this subparagraph shall have experience in a field related to mental illness, or alcohol or substance abuse, or both.

(i) Four members of the public appointed by the Governor. For the initial appointment to the committee, two members shall be appointed to serve for two-year terms and two members shall be appointed to serve for four-year terms.

(ii) One member of the public appointed by the Speaker of the Assembly. The initial appointment shall be for a three-year term.

(iii) One member of the public appointed by the Senate Committee on Rules. The initial appointment shall be for a three-year term.

(4) For the purposes of this section, a public member may not be any of the following:

(A) A current or former physician and surgeon or an immediate family member of a physician and surgeon.

(B) A current or former employee of a physician and surgeon, or a business providing or arranging for physician and surgeon services, or having any financial interest in the business of a physician and surgeon.

(C) An employee or agent or representative of any organization representing physicians and surgeons.

(D) An individual or an affiliate of an organization who has conducted business with or regularly appeared before the board.

(5) A public member shall meet all of the requirements for public members on a board as set forth in Chapter 6 (commencing with Section 450) of Division 1.

(b) Members of the committee shall serve without compensation.

(c) Except as provided for in subdivision (a), committee members shall serve terms of four years and may be reappointed.

(d) The committee shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government

Code) and the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(e) The rules adopted by the committee shall be consistent with Section 315, the guidelines of the Federation of State Physician Health Programs, Inc., as well as community standards of practice, including, but not limited to, criteria for acceptance of participants into the program and the refusal to accept a person as a participant into the program and the assigning of costs of participation and associated financial responsibilities of participants. In the event of any conflicts between standards established pursuant to Section 315 and the guidelines of the Federation of State Physician Health Programs, Inc., and community standards of practice, Section 315 shall prevail.

2344. (a) The department shall select a contractor for the Physician Health Program pursuant to a request for proposals, and the committee shall contract for a five-year term with that entity. The process for procuring the services for the program shall be administered by the department pursuant to Article 4 (commencing with Section 10335) of Chapter 2 of Part 2 of Division 2 of the Public Contract Code. However, the committee shall serve as the evaluation body for the procurement.

(b) The chief executive officer of the program vendor shall have expertise in the areas of substance or alcohol abuse, and mental disorders in health care professionals.

(c) The program vendor shall have a medical director to oversee clinical aspects of the program's operations. The medical director shall have expertise in the diagnosis and treatment of alcohol and substance abuse and mental disorders in health care professionals.

(d) The program vendor shall have established relationships with local medical societies and hospital well-being committees for conducting education, outreach, and referrals for physician and surgeon health.

(e) The program vendor shall monitor the monitoring entities that participating physicians and surgeons have retained for monitoring the participant's treatment and shall provide ongoing services to physicians and surgeons that resume practice.

(f) The program vendor shall have a system for promptly reporting physicians and surgeons unable to practice safely to the board when, contrary to agreements with the Physician Health

Program, they continue to practice unsafely. This system shall ensure absolute confidentiality in the communication to the enforcement division of the board, and shall not provide this information to any other individual or entity unless authorized by the enrolled physician and surgeon.

(g) The contract entered into pursuant to this article shall also require the program vendor to do both of the following:

(1) Report annually to the committee statistics related to the program, including, but not limited to, the number of participants currently in the program, the number of participants referred by the board as a condition of probation, the number of participants who have successfully completed their agreement period, the number of participants terminated from the program, and the number of participants reported by the program pursuant to subdivision (c) of Section 2346. However, in making that report, the program shall not disclose any personally identifiable information relating to any participant.

(2) Submit to periodic audits and inspections of all operations, records, and management related to the program to ensure compliance with the requirements of this article and its implementing rules and regulations, if any.

(h) In addition to the requirements of Section 2349, the committee shall monitor compliance of the program with the requirements of this article. The committee or its designee may make periodic inspections and onsite visits with the vendor contracted to provide Physician Health Program services.

(i) Copies of the audits referenced in paragraph (2) of subdivision (g) shall be published and provided to the appropriate policy committees of the Legislature within 10 business days of publication. A copy shall also be made available to the public by posting a link on the committee's Internet Web site homepage no more than 10 business days after publication.

2346. (a) A physician and surgeon shall, as a condition of participation in the Physician Health Program, enter into an individual agreement with the program.

