MEDICAL BOARD OF CALIFORNIA

QUARTERLY BOARD MEETING AGENDA

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.

Courtyard by Marriott
Golden A&B
1782 Tribute Road
Sacramento, CA 95815
916-929-7900 (directions only)

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

Friday, July 20, 2012
9:00 a.m. – 3:00 p.m.
(or until the conclusion of Business)

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

ORDER OF ITEMS IS SUBJECT TO CHANGE.

1. 9:00 a.m. Call to Order / Roll Call

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

3. Approval of Minutes from the May 3-4, 2012 Meeting

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

5. Adoption of Revised Emergency Contraception (EC) Protocol – Ms. Herold and Ms. Smith-Crowley

6. Update on Pharmacy Board Actions – Ms. Herold

7. Update on Controlled Substances Forum – Ms. Whitney and Ms. Herold

8. Special Faculty Permit Review Committee Update – Dr. Low
   A. Consideration of 2168 Applicants
   B. Approval of University of California, Irvine Committee Member Change

9. Physician Assistant Committee Update – Dr. Low

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

10. Presentation on Physician Assistant's Scope of Practice – Ms. Portman and Ms. Grivett, P.A.

11. Presentation on Use of Electronic Health Records: A Survey of California Physicians – Dr. Coffman, University of California, San Francisco

12. Executive Committee Update – Ms. Yaroslavsky

13. Legislation/ Regulations – Ms. Simoes
    A. 2012 Legislation
    B. Status of Regulatory Action

14. Licensing Committee Update, and Possible Consideration of Recommendation(s) – Dr. Salomonson

15. Physician Responsibility in Supervision Committee Update, and Possible Consideration of Recommendation(s) – Ms. Schipske

16. Enforcement Committee Update – Dr. Low

17. Education/Wellness Committee Update – Ms. Yaroslavsky

18. Update on Strategic Plan Implementation – Ms. Kirchmeyer

19. Update on Federation of State Medical Boards – Ms. Chang

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

21. Update on Licensing Outreach/Education Program – Mr. Schunke

22. Discussion of National Practitioner Data Bank Information –Ms. Kirchmeyer

23. Consideration of Petition to Amend Section 1379.50 of the Board's Polysomnography Regulations – Mr. Heppler and Mr. Salgado

12:00 p.m. Lunch

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

25. President's Report – Ms. Yaroslavsky

26. Executive Director's Report – Ms. Whitney
    A. Update on Staffing and Administration
    B. Budget Overview – Ms. Kirchmeyer
    C. Update and Presentation on BreEZe – Ms. Kirchmeyer and Ms. Balaam
    D. Update on Audit Report – Ms. Kirchmeyer
    E. Status of Sunset Review Report – Ms. Whitney
    F. 2013 Board Meeting Dates and Locations

27. Update from the Department of Consumer Affairs – Ms. Everhart

28. Licensing Chief's Report – Mr. Worden
    A. Staffing
    B. Program Statistics
    C. Status of International Medical School Program
    D. Status of 7/1/12 Licensing for 2065/2066 Applicants

29. Midwifery Advisory Council Update – Ms. Sparrevohn and Ms. Lowe

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
    D. Program Statistics

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

32. Election of Officers

33. Agenda Items for October 25-26, 2012 Meeting in the San Diego 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.

MEDICAL BOARD OF CALIFORNIA

QUARTERLY BOARD MEETING

Doubletree by Hilton Hotel Torrance – South Bay
Salon A & B
21333 Hawthorne Blvd.
Torrance, CA 90503

May 3-4, 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 May 3, 2012 at 3:50 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
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.
Reginald Low, M.D.

Members Absent:

Sharon Levine, M.D.

Staff Present:

Maksim Degtyar, Investigator
Dianne Dobbs, Department of Consumer Affairs, Legal Counsel
Tim Einer, Administrative Assistant
Kurt Heppler, Staff Counsel
Teri Hunley, Business Services Manager
Kimberly Kirchmeyer, Deputy Director
Natalie Lowe, Licensing Manager
Armando Melendez, Business Services Analyst
Regina Rao, Business Services Analyst
Anthony Salgado, Licensing Manager
Jaime Sandoval, Investigator

DRAFT

Kevin Schunke, Outreach Manager
Anita Scuri, Department of Consumer Affairs, Supervising Legal Counsel
Jennifer Simoes, Chief of Legislation
Linda Whitney, Executive Director
Dan Wood, Public Information Officer

Members of the Audience:

Sharon Allison, Kaiser LAMC
Teresa Anderson, California Academy of Physician Assistants
Hilma Balaian, Kaiser Permanente
Rebecca Bramble, AZCOM Midwestern
Humayun Chaudhry, D.O., Federation of State Medical Boards
Genevieve Clavreul
Yvonne Choong, California Medical Association (CMA)
Zennie Coughlin, Kaiser Permanente
Conrad Del Rosario, San Francisco District Attorney's Office
Karen Ehrlich, L.M., Midwifery Advisory Council
Julie D'Angelo Fellmeth, Center for Public Interest Law (CPIL)
Jack French, Consumers Union CA Safe Patient Network
Joseph P. Furman, Furman Healthcare Law
Stan Furmanski, M.D.
Michael J. Grace, Doc Defender
Atoosa Hoisseni, AZCOM Midwestern
Marie Lord, AZCOM Midwestern
Ryan McAtee, AZCOM Midwestern
Michele Monserratt-Ramos, Consumers Union CA Safe Patient Network
Beshoy Nashed, AZCOM Midwestern
Carlos Ramirez, Senior Assistant AG, Office of the Attorney General
Loren Reed, Department of Consumer Affairs, Public Affairs Office
Robert Sachs, P.A., Chair, Physician Assistant Committee

Agenda Item 2 Introduction of New DCA Attorney

Ms. Yaroslavsky welcomed and introduced Dianne Dobbs. Ms. Dobbs is the senior staff council at the Department of Consumer Affairs (DCA). She joined the DCA in June 2007. Since that time she has served as counsel for the Court Reporters' Board, the Respiratory Care Board, the Bureau of Automotive Repair, the Bureau for Private Postsecondary Education, the Inspection and Maintenance Review Committee, the Naturopathic Medicine Committee, and the Hearing Aid Dispensing Committee, and she is currently an instructor for the Department's Enforcement Academy.

Prior to coming to the Department, Dianne worked as a solo practice trial attorney in the areas of business, employment, family probate, and juvenile law. She earned her law degree from Golden Gate University in San Francisco and her MBA and bachelor's degrees in business management from Holy Names University in Oakland.

Ms. Dobbs was introduced to the Board because she will be replacing Ms. Scuri, who is retiring at the end of June.

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A resolution was presented to Anita Scuri on her upcoming retirement on June 30, 2012. Ms. Yaroslavsky commended Ms. Scuri on more than 18 years of outstanding and meritorious service to the Board.

Agenda Item 3 Public Comment on Items not on the Agenda

Dr. Stan Furmanski stated that there could be a problem encountered with regard to sex bias with the Microcog exam. There is a statistical difference between the scores of male and female doctors where the women are alarmingly scoring lower than men. Concern was also voiced about the making of lucrative deals with third party vendors to administer the Microcog exam. The Board has never approved the use of Microcog exams and yet several people in the Enforcement Program are presently requiring doctors to take the Microcog exam.

Michele Monserratt-Ramos from Consumers Union CA Safe Patient Network spoke that her group had met with Ms. Whitney and Ms. Kirchmeyer earlier in the year. She urged the Board to request that DCA webcast all of the Board's public meetings and that the Board post webcasts of the meetings on its website as soon as possible after the meetings are adjourned. It was suggested that the Board should provide a link, available at the time of meetings, so the public can easily access live webcasts and provide public comment. It was also suggested that the Board make clear and prominent on its website the opportunities and rules for public participation in the Board meetings and how written public testimony submitted to the Board is handled. Another request was for the Board to begin teleconferencing of its meetings to allow members of the public to participate in the meeting remotely.

Agenda Item 4 Approval of Minutes from the February 2-3, 2012 Meeting

Dr. Diego made a motion to approve the minutes from the February 2-3, 2012 meeting; s/Chang; motion carried, with Ms. Schipske abstaining.

Agenda Item 5 Update of Pharmacy Board Actions

Virginia Herold, Executive Officer of the CA State Board of Pharmacy, provided a presentation on counterfeit drugs. Ms. Herold urged the Board members that if they believe they have come in contact with a counterfeit drug or a fraudulent transaction involving that drug, that they notify the CA State Board of Pharmacy, as this is part of the CA Business and Professions Code.

Dr. GnanaDev asked how the Board of Pharmacy is working with the FDA and the AG's office on the growing shortage of routine drugs available in hospitals to verify that an entrepreneur will not take advantage of this shortage of drugs and readily come up with more counterfeit drugs.

Ms. Herold explained that regrettably, some entrepreneurs have already done this and are currently under investigation. Ms. Herold advised that prescription medications should only be purchased from a licensed wholesaler. This truly is a FDA issue but, it was advised that if something seems suspicious to report that to the Board of Pharmacy.

Ms. Yaroslavsky inquired about what is being done as far as the coding on pills for identification purposes.

Ms. Herold responded that this is a very new technology where the manufacturer imprints a unique serialized number on a pill so it can be tracked. This is something that could be made available in the future for biotech and advanced products and very expensive pills, because those are the drugs that are being counterfeited.

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Ms. Yaroslavsky inquired if the Board of Pharmacy provides medication alerts on their website.

Ms. Herold informed the Board that they do provide alerts when there is a problem with a particular drug and provided an example of a current recall of a sterile injectable product.

Ms. Yaroslavsky asked about pharmacies receiving medications from abroad.

Ms. Herold strongly urged caution to a either a practitioner or a patient if they buy prescriptions off the internet or from outside the United States.

Ms. Yaroslavsky requested to know if this was legal.

Ms. Herold explained that it is not legal and periodically the FDA will go into the mass mail distribution centers where these products come from and prevent them from doing this.

Agenda Item 6 Update on Pain Management Summit

Ms. Herold continued that she and Ms. Whitney remain steadfast in working together to conduct a joint pain management summit. The tentative dates are November 28-29, 2012 and will most likely take place in the San Francisco Bay Area. The intention of the pain management summit is to discuss appropriate pain management. It will focus on the use of narcotics and other drugs, discuss the CURES program, and deal with communication for ideal pain therapy so that pharmacists understand what prescribers are dispensing and that prescribers understand when pharmacists may call to verify why a particular set of drugs or regiment is prescribed.

Ms. Whitney added that the Board staff has a working group that will provide input. Once ideas and materials are put together, Board staff will then reach out to interested parties. The Board is currently looking at CME for both pharmacists and physicians. The desire is for this to be a working summit for both parties with needed information provided to those individuals.

Dr. Low asked who the target audience would be for the pain management summit.

Ms. Whitney stated that the target audience will be physicians as well as pharmacists. Part of it will be targeting the pain physicians but it will also be a chance for all physicians to develop a better rapport with pharmacists and help with ongoing issues with interconnectivity.

Dr. Carreon made a suggestion to create a comprehensive multidisciplinary meeting. The pain management summit is fine but, there should be more. The problem is much deeper and there should be a multidisciplinary approach to find the root cause analysis that is killing young people in our communities.

Public comment was provided for this agenda item.

Conrad Del Rosario, supervising prosecutor for the San Francisco District Attorney's Office, expressed his support for the pain management summit. The pain management summit will be a great opportunity to bring together the medical community and the law enforcement community. This would afford a platform for his agency to be a resource for the pain management summit and he welcomed this opportunity.

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Genevieve Clavreul voiced concern about the quality of generic medications that are being received. These generic medications involve huge variations to the actual brand prescriptions. There was also a suggestion that the pain management summit should include nurses. Many nurses also prescribe and they have a group that specializes in pain management and those members should be involved in this very important summit.

Joseph P. Furman brought to the Board's attention the organization that he is a part of that provides CME to physicians. It is called Pain Week, Pain.edu. Pain Week is conducted in Las Vegas every year and this year, the five day conference will be held in September, the Tuesday after Labor Day. The convention or CME meeting is for frontline practitioners in pain management, as well as any other physicians. The Federation of State Medical Boards executive directors and assistant US attorneys all are participating. It is precisely as Dr. Carreon noted, a multidisciplinary approach that includes physicians that are in family practice, physicians that are anesthesiologists who are pain management specialists, pharmacists, people in the community who are suffering from chronic pain, and law enforcement. This organization could be an important resource for the Board.

Agenda Item 7 Physician Assistant Committee Update

Dr. Low reported that the most recent Physician Assistant Committee (PAC) was held in February. Two of the members were not reappointed and there are now three vacant positions.

In 2009, a new law became effective that allows physician assistants to obtain a fluoroscopy permit. The Department of Public Health has determined that more regulations will have to be adopted before they can implement these provisions and they are working on that now.

It was reported that the Enforcement Program goals have been met for complaint intake and processing, investigation, disciplinary action, probation intake, and probation violation processing.

The half time licensing position that was vacant for one year has been filled and the PAC is completely current on applications with no backlog.

The PAC has discussed the regulatory proposal to implement legislation governing sponsored healthcare events. This would allow physician assistants licensed in other states to offer their services at healthcare events, similar to the regulations the Board is promulgating. This will remain in the discussion stage for now and a review of the draft language will occur at their May meeting.

There was a regulatory hearing held on the requirements for preceptors and training requirements. A 15-day notice is being sent out and then the PAC will discuss and possibly approve this at its next meeting.

There was a sunset hearing for the PAC held on March 19, 2012. The PAC was represented by the Chairman, Bob Sachs and Executive Officer, Elberta Portman. Some of the recommendations included:

- All of the reporting requirements under the section 800 series of the Business and Professions Code should apply to physician assistants.
- The name of the PAC should be changed to the Physician Assistant Board or the PA Board, as it is the only remaining committee in the Department of Consumer Affairs and

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this would make it consistent with all the other Boards.

- Replacing the PAC's physician member with a PA member. By law, the physician member of the PAC must be a member of the Medical Board. During the hearing, two members of the PAC respectfully requested that the Medical Doctor member be retained to ensure that there is a good line of communication between the Medical Board and the PAC.

The Sunset Committee bill extends the PAC to January 1, 2017.

Ms. Yaroslavsky asked if the three vacancies on the PAC are public members and who appoints them.

Dr. Low and Mr. Sachs replied that currently the three vacancies are for physician assistants and they are appointed by the Governor.