(b) The agreement between the physician and surgeon and the program shall include all of the following:

(1) A jointly agreed-upon plan and mandatory conditions and procedures to monitor compliance with the program, including, but not limited to, an agreement to cease practice.

(2) Compliance with terms and conditions of treatment and monitoring.

(3) Limitations on practice.

(4) Conditions and terms for return to practice.

(5) Criteria for program completion.

(6) Criteria for termination of the participant from the program.

(c) In addition, if the physician and surgeon retains the services of a private monitoring entity, he or she shall agree to authorize the program vendor to receive reports from the private monitoring entity and to request information from the private monitoring entity regarding his or her treatment status. Except as provided in subdivisions (b), (c), (d), and (e), and subdivision (f) of Section 2344, a physician and surgeon's participation in the program pursuant to an agreement shall be confidential unless waived by the physician and surgeon.

(d) Any agreement entered into pursuant to this section shall not be considered a disciplinary action or order by the board, and shall not be disclosed to the committee or the board if both of the following apply:

(1) The physician and surgeon did not enroll in the program as a condition of probation or as a result of an action of the board.

(2) The physician and surgeon is in compliance with the conditions and procedures in the agreement.

(e) (1) The program shall immediately report the name of a participant to the committee when it learns of the participant's failure to meet the requirements of the program including failure to cease practice when required or failure to submit to evaluation, treatment, or biological testing when required. The program shall also immediately report the name of a participant to the committee when it learns that the participant's impairment is not substantially alleviated through treatment, or if the participant withdraws or is terminated from the program prior to completion, or if, in the opinion of the program after a risk assessment is conducted, the participant is unable to practice medicine with reasonable skill and safety.

(2) Within two business days of receiving a report pursuant to paragraph (1), the committee shall refer the matter to the board.

(f) Except as provided in subdivisions (b), (c), and (e) and subdivision (f) of Section 2344, and this subdivision, any oral or written information reported to the board pursuant to this section,

including, but not limited to, any physician and surgeon's participation in the program and any agreement entered into pursuant to this article, shall remain confidential as provided in subdivision (c) of Section 800, and shall not constitute a waiver of any existing evidentiary privileges under any other provision or rule of law. However, confidentiality regarding the physician and surgeon's participation in the program and of all information and records created by the program related to that participation shall not apply if the board has referred a participant as a condition of probation.

(g) Nothing in this section prohibits, requires, or otherwise affects the discovery or admissibility of evidence in an action by the board against a physician and surgeon based on acts or omissions within the course and scope of his or her practice.

(h) Any information received, developed, or maintained by the committee regarding a physician and surgeon in the program shall not be used for any other purposes.

2347. The committee shall report to the department statistics received from the program pursuant to Section 2344, and the department shall, thereafter, report to the appropriate policy committees of the Legislature on or before ____, and annually thereafter, the outcomes of the program, including, but not limited to, the number of individuals served, the number of participants currently in the program, the number of participants referred by the board as a condition of probation, the number of individuals who have successfully completed their agreement period, the number of participants terminated from the program, and the number of individuals reported to the board for noncompliance pursuant to subdivision (c) of Section 2346. However, in making those reports, the committee and the department shall not disclose any personally identifiable information relating to any physician and surgeon participating in the program pursuant to an agreement entered into pursuant to Section 2346.

2349. (a) The committee shall biennially contract to perform an audit of the Physician Health Program and its vendors. This section is not intended to reduce the number of audits the committee may otherwise conduct. The initial audit shall commence two years after the award of an initial five-year contract. Under no circumstances shall General Fund revenue be used for this purpose.

(b) Any person or entity conducting the audit required by this section shall maintain the confidentiality of all records reviewed and information obtained in the course of conducting the audit and shall not disclose any information identifying any program participant.

(c) The biennial audit shall be done by ____ and shall ascertain if the program is operating in conformance with the rules and regulations established by the committee.