Agenda Item 8 Consideration of Regulatory Proposal to Revise Physician Assistant Scope of Practice (Section 1399.541 – Medical Services Performable)
Mr. Sachs and Mr. Heppler advised the Board that most regulations for Physician Assistants (PA) can be adopted by the PAC. However, any regulations defining the scope of practice of a PA have to be adopted by the Board with the recommendation coming from the PAC.

The PAC is requesting that that the Board amend a current regulation that addresses the medical services that can be performed by a PA and the personal presence of a physician in supervising the PA. The proposal would amend California Code 1399.541 and would update and clarify PA requirements. The new regulation would include that a PA would be able to perform surgical procedures without the supervising physician being physically present in the OR suite as long as a licensed healthcare practitioner administering the anesthesia is physically present in the operating room.

Following a detailed discussion by the Board, a consensus was not reached. Ms. Yaroslavsky recommended that this be sent back to the PAC. Mr. Sachs was advised to work with the PAC staff and the Board staff to bring back something from the PAC that addresses the Board's concerns regarding the wording that this would permit the PA to perform surgical procedures. The current language is too broad and it should address appropriate portions of surgical procedures.

Agenda Item 9 Consideration of Revised Regulatory Proposal Regarding Sponsored Healthcare Events
Ms. Scuri explained to the Board members that previously they approved these sponsored healthcare events regulations which will implement the provisions of section 901 of the Business and Professions Code, relating to sponsored healthcare events, also known as healthcare fairs.

The proposed regulations were disapproved by the Office of Administrative Law (OAL) for reasons relating to the clarity of the registration forms. Board staff has met with OAL and DCA to make the appropriate revisions to the forms and supporting documents. The Board has circulated the revised text for the required 15 days to receive comments.

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Dr. Low made a motion to approve the revisions and to adopt the regulations and to also authorize the Executive Director to complete the rule making file to make any necessary technical changes that may be requested by the control agencies. Furthermore, the motion would include that the regulation would be effective immediately upon filing with the Secretary of State; s/GnanaDev; motion carried.

Agenda Item 11 Physician Responsibility in Supervision Committee Update

Ms. Schipske reported that the Physician Responsibility in Supervision Committee met in Long Beach on April 11, 2012. The purpose of the meeting was to discuss the requirement of SB 100 that was signed into law last year. SB 100 requires the Board to adopt regulations regarding the appropriate level of physician availability needed within clinics or other settings using laser or intense pulse light (IPL) devices for elective cosmetic procedures. The purpose of the discussion was to obtain professional and stakeholder input to assist the Board in drafting regulatory language. The Committee did not have a quorum for purposes of submitting those today to the Board but it is anticipated that they can be submitted at the next Board meeting.

After a robust discussion, there was a general consensus that a physician does not have to be physically present at all times when a laser or IPL device is being used. There was also a general consensus that the telephone is an appropriate mode for being immediately available in many circumstances. Members of the Committee and stakeholders agreed that it would not be appropriate to specifically list procedures that require different levels of availability in the regulatory language and that geographic or chronological limitations should not be included in the regulatory language related to the physician's availability.

Members and stakeholders voiced significant concerns with applying a particular availability standard that would only be applicable where lasers or IPLs are used for elective cosmetic procedure. It was voiced that availability standards should be implemented across the board, not only for elective cosmetic procedures. Another important factor that was discussed was the level of training of the practitioner. Many in the meeting felt that the availability issue is closely tied with the level of training of the practitioner using the laser or IPL and perhaps standards should be developed for the training required to use these devices.

There was discussion around existing law related to what type of procedures can be performed by mid-level practitioners and the requirement in existing law regarding an appropriate exam. There was also discussion around a public education campaign to inform the public of the laws related to outpatient settings and possibly working with the Board of Registered Nursing on educating the public on current law related to nurses. There would also be a reminder to the public, physicians, and mid-level practitioners on the ban on the corporate practice of medicine. The outcome of these future discussions could result in the development of future regulations that could be presented to the Board.

The next step for this Committee is to meet again in June or early July to hold a stakeholder meeting in Sacramento and obtain more input and also have staff from the Senate B&P Committee attend. Future agenda items were discussed, one related to possibly defining "medical spa", and another would be to have a presentation on the fictitious name permit requirements and process.

Dr. Bishop discussed that as a participant in the Committee meeting he did not feel that a consensus had been achieved. He commented that the Committee should come up with some

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recommendations based on common sense and let the community standard of care take the lead.

Ms. Yaroslavsky made the suggestion that this discussion should be continued at their next Committee meeting.

Dr. Low asked legal counsel if the Board still deals with the community standard of care versus the national standard of care? There is a tremendous variability in many communities such as a big city and rural areas and those community standards can be a lot different and there is a lot of danger in using community standard as the reference.

Ms. Dobbs answered that it is generally the community standard of care that is used.

Public comment was received for this agenda item.

Genevieve Clavreul commented that during the Committee update, it was mentioned to work with the Board of Registered Nursing. Ms. Clavreul wanted the Board to know that as of December, the Board of Registered Nursing does not exist and Governor Brown has not appointed anybody since then. It was encouraged that the Board put forth an effort to make sure that there are new members that are part of the Board of Registered Nursing for participation in upcoming Committee meetings.

Agenda Item 12 Enforcement Committee Update

Dr. Low reported the Enforcement Committee had met earlier that afternoon. Mr. Kurt Heppler provided an informative presentation on Enforcement Core Concepts where he discussed concepts that included due process, consumer protection, statutes and regulations. Mr. Heppler also reviewed the Board's function, to license qualified applicants, carry out disciplinary action and promulgate regulations. What the Board does not do is to determine civil liability or award monetary damages.

Ms. Laura Sweet provided the Committee with an update on the expert reviewer training project that is in its final stages. The very first expert reviewer training program is going to be held on May 19, 2012 and there are already over 110 experts that have committed to attending the program. Ms. Sweet also provided a demonstration of the power point presentation that will be utilized during this interactive meeting. The entire process of this program is to standardize expert reviews and hopefully decrease variability and improve quality.

Dr. Low provided an update on a training program for the Administrative Law Judges. Judge Jonathan Lew met with Dr. Low some time ago to go over an agenda that should be used so that there is more standardization amongst the judges. This training program is scheduled for June 22, 2012.

On April 2, 2012, the Board's report to the Legislature on the vertical enforcement and prosecution model was emailed and hand delivered to the legislature. It was distributed to Board members, staff, and posted on the website as well. This report contained actions to implement recommendations made to strengthen the vertical enforcement and prosecution model. The Board in conjunction with the Health Quality Enforcement Section (HQES) of the Department of Justice (DOJ) have implemented some of the more substantial recommendations. These implementations include updating the joint manual, holding a statewide training for Board investigators and HQES attorneys, and as reported earlier an eight hour training module for

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medical expert reviewers that is to be conducted on May 19, 2012. Dr. Low did remark that the Board and DOJ had limited data during the time that the report was completed. The legislature approved the Board to provide only a narrative report and then a full report with the comprehensive data during the Board's sunset review process.

Agenda Item 13 Licensing Committee Update

Dr. Salomonson reported that the Licensing Committee had met earlier that afternoon. At the meeting, Mr. Salgado provided an update on staffing in the licensing program. Positions are being filled, but there are a lot of people in training; they continue to do a remarkable job in a still stressed situation. Mr. Salgado also provided updates on the business process reengineering project with the primary recommendations including revision of the application and streamlining the process, the Board's website relative to the applicants, the Post Graduate Training Authorization Letter (PTAL) process, and revision of the policy and procedure manual.

Ms. Lowe provided an update on implementation of SB 100, regarding the outpatient surgery center requirements and the component that is under the purview of licensing. The Board is implementing a database that is going to appear on its website with information on the status of outpatient centers with respect to the four accreditation agencies. At this time staff is still trying to gather the data in a consistent fashion. However, it was stated that consumers can call the Board and inquire about a particular surgery center and find out about the accreditation status.

Mr. Salgado provided an update on the implementation of the Polysomnography Program (Polysom) and it is now up and running.

Also discussed was an update on the compliance of Section 2168, relating to the special faculty permit holders.

Agenda Item 16 Health Professions Education Foundation Update

Dr. Duruisseau advised the Board that at the last Foundation meeting members discussed the issue of access to care and the affordable care act of 2014 and when implemented, what might be the impact. Many believe that the impact will be enormous and at the same time there was a brief discussion of the Health Professions Education Foundation (HPEF) loan program. It was requested that staff provide statistics on how the recipients are engaged in increasing the accessibility of healthcare and promoting the longevity of primary care physicians in medically underserved areas of California. The statistics requested were to examine the percentage of these physicians staying in these underserved areas after the loan payment program expires. Information from the HPEF was distributed to the members to provide a background of participants, the amount of money that has been awarded, comments about where these physicians are still located and practicing, and useful comments about the population that they are currently serving.

Dr. Duruisseau also focused on the MBC Newsletter and the testimony from five individuals that are participating in the program and the comments that are reflected as a result of their work.

Mr. Schunke provided a summary of the HPEF Loan Repayment Program Awardees. Legislation implementing the loan payment program was enacted in 2002 and the first three award cycles administered by the Board were 2003-2005. These three years are the only information fully available to the Board before the program transitioned to the HPEF. During the three years during which Mr. Schunke administered the program, awards were granted to 69 recipients.

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There is not accurate contact information for all the recipients or current work locations. However, it is believed that about 39% of the awardees, or 27, are still working at the same practice site where they were working when they received the award, and that 24 of them, 35%, are working at other practice sites that are believed to be eligible under the program. Combining those two statistics is 74%. Mr. Schunke concludes that 18 of the awardees or 26%, may have moved on to other sites, some may have been elevated to faculty members at various medical schools around the country, and some may have moved to hospital sites in California.

Before moving onto the next agenda item, Ms. Yaroslavsky requested that Mr. Zerunyan come forward. Mr. Zerunyan was presented with an award for appreciation for his past service on the Board. He was appointed to the Board in October 2006 by former Governor Schwarzenegger and served as Vice President of the Board during 2010 and 2011, and was on the Enforcement, Budget, Access to Care, and Physician Recognition Committees of the Board.

Agenda Item 15 Federation of State Medical Boards Update
Ms. Chang reported the Federation of State Medical Boards (FSMB) recently had its 100 year anniversary and annual conference.

Dr. Chaudhry from the FSMB was introduced and he presented the Board with a plaque. This award honors the Board as a valued member of the FSMB and for serving the public interest and protecting the health of California citizens.

Ms. Chang continued by thanking the participation and commitment by various Board members that are serving on different organizations and committees within the FSMB. Ms. Yaroslavsky has been appointed to the Special Committee on Ethics and Professionalism, as well as Dr. Duruisseau. Dr. Diego is serving on the Post-Licensure Assessment System Program Committee, Dr. Salomonson was appointed to the USMLE Step 3 Committee, and Ms. Chang continues her work on the FSMB Board, the Post-Licensure Assessment System Program Committee, and the FSMB Foundation.

Ms. Yaroslavsky adjourned the meeting at 6:00 p.m. and announced that the Board Meeting would reconvene on Friday, May 4, 2012 at 9:00 a.m.

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Agenda Item 19 Call to Order/ Roll Call
Ms. Yaroslavsky called the meeting of the Medical Board of California (Board) to order on May 4, 2012 at 9:25 a.m. A quorum was present and notice had been sent to interested parties.

Members Present:

Barbara Yaroslavsky, President
Janet Salomonson, M.D., Vice President
Gerrie Schipske, R.N.P., J.D., Secretary
Michael Bishop, M.D.
Jorge Carreon, M.D.
Hedy Chang
Silvia Diego, M.D.
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Dev GnanaDev, M.D.

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Reginald Low, M.D.

Members Absent:
Sharon Levine, M.D.

Staff Present:
Russell Chee, Supervising Investigator I
Dianne Dobbs, Department of Consumer Affairs, Legal Counsel
Tim Einer, Administrative Assistant
Jon Genens, Investigator
Kurt Heppler, Staff Counsel
Teri Hunley, Business Services Manager
Kimberly Kirchmeyer, Deputy Director
Mercedes Lescaille, Investigator
Natalie Lowe, Licensing Manager
Armando Melendez, Business Services Staff
Kathleen Nicholls, Supervising Investigator II
Regina Rao, Business Services Staff
Anthony Salgado, Licensing Manager
Kevin Schunke, Outreach Manager
Anita Scuri, Department of Consumer Affairs, Supervising Legal Counsel
Jennifer Simoes, Chief of Legislation
Mark Smith, Investigator
Robert Wagner, Investigator
Linda Whitney, Executive Director
Dan Wood, Public Information Officer

Members of the Audience:
Sharon Allison, Kaiser LAMC
Eric Alyea, AZCOM Midwestern
Teresa Anderson, California Academy of Physician Assistants
Hilma Balaian, Kaiser Permanente
Michelle Anne Bholat, M.D., UCLA IMG
Maxwell Braverman, AZCOM Midwestern
Ashley Casano, AZCOM Midwestern
Humayun Chaudhry, D.O., Federation of State Medical Boards
Genevieve Clavreul
Yvonne Choong, California Medical Association (CMA)
James Conway, Pacific Assistance Group
Zennie Coughlin, Kaiser Permanente
Ann D'Amato, LA County Medical Association
Julie D'Angelo Fellmeth, Center for Public Interest Law (CPIL)
Rocky Delgadillo, LA County Medical Association
Karen Ehrlich, L.M., Midwifery Advisory Council
Reichel Everhart, Department of Consumer Affairs, Deputy Director for Board Relations
Nathalie Foray, AZCOM Midwestern
Jack French, Consumers Union CA Safe Patient Network
Joseph P. Furman, Furman Healthcare Law
Stan Furmanski, M.D.
Bruce Gipe, M.D., Primary Critical Care Medical Group

DRAFT

Kimberly Grueneisen, AZCOM Midwestern
Randall Hagar, CA Psychiatric Association
Paniz Heidari, AZCOM Midwestern
Bernard Karmatz
Matthew McEwan, AZCOM Midwestern
Michele Monserratt-Ramos, Consumers Union CA Safe Patient Network
Dung Nguyen, AZCOM Midwestern
John Nguyen, AZCOM Midwestern
Carlos Ramirez, Senior Assistant AG, Office of the Attorney General
Loren Reed, Department of Consumer Affairs, Public Affairs Office
Carrie Sparrevohn, Midwifery Advisory Council

Agenda Item 20 Public Comment on Items not on the Agenda

Rocky Delgadillo, LA County Medical Association, welcomed the Board to Los Angeles County. The LA County Medical Association is interested in partnering with the Board and is always looking for new opportunities to work together in healthcare protection campaigning in the county. The LA County Medical Association is currently revamping their Southern California physicians magazine and that is another area for opportunity where the Board could provide content for that magazine. Their association has started a foundation and it is currently in the process of raising money to award scholarships for medical school for underprivileged children.