~~SECTION 1. Section 2842 of the Business and Professions Code is amended to read:~~

~~2842. (a) Each member of the board shall be a citizen of the United States and a resident of the State of California. The board shall have the following composition:~~

~~(1) Two members shall be duly licensed vocational nurses who have been licensed for a period of not less than three years prior to appointment.~~

~~(2) Two members shall be licensed psychiatric technicians, each of whom shall have had not less than five years' experience in a psychiatric hospital, or in a psychiatric unit of a hospital licensed by the State Department of Health Care Services, or a private institution licensed by the State Department of Health Care Services.~~

~~(3) One member shall be a licensed vocational nurse or registered nurse who shall have had not less than five years' experience as a teacher or administrator in a board-approved school of vocational nursing.~~

~~(4) Six members shall be public members who are not licentiates of the board or any other board under this division or of any board referred to in Sections 1000 and 3600.~~

~~(b) No person may serve as a member of the board for more than two consecutive terms.~~

~~(c) Per diem and expenses of members of the board who are licensed psychiatric technicians shall be paid solely from revenues received pursuant to Chapter 10 (commencing with Section 4500) of Division 2.~~

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SB 1488

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1488
Author: Yee
Bill Date: February 24, 2012, introduced
Subject: Traditional Chinese Medicine Traumatologist Certification
Sponsor: Author

STATUS OF BILL:

This bill is on the Senate Floor.

DESCRIPTION OF CURRENT LEGISLATION:

This bill defines Traditional Chinese Medicine Traumatology and would establish the Traditional Chinese Medicine (TCM) Traumatology Council; a nonprofit organization that would develop standards and certify the practice of TCM Traumatology. The Council would issue certificates for certified TCM Traumatology to individuals who apply and meet specified training and clinical experience, as set forth in the standards that the Council would be required to establish. This bill would limit the time frame for new applications from January 1, 2013, to December 16, 2013. After December 16, 2013, the Council would only issue renewals. This bill would sunset January 1, 2017.

ANALYSIS:

According to the Author, traumatology is one of the modalities that constitute TCM. Before China systemized its health care system, the mastery of traumatology was acquired through master-apprentice relationships through hands-on training, so it is difficult to obtain proof of their training.

According to the National Institutes of Health's (NIH) National Center for Complementary and Alternative Medicine (Center), "TCM originated in ancient China and has evolved over thousands of years. TCM practitioners use herbs, and other methods to treat a wide range of conditions. In the United States, TCM is considered part of complementary and alternative medicine. Herbal remedies and acupuncture are the treatments most commonly used by TCM practitioners. Other TCM practices include cupping, mind-body therapy and dietary therapy. Although TCM is used by the American public, scientific evidence of its effectiveness is, for the most part, limited. Acupuncture has the largest body of evidence and is considered safe if practiced correctly."

This bill would define "Traditional Chinese Medicine Traumatology" to include a range of treatments to address both acute and chronic musculoskeletal conditions, as well as nonmusculoskeletal conditions. Techniques would include, but are not limited to, brushing, kneading, rolling, pressing, and rubbing areas between the joints to pen the body's defensive chi and stimulate the energy movement in both meridians.

This bill would establish the TCM Traumatology Council as a non- profit organization for the purpose of developing standards for, and certifying the practice of, TCM Traumatology. The Council would consist of seven members, **including a member from the Medical Board of California (Board).** The Council would be required to determine the certification standards, including the level of experience and training needed to qualify for TCM Traumatology Certification.

This bill would require an individual to apply to the Council for a certificate for TCM Traumatology and an applicant would have to meet specified requirements set forth by the Council, in order to obtain the certificate. This bill would require an individual to possess a certificate issued by the Council for TCM Traumatology, in order to hold himself or herself out as a certified TCM Traumatologist. This bill would also specifically prohibit a certified TCM Traumatologist from practicing medicine and from practicing within the chiropractic scope of practice. This bill would limit the time frame for new applications to be from January 1, 2013, to December 16, 2013. After December 16, 2013, the Council would only issue renewals. This bill would sunset January 1, 2017.

This bill would require a certified TCM Traumatologist when engaging in TCM Traumatology to be supervised by a physician and surgeon who has completed an orthopaedic residency program. This bill would require the extent of the relationship between the physician and the TCM Traumatologist to be determined by the Council after the qualifications necessary for certification are defined and adopted by the Council.

Board staff is bringing this bill to the Board's attention because a member of the Board would be required to sit on the Council.

FISCAL: None

SUPPORT:
American Association of Acupuncture and Traditional Chinese Medicine
American Chinese Cultural Exchange & Trading Association
American Traditional Chinese Medical Traumatology Association
California Acupuncture Medical Association
National Guild of Acupunture and Oriental Medicine
Numerous Groups and Individuals (over 450 letters received)

OPPOSITION:
California Acupuncture Coalition
California Orthopaedic Association
Numerous Individuals

POSITION: Recommendation: No Position

SENATE BILL No. 1488

Introduced by Senator Yee

February 24, 2012

An act to add and repeal Chapter 12.5 (commencing with Section 4979.1) of Division 2 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 1488, as introduced, Yee. Healing arts: traditional Chinese Medicine traumatologist certification.

Existing law, the Acupuncture Licensure Act, establishes the Acupuncture Board and makes it responsible for enforcing and administering the act, including licensing persons who meet specified licensure requirements. Under the act, licensees are titled "acupuncturists," and are authorized to perform designated activities pursuant to their license. The unlawful practice of acupuncture and any other violation of the act is a crime.

This bill would establish the Traditional Chinese Medicine Traumatology Council as a nonprofit organization to provide for the certification and regulation of the practice of traditional Chinese Medicine traumatologists, as defined. The bill would require the council to issue a certificate to practice as a traditional Chinese Medicine traumatologist to an applicant who meets certain training and clinical experience requirements and pays a specified fee. This bill would make the meetings and deliberations of the council subject to the open meeting requirements that apply to state bodies.

This bill would limit the timeframe for new applications to the period from January 1, 2013, to December 15, 2013. Thereafter, the council may only issue renewals of current certificates.

This bill would set forth procedures for the renewal of a certificate to perform traditional Chinese Medicine traumatology and would establish specified fees in that regard.

This bill would also require specified treatment procedures to be performed under the supervision of an orthopedic surgeon and prohibit treatment that constitutes the practice of medicine or chiropractic procedures, as defined.

This bill would also make it an unfair business practice to use the title of "certified traditional Chinese Medicine traumatologist" without meeting these certification requirements.

This bill would repeal these provisions on January 1, 2017, unless legislation is enacted before that date to remove or extend that deadline.

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

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

1 SECTION 1. Chapter 12.5 (commencing with Section 4979.1)
2 is added to Division 2 of the Business and Professions Code, to
3 read:
4
5 CHAPTER 12.5. TRADITIONAL CHINESE MEDICINE
6 TRAUMATOLOGY
7
8 4979.1. As used in this chapter:
9 (a) "Certified traditional Chinese Medicine traumatologist"
10 means a person who has been certified by the Traditional Chinese
11 Medicine Traumatology Council to perform traditional Chinese
12 Medicine traumatology.
13 (b) "Traditional Chinese Medicine traumatology" includes a
14 range of treatments to address both acute and chronic
15 musculoskeletal conditions, as well as many nonmusculoskeletal
16 conditions. Techniques include, but are not limited to, brushing,
17 kneading, rolling, pressing, and rubbing the areas between each
18 of the joints to open the body's defensive chi and stimulate the
19 energy movement in both meridians.
20 4979.2. The Traditional Chinese Medicine Traumatology
21 Council shall be established as a nonprofit organization for the
22 purpose of developing standards for, and certifying the practice
23 of, traditional Chinese Medicine traumatology.

4979.3. (a) (1) The council shall consist of seven members, composed of three representatives from the clinical settings of traumatology, two representatives from the California Orthopaedic Association, and one representative each from the Medical Board of California and the California Medical Association.

(2) Representatives from the clinical settings of traumatology shall be selected by professional societies, associations, or other entities, whose memberships are comprised solely of practitioners of traditional Chinese Medicine traumatology.

(3) To qualify, a professional society, association, or entity shall have a dues-paying membership in California of at least 30 individuals for the last three years and shall have bylaws that require its members to comply with a code of ethics.

(b) (1) Subject to subdivision (d), the council shall meet and confer to determine the certification standards, including the level of experience and training needed for an individual to qualify for traditional Chinese Medicine traumatology certification.

(2) The council shall develop the application form for certification.

(3) The meetings and deliberations of the council shall be subject to the provisions of the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code).

(c) The council shall issue a certificate for certified traditional Chinese Medicine traumatology to any person who makes an application and meets all of the following requirements, as determined by the council pursuant to subdivision (d):

(1) Is at least 18 years of age.