Dr. Salomonson commented that Mr. Delgadillo recently spoke at her community hospital. She was very impressed and a thought that she had was that if malpractice insurance were more affordable, physicians could stay in the workforce longer on a part-time basis.

Mr. Delgadillo thanked Dr. Salomonson for her comment and that is an issue that he could take with him. The association is currently getting better discounts on medical malpractice insurance coverage and perhaps there is also another way for them to help doctors too.

Dr. Stan Furmanski voiced concerns relating to CPEP and KSTAR. Several employees of the Board are making arrangements with third party vendors who are not qualified to do business in California, in Colorado or anywhere else. It is a misuse of the authority of the Board to have employees threatening doctors that they must go to Colorado to participate in a program that is not licensed here and not licensed in Colorado. Dr. Furmanski provided exhibits for the Board and Mr. Heppler's review.

Julie D'Angelo Fellmeth, Center for Public Interest Law (CPIL) wished Anita Scuri a healthy and happy retirement.

Genevieve Clavreul commented that in the past she had requested from the Board clarification on a prescribing medical order and in return she received a definition on what an apothecary is. Ms. Clavreul specifically wanted to know if it is legal in a specific formula for a physician to write orders for a drug using the apothecary system versus a matrix system. Ms. Yaroslavsky suggested that Ms. Clavreul speak to Deputy Director Kirchmeyer separately and apart from this meeting about this concern.

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Agenda Item 14 Executive Committee Update
Ms. Yaroslavsky pointed out that Executive Committee did meet and they are moving forward on developing and modifying an assessment tool and the evaluation will be taking place at the July meeting.

Agenda Item 21 Presentation on Use of Hospitalists
Ms. Yaroslavsky introduced Dr. Bruce Gipe. Dr. Gipe is well known in Southern California and the world as one of the foremost authorities on what hospitalists mean to modern day healthcare. He is the founder and Medical Director of the Primary Care Group, a hospitalist company based in North Hollywood.

Dr. Gipe provided a presentation that covered three main topics he wished to share with the Board. First, the things that are happening in private practice that effect group practice of hospitalist medicine; second, a history of how the hospitalist group evolved; and finally, an update on certain state of the art hospitals in California and the United States.

Dr. Gipe's full slideshow presentation is available on the MBC website under agenda item 21.

Ms. Yaroslavsky and the Board thanked Dr. Gipe for his extremely informative report.

Public comment was provided for this agenda item.

Genevieve Clavreul provided comment that she felt the presentation was very one sided as she has done quite a bit of research on hospitalists. She strongly urged the Board to look at the whole picture as her research concluded that this is almost seen as a dead end career and it is very difficult for those hospitalists to get promoted or to find a satisfying position.

Agenda Item 22 REGULATIONS – PUBLIC HEARING
Ms. Yaroslavsky opened the public hearing on the proposed regulation to adopt Section 1355.45 in Article 1, Chapter 2, Division 13 in the California Code of Regulations as described in the notice published in the California Regulatory Register and sent by mail to those on the Board's mailing list. The proposed regulation will implement, interpret, and make specific the type of notice required to be submitted to the Board when a physician is no longer incarcerated. This regulation will also provide a definition to the public on the term "inactive" when posted to the Board's Internet site in connection to a physician who is incarcerated and unable to practice medicine. For the record, Ms Yaroslavsky stated the date was May 4, 2012; the hearing began at approximately 10:30 a.m.

One written comment was received and given to the Board members. The written comment did not accurately reflect what the Regulations are prescribed to do. No oral testimony was offered during the public hearing. Ms. Yaroslavsky closed the hearing.

Dr. Duruisseau made a motion to adopt the regulation as it is written and direct the executive director to complete the rule making process; s/Chang; motion carried.

Agenda Item 23 Board Member Communications with Interested Parties
No interested party communications were reported by members.

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Agenda Item 24 President's Report
Ms Yaroslavsky noted that she participates in weekly phone conversations with staff and they always prove to be instructive and informative. She visited the MIND Institute in Sacramento. There has been one phone call with board presidents and the new director of DCA. Ms. Yaroslavsky has also had various phone calls with the Governor's appointment staff and continues to work with them in helping to move on appointments to the Board.

Agenda Item 25 Executive Director's Report
Ms. Whitney announced the Spring Newsletter was available. This edition has links to audio and video files and will continue to become more interactive. Feedback on the Newsletter can be submitted to Public Information Officer, Dan Wood.

Ms. Whitney reported that as she meets with executives from various boards, she has gained insight on similarities and differences with the common goal of consumer protection. She will continue to bring back to the Board or Committees various ideas and discussions in the evolving practice of medicine. One example was a discussion at the Board of Pharmacy regarding a video display of the notice to consumers. This will be a concept that will be forwarded to the Education Committee to review and to determine if the Board's regulations should be examined and possibly revised.

An ongoing review of possible improvements on the Board's website continues in order to provide information to consumers, applicants and licensees. The systematic review will take some time and input is welcome from consumer groups, physician groups, medical societies, hospitals, and any interested parties. Some of these parties will be invited to review material and provide feedback to get the best product for the Board's consumers and licensed physicians.

Ms. Whitney participated in two conference calls with the Federal Drug Administration regarding counterfeit drugs. Some of this information is on the Board's website and will also be included in the Newsletter.

The Administrators in Medicine (AIM), met on April 24, 2012. AIM is a meeting of the executive directors from all the state medical boards and osteopathic boards. Ms. Whitney has materials and will be providing a short summary and information to the members of what was learned in the future.

A. Staffing and Administrative Update
Ms. Whitney informed the Board that she testified at the Senate Budget Sub 4 Committee regarding the need for the Board's Office of Safe Medicine and the positions that go along with it. The Subcommittee approved the proposal to permanently establish the unit with six staff. Subsequently, the Assembly Subcommittee approved it too.

As Ms. Whitney informed the Board on April 23, 2012, the Department of Finance, pursuant to Budget Letter 12-03, swept or took 18.1 positions from the Board's total of 283.2 positions, as part of the salary savings elimination. Since the Board has 15.5 vacant positions from the Consumer Protection Enforcement Initiative (CPEI), this will not significantly impact existing positions. It will eliminate those positions that were targeted to help reduce complaint processing and investigation timelines.

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Ms. Whitney participated in meetings with the DCA Chief Deputy Director and various executive officers to discuss issues related to travel and payment of travel claims. In addition, DCA will no longer allow the purchase of frames or plaques to provide to individuals as this is part of a recognition award and the state does not consider that appropriate.

The Board has received a request from the Donate Life California requesting that the Board send a letter of support to appropriate parties requesting that the California Attorney General issue a statement in support of the interpretation of law that first person consent is the law in California as stated in the Uniform Anatomical Gift Act and is binding after the donor's death. This statement would make it clear to consumers and health care providers that the gift of life after death is binding. Ms. Whitney further clarified that this is to ensure that physicians are not fearful or concerned that if they go ahead and remove organs pursuant to the donor's request that they would not come under scrutiny by this Board or other law enforcements offices. Ms. Whitney concluded that she would complete the letter on behalf of the Board.