(2) Furnishes satisfactory evidence of training and clinical experience that meets the standards established by the council.

(3) Is not subject to denial pursuant to Division 1.5 (commencing with Section 475).

(d) The council shall evaluate whether an applicant meets the certification standards, including the level of experience and training to sufficiently qualify for the traumatology certification.

(e) An individual who is not qualified to receive a certificate under this section, or who fails to apply for certification under this section, shall not hold himself or herself out as a certified traditional Chinese Medicine traumatologist pursuant to this section.

4979.4. (a) A certified traditional Chinese Medicine traumatologist, when engaging in traditional Chinese Medicine traumatology manipulation techniques to realign the musculoskeletal and ligamentous relationships, shall be supervised by a physician and surgeon who has completed an orthopaedic residency program. The extent of the relationship between a traditional Chinese Medicine traumatologist and orthopedic surgeon regarding those manipulation techniques shall be determined by the council after the qualifications necessary for certification are defined and adopted by the council.

(b) A certified traditional Chinese Medicine traumatologist shall not practice medicine, as defined in Section 2052.

(c) A certified traditional Chinese Medicine traumatologist shall not practice within the scope of activities regulated by the State Board of Chiropractic Examiners.

4979.5. (a) An applicant for traditional Chinese Medicine traumatology certification shall, commencing January 1, 2013, until December 15, 2013, file an application for a certificate for traditional Chinese Medicine traumatology with the council.

(b) On and after December 16, 2013, the council shall not issue an initial certificate to any applicant.

(c) On and after December 16, 2013, the council may issue only a renewal of a certificate under this section.

(d) An individual who is not qualified to receive a certificate under this section, or who fails to apply for certification under this section by December 15, 2013, shall not hold himself or herself out as a certified traditional Chinese Medicine traumatologist.

4979.6. An applicant for certification as a traditional Chinese Medicine traumatologist shall pay an application fee in a reasonable amount, not to exceed two hundred dollars ($200) for the regulatory cost to the council of processing the application, when submitting his or her application to the council.

4979.7. A certified traditional Chinese Medicine traumatologist shall renew his or her certificate every two years.

4979.8. An expired certificate may be renewed at any time within six months after its expiration. The holder of the certificate shall pay all accrued and unpaid renewal fees, plus a delinquency fee.

(a) The renewal fee shall be one hundred dollars ($100).

(b) The delinquency fee shall be twenty-five dollars ($25).

(c) The fee for a duplicate or replacement engraved wall certificate shall be fifteen dollars ($15).

(d) The fee for a duplicate or replacement renewal receipt/pocket certificate shall be ten dollars ($10).

4979.9. Moneys received under this section shall be utilized by the council to pay for the costs associated with administering this chapter.

4979.10. It is an unfair business practice for any person to hold himself or herself out as a certified traditional Chinese Medicine traumatologist or use the title of "certified traditional Chinese Medicine traumatologist" without meeting the requirements of this chapter.

4979.11. This chapter shall remain in effect only until January 1, 2017, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2017, deletes or extends that date.

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SCR 69

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SCR 69
Author: Pavley
Bill Date: April 16, 2012, amended
Subject: California Autism Awareness Month
Sponsor: Author

STATUS OF BILL:

This bill is on the Assembly Consent Calendar.

DESCRIPTION OF CURRENT LEGISLATION:

This concurrent resolution would designate April 2012 as California Autism Awareness Month. This resolution would also affirm the Legislature's commitment to autism spectrum disorders (ASDs) issues; would emphasize that every individual with an ASD is a valued member of society; would commend the individuals and nonprofit organizations contributing to the well-being of individuals with ASDs and their families; and, would stress the need to identify children with ASD to begin early intervention, integrated, seamless, comprehensive, and competent services and supports for individuals with ASDs and their families.

ANALYSIS:

In addition to designating April 2012 as California Autism Awareness Month, this resolution would also make the following legislative findings:

- ASDs impact one out of every 110 children and one in every 70 boys in the United States; and, ASDs are the fastest growing serious developmental disability, making these disorders more common than pediatric cancer, diabetes, and acquired immunodeficiency syndrome combined.

- Many Californians are not adequately informed about ASDs and the value and importance of early identification, assessment, and treatment of these disorders; and, scientific research demonstrates that early identification and intervention can result in significant positive outcomes in many children with ASDs.

- The Legislature supports the goal of increasing research to learn the root causes of autism and identify the best methods of early intervention and treatment, expanding programs for individuals with autism across their lifespan, and promoting understanding of the special needs of people with autism.

- The Senate Select Committee on Autism and Related Disorders established in 2009 has appointed regional autism taskforces to assist and support the work of the Committee; and in 2007, the Legislative Blue Ribbon Commission on Autism submitted its report, "An Opportunity to Achieve Real Change for Californians with Autism Spectrum Disorders," which provided specific findings and recommendations.

This resolution would affirm the Legislature's commitment to autism spectrum disorders (ASDs) issues; would emphasize that every individual with an ASD is a valued member of society; would commend the individuals and nonprofit organizations contributing to the well-being of individuals with ASDs and their families; and, would stress the need to identify children with ASD to begin early intervention, integrated, seamless, comprehensive, and competent services and supports for individuals with ASDs and their families.

Board staff suggests the Board take a support position on this bill, as ASD is an important health issue in California and the Board should support any efforts to promote consumer awareness and the importance of early intervention for ASDs.

FISCAL: None

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY APRIL 16, 2012

AMENDED IN SENATE MARCH 26, 2012

Senate Concurrent Resolution No. 69

Introduced by Senator Pavley

(Coauthors: Senators Alquist, Cannella, Correa, DeSaulnier, Dutton, Evans, Fuller, Liu, Price, *Steinberg,* Strickland, and Wolk)

(Coauthors: Assembly Members *Alejo,* Ammiano, *Block,* Hall, Huffman, Ma, Miller, Monning, Portantino, Wieckowski, Williams, and Yamada)

February 23, 2012

Senate Concurrent Resolution No. 69—Relative to California Autism Awareness Month.

LEGISLATIVE COUNSEL'S DIGEST

SCR 69, as amended, Pavley. California Autism Awareness Month.

This measure would designate April 2012 as California Autism Awareness Month, would affirm the Legislature's commitment to the important issues related to autism spectrum disorders (ASDs), and would emphasize that each and every individual with an ASD is a valued and important member of our society.

Fiscal committee: no.

1 WHEREAS, Autism spectrum disorders (ASDs) now impact
2 one out of every 110 children, and one in every 70 boys, in the
3 United States and are the fastest growing serious developmental
4 disability, making these disorders more common than pediatric
5 cancer, diabetes, and acquired immunodeficiency syndrome (AIDS)
6 combined; and

WHEREAS, The prevalence of autism is increasing by 10 to 17 percent annually and ASDs cost the nation over $35 billion per year, and this cost is estimated to exceed $200 billion in 10 years; and

WHEREAS, Most school districts in California have seen a doubling of pupils with ASDs in the past five years. The number of Californians with ASDs who are served by the State Department of Developmental Services now exceeds 50,000, which ~~is a number that~~ has increased fivefold since 1998, and is more than 12 times what it was in 1987; and

WHEREAS, Many Californians are not adequately informed about ASDs and the value and importance of early identification, assessment, and treatment of these disorders; and

WHEREAS, Current scientific research demonstrates that the early identification ~~of~~ and intervention ~~with~~ *of* children with ASDs can result in significant positive outcomes ~~in many children with ASDs~~; and

WHEREAS, The Legislature supports the goal of increasing research to learn the root causes of autism and identify the best methods of early intervention and treatment, expanding programs for individuals with autism across their lifespan, and promoting understanding of the special needs of people with autism; and

WHEREAS, Parents and family members have made invaluable contributions through their commitment, care, and advocacy, to important advances in research, education, and treatment for individuals with ASDs; and

WHEREAS, Public information and awareness efforts are of paramount importance in accelerating early identification efforts and the proliferation of early intervention programs and services; and

WHEREAS, The Senate Select Committee on Autism and Related Disorders has appointed regional autism task forces that are comprised of consumers and their family members, advocates, providers, researchers, and other experts in the area of ASDs, and other stakeholders, to provide assistance to, and to support the work of, the select committee. Senator Steinberg, as Chair of the Senate Select Committee on Autism and Related Disorders, has established the Statewide Coordinating Council of Autism Taskforces that consists of the leadership of the regional autism task forces and has provided input and integrated recommendations

for consideration by the Senate Select Committee on Autism and Related Disorders; and