Ms. Yaroslavsky stated that this information might be something to include in the Newsletter.

Ms. Kirchmeyer began by thanking the members for their support for the 2011 holiday party. As a token of appreciation, the staff presented the members with a group photo and collage from the party.

A new method of obtaining Board meeting materials has been implemented by utilizing the secure website SharePoint. This current meeting did result in some delays in the electronic transfer due to the size, but staff is looking into possibly posting the materials in different components rather than all together. All future materials for panel meetings and Board meetings will be sent to the SharePoint website. The members were urged to contact the staff if there are any problems with the delivery of materials.

At the last Board meeting it was reported that the Board had 51 vacancies including the CPEI positions. As of May 1, 2012, the Board has 42 vacancies including those positions from CPEI. Of the 42 vacancies, there are approximately 14 individuals awaiting either a background investigation or confirmation of eligibility at DCA so they can be hired. However, there will also be four future vacancies occurring due to staff transferring to other agencies. 42 vacancies equates to a 15% vacancy rate at the Board compare to 18% from the last meeting. If the CPEI positions are removed from those figures, there is actually a 9% vacancy rate. As mentioned by Ms. Whitney, the Department of Finance has indicated that the Board will have 18.1 positions swept, although the specifics of the elimination of these positions are not known at this time. The Board will need to remove 18.1 positions from the 42 vacancies. The Board will not be moving to fill those positions due to the need for elimination of the 18 positions. Ms. Kirchmeyer summarized by stating that there are basically 24 vacancies of which 14 individuals are in background, leaving 10 vacancies. Ms. Kirchmeyer and Ms. Whitney will be meeting to identify the specific positions that will be eliminated once more information is received from the Department of Finance. Positions are being filled as quickly as possible to ensure that the Board is able to perform its mission.

The Board has hired Cynthia Robinson and Anita Winslow in the Executive Office. Ms. Robinson and Ms. Winslow will be providing support services to the Executive staff and the Board members.

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Dr. Diego expressed concern that with 18 positions going away and with 15 vacancies that would mean an additional three positions that would be up for elimination.

Ms. Kirchmeyer confirmed that was correct and more positions from other units within the Board will have to be pulled to meet the number of positions that have to be swept.

Ms. Yaroslavsky also voiced concern and wanted it reflected in the record that this sweep of positions is going to impact the Board's ability to do what is expected of them to do. The issue is the Board's budget is funded by licensing fees and is not part of the general fund budget.

Dr. Bishop added that he wanted the public to understand that the Board's budget is completely paid for by physicians' fees and to take funds away from the Board to use for other state projects essentially creates an excessive tax on physicians.

B. Budget Overview

Ms. Kirchmeyer continued with an overview of the budget. The fund condition is the same as reported at the February 2012 meeting. The Governor's budget included the position authority for reestablishment of six positions in the Operation Safe Medicine Unit. However, the Board was not approved for the funding for these positions and therefore will have to absorb the cost for this unit within the existing budget. Additionally, the BreEZe project was also included in the Governor's budget for a one time augmentation of $1.278 million in fiscal year 2012/2013. Both of these budget change proposals for the positions and augmentations have been approved by the Budget Subcommittees for both the Senate and the Assembly, these approvals will become effective on July 1, 2012.

Ms. Kirchmeyer and Ms. Whitney have discussed with the Board the possible need for two investigators for the Northern Operation Safe Medicine Unit, the data may not support a complete unit equal to the one established in Southern California. It is believed that a smaller Northern California unit can be supported and the Board will be requesting an augmentation for an additional two positions for this unit for the 2013/2014 budget.

The fund condition shows that if the Board spends as planned, it will be within its statutory mandate at the end of the fiscal year 2011/2012 and in the middle of the mandate in fiscal year 2012/2013. The mandate is between two to four months reserve. It is still not prudent to consider any reduction in fees at this time, as previously recommended by the Bureau of State Audits. The Board staff continues to review its fund condition and if the Board continues with expenditures as planned, it will be within the mandate by fiscal year 2012/2013.

Dr. GnanaDev inquired about the figures showing that the reserves would drop to $1 million for 2015.

Ms. Kirchmeyer confirmed that he was correct. If the Board spends as planned, in 2013/2014 it will be at one month reserve. She did indicate that this does not take into consideration the $15 million loaned to the general fund. As soon as the Board is at the point it will not be able to provide services, contact will be made to the Department of Finance to ask for return of the money from the general fund.

Ms. Yaroslavsky inquired about what is mandated in law to maintain a certain percentage or certain amount in reserve.

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Ms. Kirchmeyer confirmed that in statute a two to four month reserve is required. It was mentioned that the current figures do not reflect the final budget for fiscal year 2011/2012 and there should be a more accurate picture at the next meeting.

Dr. GnanaDev requested clarification on the program expenditures jumping from $47 million to $54 million.

Ms. Whitney clarified that the $47 million was actual spending and lower during the 2010/2011 fiscal year due to furloughs and the 5% cut on salaries and also the high number of vacancies due to the hiring freeze. These contributed to not expending to the full authorization.

Ms. Kirchmeyer added that the lower amount is also a result from the inability to travel and also inability to purchase items such as vehicles.

Dr. GnanaDev queried when the interest from the loan to the general fund would be repaid.

Ms. Kirchmeyer responded that when the Board requests the return of the money, the interest would be included.

Ms. Kirchmeyer focused attention to the Board's actual expenditures as of February 29, 2012. The Board continues to remain within the budget allotment and projections indicate that it will continue that way through the end of the fiscal year. The Board is continuing the purchase of the video conferencing equipment for three of the field offices as well as the headquarters office.

The members were reminded to submit travel claims and per diem in a timely manner. This assists in the ability to monitor spending as well as making certain that accurate reports are available for the meetings.

The final budget item discussed was travel. As Ms. Whitney had pointed out, DCA is taking a close look at the travel by staff and Board members to verify that adherence to travel rules including the requirement for the least costly travel to the state. Members need to use the contracted airlines, use a rental car instead of personal vehicle when the travel is more than 100 miles away, use Super Shuttle if it is cheaper than a taxi, and use a rental car if it is cheaper than a taxi. It is the Board's understanding that claims that do not use the least cost to the State may not be completely reimbursed when submitted. The members were encouraged to contact Tim Einer in the Executive Office with any questions when travel arrangements were being made.

C. BreEZe Update

Ms. Kirchmeyer reported that the Board staff is still very involved in the BreEZe project. There currently are multiple staff working full time on the project from the Information Systems Branch. Staff from all of the units are reviewing the system requirements and determining whether it will meet their needs. The system is still scheduled to be implemented in the fall of 2012 and work will continue on communication plans for licensees, interested parties, and the public on this new system. It is planned to have a complete presentation of the new system at the July Board meeting.

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D. Audit Updates

As previously stated, legislation which changed the Board's reserved mandate from two months to between two and four months, 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. This includes but is not limited to its projections related to expenses, revenues, reserves, and the impact of the loan from the contingent fund to the general fund made pursuant to the Budget Act of 2008. This audit is in its final review and the Board has been notified that it will receive the draft sometime between May 14-16, 2012. Once the report is received, the Board will have 10 days to provide a response, which will be reviewed with the budget subcommittee. A copy of the audit and the Board's response will be provided at the next meeting.