WHEREAS, California has been the established leader in providing services and support for the early identification, assessment, intervention, education, and treatment of individuals with ASDs. This leadership began with the passage of landmark state legislation, such as the Lanterman Developmental Disabilities Services Act in 1969 and Assembly Bill 3854 (Chapter 1527 of the Statutes of 1974), relating to autism and public education; and

WHEREAS, In 2007, the Legislative Blue Ribbon Commission on Autism submitted its report, "An Opportunity to Achieve Real Change for Californians with Autism Spectrum Disorders," which provided specific findings and recommendations; and

WHEREAS, In 2009, the Senate Committee on Rules, pursuant to Senate Rule 12.5, established the Senate Select Committee on Autism and Related Disorders and this committee has appointed regional autism task forces; now, therefore, be it

Resolved by the Senate of the State of California, the Assembly thereof concurring, That the Legislature designates April 2012 as California Autism Awareness Month, affirms the Legislature's commitment to the important issues related to ASDs, and emphasizes that each and every individual with an ASD is a valued and important member of our society; and be it further

Resolved, That the Legislature recognizes and commends the parents and relatives of individuals with ASDs for their sacrifice and dedication in providing for the special needs of individuals with ASDs; and be it further

Resolved, That the Legislature recognizes and commends the work of all of the nonprofit organizations that contribute to the well-being of individuals with autism and their families; and be it further

Resolved, That the Legislature stresses the need to identify children with ASDs and to begin early intervention services immediately after a child has been diagnosed with autism; and be it further

Resolved, That the Legislature also stresses the need to provide these intervention services, as well as supports, for individuals with ASDs and their families in an integrated, seamless, comprehensive, and competent manner that is delivered across the child's lifespan; and be it further

1 *Resolved,* That the Secretary of the Senate transmit copies of
2 this resolution to the author for appropriate distribution.

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TRACKER II

MBC TRACKER II BILLS
4/25/2012

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 70	Monning	Public Health: Federal Grant Opportunities	Senate	01/23/12
AB 137	Portantino	Health Care Coverage: Mammographies	Sen. Health	01/23/12
AB 174	Monning	Health Information Exchange	Sen. Health	03/21/11
AB 369	Huffman	Health Care Coverage: Prescriptions Drugs	Sen. Health	
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 510	Lowenthal, B.	Radiation Control: Health Facilities and Clinics: Records	Sen. Approps	04/16/12
AB 714	Atkins	Health Care Coverage: California Health Benefit Exchange	Sen. Approps	06/30/11
AB 916	Perez, M.	Health: Underserved Communities	Sen. Health	08/15/11
AB 972	Butler	Substance Abuse: Treatment Facilities	Sen. Approps	08/15/11
AB 1217	Fuentes	Surrogacy Agreements	Sen. Judiciary	04/09/12
AB 1280	Hill	Ephedrine: Retail Sale	Sen. Approps	02/09/12
AB 1409	Perez, M.	Regulations: Small Business	Sen. B&P	03/22/12
AB 1431	Comm. on Acct. & Admin Review	Government Reports	Senate	01/24/12
AB 1453	Monning	Essential Health Benefits	Asm. Approps	04/17/12
AB 1461	Monning	Individual Health Care Coverage	Asm. Approps	04/09/12
AB 1580	Bonilla	Health Care: Eligibility: Enrollment	Senate	
AB 1584	Eng	Health Education: Health Science & Medical Technology Project	Asm. Approps	04/23/12
AB 1588	Atkins	Reservist Licensees: Fees and Continuing Education	Asm. Approps	03/05/12
AB 1636	Monning	Health and Wellness Programs	Asm. Approps	
AB 1687	Fong	Worker's Compensation: Utilization Review	Asm. Approps	03/12/12
AB 1731	Block	Newborn Screening Program: Critical Congenital Heart Disease	Asm. Approps	04/09/12
AB 1733	Logue	Telehealth	Asm. Health	04/16/12
AB 1904	Block	Military Spouses: Temporary Licenses	Asm. Approps	
AB 1914	Garrick	Agency Reports	Asm. Approps	04/09/12

MBC TRACKER II BILLS
4/25/2012

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 1932	Gorrell	United States Armed Services: Healing Arts Boards	Asm. Veterans	04/17/12
AB 1976	Logue	Licensure and Certification Requirements: Military Experience	Asm. Veterans	04/11/02
AB 1982	Gorrell	Regulations: Effective Date: Legislative Review	Asm. B&P	04/18/12
AB 2009	Galgiani	Communicable Disease: Influenza Vaccinations	Asm. Approps	04/16/12
AB 2064	Perez, M.	Immunizations for Children: Physician Reimbursement	Asm. Health	
AB 2109	Pan	Communicable Disease: Immunization Exemption	Asm. Approps	04/23/12
AB 2214	Monning	Health Workforce Development	Asm. Approps	03/27/12
AB 2221	Block	Public Records	Asm. Approps	03/28/12
AB 2285	Eng	Peace Officer Testing: Cheating	Asm. Consent	04/11/12
AB 2312	Ammiano	Controlled Substances: Marijuana	Asm. Approps	
AB 2343	Torres	Criminal History Information	Asm. Consent	03/28/12
AB 2348	Mitchell	Registered Nurses: Dispensation of Drugs	Asm. B&P	03/29/12
AB 2356	Skinner	Tissue Donation	Asm. Health	03/29/12
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	Inactive File	08/30/11
SB 628	Yee	Acupuncture: Regulation	Asm. B&P	02/23/12
SB 728	Hernandez	Health Care Coverage	Asm. Health	05/31/11
SB 764	Steinberg	Developmental Services: Telehealth Systems Program	Asm. Human Svcs.	01/12/12
SB 951	Hernandez	Health Care Coverage: Essential Health Benefits	Sen. Approps	04/16/12
SB 961	Hernandez	Individual Health Care Coverage	Sen. Approps	04/09/12
SB 975	Wright	Professions & Vocations: Regulatory Authority	Sen. B&P	03/27/12
SB 1050	Alquist	Autism: Telehealth Task Force	Sen. Human Svcs.	04/12/12
SB 1079	Rubio	Inmates: Medical Treatment	Sen. Public Safety	03/20/12

MBC TRACKER II BILLS
4/25/2012

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 1134	Yee	Persons of Unsound Mind: Psychotherapist Duty to Protect	Sen. Judiciary	03/28/12
SB 1136	Steinberg	Mental Health Services Act	Sen. Health	04/16/12
SB 1172	Lieu	Sexual Orientation Change Efforts	Sen. Judiciary	04/16/12
SB 1182	Leno	Medical Marijuana	Sen. Public Safety	04/09/12
SB 1185	Price	Centralized Intelligence Partnership Act	Sen. Gov. Org.	04/09/12
SB 1199	Dutton	Radiologic Technologists	Sen. Approps	04/17/12
SB 1236	Price	Healing Arts Boards	Sen. Approps	04/17/12
SB 1250	Alquist	Medical Records: Confidentiality	Sen. Judiciary	02/23/12
SB 1267	Padilla	Genetic Information Privacy Act	Sen. Judiciary	03/27/12
SB 1301	Hernandez	Prescription Drugs: 90-Day Supply	Sen. Approps	04/16/12
SB 1320	Harman	Retainer Practices	Sen. Health	03/28/12
SB 1329	Simitian	Prescription Drugs: Collection & Distribution Program	Sen. B&P	03/29/12
SB 1374	Harman	Liability: Good Faith Reliance on Administrative Regulation	Sen. Judiciary	04/23/12
SB 1407	Leno	Medical Information: Disclosure	Sen. Judiciary	04/16/12
SB 1524	Hernandez	Nursing	Sen. Approps	03/28/12
SB 1538	Simitian	Health Care: Mammograms	Sen. Approps	03/27/12
SCR 72	Price	National Consumer Protection Week	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	Became eff. 2/18/12	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	1/19/12
Sponsored Free Health Care Events	Disapproved Modified Text 15-day comment period ends 4/25/12	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	2/10/12 Disapproved 3/13/12	
Misdemeanor Convictions	Reg Hearing scheduled 5/04/12	2/03/12	3/09/12	5/04/12				
Non-substantive changes from all units (Section 100 changes)	Next review of MBC regulations – Summer 2012							

Prepared by Chris Valine
Updated April 16, 2012
For questions, call (916) 263-2466

* - 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