Agenda Item 26 Department of Consumer Affairs Update

Ms. Everhart discussed that the Director of DCA has recently met with consumer organizations and other interested stakeholders regarding teleconferencing of Board meetings. DCA continues to look into teleconferencing and legal questions to see if that is a viable option.

Mr. Yaroslavsky inquired about the use of state buildings throughout the state system that have meeting rooms and if DCA has considered using these for meeting or teleconferencing.

Ms. Everhart stated that is one of the options that is being investigated. The other would be to provide a toll free call in number for members of the public but, they would also have to look into who would be required to staff that number to get the questions and then relay those to the members of boards and bureaus of DCA.

Ms. Yaroslavsky cautioned about the use of teleconferencing in the platform of a public meeting. Sometimes the lack of a physical presence makes it difficult to get the gist of what the speaker is communicating without the benefit of seeing them.

Ms. Everhart continued that DCA maintains its efforts to work closely with the Governor's office on Board appointments. She affirmed that DCA will continue to have open communications with the Board for a collaborative working relationship.

Ms. Yaroslavsky expressed several concerns that she requested Ms. Everhart take back to DCA. The first concern is with the Board's vehicles and the use of home storage permits. It is very important that the Board has safe vehicles. It is also important that in order for investigators to do their work, to be able to safely store their vehicles at home and then be able to use them for their investigation work. The second concern relates to continued travel restrictions and the effect that it has for this Board to provide public protection and the timely issuance of licenses.

Public comment was provided for this agenda item.

Hilma Balaian from Kaiser Permanente expressed support for the benefits of Mr. Schunke being able to continue with orientations on best practices. This has been a very valuable tool that creates a smooth licensing process and encouraged the Board and DCA to allow this program to continue.

Genevieve Clavreul reminded the Board of her comment from the prior day regarding the Board of Registered Nursing and that there is only one appointed member out of nine on this Board. Ms. Yaroslavsky advised Ms. Clavreul to communicate her comment directly to Ms. Everhart.

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Agenda Item 27 Licensing Chief's Report

A. Staffing

Mr. Salgado reported that on behalf of Curt Worden, he would like to thank all of the licensing staff as they continue to do an outstanding job and have maintained processing goals for every week during this quarter. The licensing manager position that was last held by Letitia Robinson has been filled by Natalie Lowe. Due to an increased workload in the review of international medical schools, an additional associate governmental program analyst has been requested and is pending approval. Once approved, the Board will advertise, conduct interviews, and hire a new staff person. This position will assist Cheryl Thompson, who is the current international medical school analyst. Licensing currently has three office technician vacancies; two of the vacancies are in the call center and one is in administrative support. These positions have been advertised and interviews are being conducted. Approximately 40% of the licensing staff are in various stages of training for their positions. Even though vacancies have significantly reduced, there is still a great deal of training.

B. Program Statistics

Mr. Salgado reported that during the third quarter of the fiscal year the Board received 1,862 physician and surgeon applications. 1,979 applications were reviewed, including post graduate training authorization letter applications. There are a total of 4,515 pending physician and surgeon applications and of those 3,928 have been reviewed. 587 are pending review and 1,419 physician and surgeon licenses were issued this quarter. During the third quarter, the consumer information unit answered approximately 28,000 phone calls. In application review, last year at this time the initial review of applications was 36 days for US graduates and 30 days for international medical school graduates. The pending mail was seven days for both US and international medical schools. Currently the US file reviews are at 40 days for initial review and the international medical school files are at 30 days for initial review. Pending mail is still seven for both US and international medical school graduates.

The members were referred to the workload report that referenced Strategic Plan Goal 5: Organizational Effectiveness; Objective 5.1: Licensing Applications to be Reviewed Within 45 Days. In the third quarter, the Board had one week of the total 13 weeks where the initial review exceeded the goal of 45 days. However, during that week the Board only exceeded its review by no more than five days.

Business and Profession Code 2065 and 2066 statistics, as of May 3, 2012: the Board received 994 applicant names submitted by the 39 participating hospitals. 947 of these applications have been received and 921 of these applications have been reviewed. Out of the 921 applications that have been reviewed, 616 applicants have been licensed. All of the remaining applicants have been notified by the Board and these applicants are being diligently tracked for licensure at the end of June if all documentation is received.

C. Status of International Medical School Program

Seven additional schools have been recognized under CA Code of Regulations §1314.1 (a)(1). The seven schools are in addition to the two schools that were listed in the Board materials, bringing the total for the quarter to nine newly recognized schools. The additional nine schools impact 14 applicants who are awaiting school recognition before their PTAL could be issued. All other schools have been contacted and the Board is currently awaiting responses in regards to recognition.

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There was discussion from the members about the look up system that licensees access to check on the status of their application and what is missing. Ms. Yaroslavsky verified that there is a system in place that all physicians that apply can look up the status of their application and see exactly what is missing and timeline information. She suggested that this is something that could be added to the Newsletter to remind physicians there is an online look up system available to them after they have applied for licensure.

For the next meeting, Dr. Salomonson requested a percentage breakdown of the number of US/Canadian applicants versus international applicants. This information would be helpful as the processing of international graduates tends to be a much more lengthy process.

Agenda Item 28 Midwifery Advisory Council Update
B. Interested Parties Meeting Regarding Regulatory Proposals Update
Ms. Lowe reported that on March 29, 2012 a midwifery regulations and interested parties workshop was held. Discussions included proposed regulations for section 1379.23, physician supervision and collaborative relationship and section 1379.24 midwifery authority to obtain, order, and administer drugs, devices, and tests. Based on the discussion at the meeting, edits have been made to the proposed regulations and are anticipated to be presented at the August 30, 2012 MAC meeting in Sacramento.

C. Council Update
Carrie Sparrevohn, L.M., the new Chair of the MAC, introduced herself to the Board. Ms. Sparrevohn reported that the interested parties meeting was well attended by midwives from all over the state as well as members of the physician community and ACOG. She looks forward to the presentation of the final language at the August MAC meeting.

One item that has been coming forward is the issue of midwifery students and assistants. Clarity is needed and Ms. Sparrevohn seeks to create a taskforce to look at the issues surrounding this. There is interest in this taskforce who can delve into what the questions are. It can address these issues in a concise manner so that staff would not have to spend so many phone hours responding to these questions and concerns.

The second item that should be discussed within the MAC is the possible setting of term limits for the MAC members. It is important to continue to have valuable input from various members. Rotation of the licensed midwifery community, as well as other interested parties in home birth and midwifery care, could be helpful.

Another agenda topic for the MAC will be the discussion and approval of the language of the proposed regulations based upon the interested parties meeting.

One final item is the shifting of the data collection to a system that is already in place. Currently the data for the MAC is collected in a retrospective manner and this is not a very reliable method for data collection. The Midwives Alliance of North America has been gathering information on home births throughout the country and Canada for greater than 12 years. Ms. Sparrevohn would like to convene a taskforce to look at the feasibility of going forward with using the Midwives Alliance of North America as a data collection tool.

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A. Discussion and Consideration of Appointments to the Council

Ms. Lowe cited that existing law requires the Board to appoint members to the MAC. At the February 2-3 quarterly Board meeting, it was determined that vacant public member positions on MAC would be filled by one California licensed physician practicing in the area of obstetrics/gynecology and one non-licensee of the Board. In addition there is a vacant Board licensed midwife. 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 this May 2012 meeting.

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

Ms. Chang made a motion to accept the request to appoint Karen Ehrlich to a three-year term in the Licensed Midwife position with the MAC; s/GnanaDev; motion carried.

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.

Dr. GnanaDev made a motion to accept the request to appoint James Byrne, M.D. to a three-year term in the Public Member position with the MAC; s/Diego; motion carried.

Ms. Monique Webster has a Master's degree in Public Heath 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.

Ms. Chang made a motion to accept the request to appoint Monique Webster to a three-year term in the Public Member position term with the MAC; s/Low; motion carried.

Ms. Schipske made a motion that the agenda items for the next MAC meeting on Aug 30, 2012, would include the discussion to create a taskforce for issues concerning midwife students and assistants, setting term limits on members of the MAC, discussion of the proposed regulation changes and a discussion on data collection; s/Chang; motion carried.

Agenda Item 29 Presentation: FSMB Centennial Meeting and Projects of the Board

Ms. Chang introduced Dr. Humayun "Hank" Chaudhry, the President and CEO of the Federation of State Medical Boards (FSMB) of the United States.

Dr. Chaudhry provided a presentation that highlighted what the FSMB does for the Board, new directions on its vision and mission statement, its structure and function and how it seeks to be

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the leader in medical regulation. The goal is to share with each state best practices to encourage the practice of safe medicine.

At the heart of the FSMB work are three elements:

1) Advocacy
2) Education
3) Data

Dr. Chaudry's full presentation is available on the website under agenda item 29.

Agenda Item 17 Licensing Outreach/Education Report

Mr. Schunke provided an update to the 2012 matrix statistics. There are 39 hospitals participating this year and four of these are new. Of the 39, there are two from last year that are not participating this year because all of their residents are already licensed. Mr. Worden and his licensing staff are to be commended for their tremendous work. There are almost 1,000 names on the matrix however last year at this time there were almost 1,500. There are 616 individuals that have already been licensed. Unfortunately, of the names that have been reported to the Board, there are still about 50 people who have not applied. Invariably it is two to three weeks before the licensing deadline when the Board generally receives the last applications. There are also approximately 11 people whom need a license this summer that have been identified as having a significant licensing issue whether it be a criminal history, dishonesty, performance issues, or substance abuse problem, and will be reviewed and considered in a separate process.

Outreach at the teaching hospitals continues. Some of the smaller hospitals that have not participated in the past now have residents asking their GME offices to contact the Board. Mr. Schunke is not expending additional funds to visit these smaller hospitals; coordination is being made to include them when they are in the geographic area of a large hospital that is being visited. This is to be mindful of travel restrictions.

Public comment was provided for this agenda item.

Hilma Balaian, from Kaiser Permanente expressed concern that the Federation timeline for the USMLE Step 3 test results are going to come out during a period of time when they are already very busy getting licenses ready for the July deadline.

Ms. Yaroslavsky thanked Ms. Balaian for bringing this to the Board's attention and suggested that staff contact the Federation and inform them of this concern.

Agenda Item 32 Legislation/Regulation

Ms. Simoes reported that per the strategic plan, she contacted over 40 legislative district offices to let them know that the quarterly Board meeting was being held in Southern California and to extend an invitation to them. Ms. Simoes continues to meet with legislative and committee staff on a daily basis on Board sponsored bills, bills where the Board has a position, and on bills or issues that surface that might impact the Board.

Board Sponsored Bill:

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

  This bill would authorize a pilot for the University of California (UCLA) International Medical Graduate (IMG) program. The pilot would allow program participants to engage in

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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. 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 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 of expansion of the pilot program. The bill would sunset the pilot program on January 1, 2019.

Some amendments were taken. The amendments 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.

This bill has not received any "no" votes. It was on consent in Assembly Appropriations and on the Assembly Floor, and is currently in the Senate, awaiting hearing in the policy committee.

Public comment was provided for this agenda item.

Michelle Anne Bholat, M.D. from the UCLA IMG program provided public comment. Dr. Bholat provided a background of the UCLA IMG program as an innovative approach to help address the healthcare issue of physician work shortage in California. Dr. Bholat thanked the Board for its support of this bill.

- **Omnibus**
- **SB 1575** (Senate B&P)
  This bill is the vehicle by which omnibus legislation has been carried by the Senate Business, Professions and Economic Development Committee (B&P). 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 other technical changes. This bill passed out of Senate B&P Committee on consent and is now in the Senate Appropriations Committee.

  There is language being proposed by Senate B&P Committee and this language is to extend the sunset date of the Vertical Enforcement Program (VEP) to the same date as the Board's sunset, from 1/1/13, to 1/1/14. This change will allow for the full evaluation of VEP as part of the Board's 2013 sunset review process.

Public comment was provided for this agenda item.

Julie D'Angelo Fellmeth, Center for Public Interest Law (CPIL) asked for clarification if the entirety of HQE would go away on January 1 and if they would have to be extended as well.

Ms. Simoes confirmed that the VEP part of HQE would go away on January 1.

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- **SB 1236** (Senate B&P Comm.)
  This is a sunset bill that impacts the Physician Assistant Committee. This bill is still in the beginning stages of development so staff is not bringing it to the Board for a position at this time. This bill would create the Physician Assistant Board, which would no longer be under the auspices of the Medical Board. Staff will continue to watch this bill closely and bring it to the Board for a position at the July Board meeting.

A. 2012 Legislation

- **AB 1621** (Halderman) Physicians and Surgeons: Prostate Cancer
  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.

Dr. GnanaDev made a motion that the Board support AB 1621; s/Low; motion carried.

- **AB 1896** (Chesbro) Tribal Health Programs: Health Care Practitioners
  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 tribal health programs from California licensure, if they are licensed in another state.

  Board staff will continue to work with the California Rural Indian Health Board (CRIHB), the author's office, and other interested parties to ensure that if this bill passes, it is implemented in a way that will ensure consumer protection for all patients served in tribal health programs. No vote was necessary as the Board does not need to take a position at this time. It may be presented to the Board in July for a position.

- **AB 2561** (Hernandez) Certified Surgical Technologists
  This bill would define certified surgical technologists (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. The bill does not raise any concerns for the Board; staff suggested the Board be neutral on this bill.

Dr. Duruisseau made a motion that the Board take a neutral position on AB2561; s/Bishop; motion carried.

- **AB 2570** (Hill) Licensees: Settlement Agreements
  This bill would prohibit licensees within DCA 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.

Dr. GnanaDev made a motion that the Board support AB 2570; s/Duruisseau; motion carried.

- **SB 1095** (Rubio) Pharmacy: Clinics
  This bill is sponsored by the California Ambulatory Surgery Association (CASA) and 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

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purchase drugs at wholesale for administration or dispensing to clinic patients for pain and nausea under the direction of a physician.

Dr. Salomonson made a motion that the Board support AB 1095; s/Duruisseau; motion carried.

- **SB 1274** (Wolk) Healing Arts: Hospitals: Employment
  This bill would allow Shriners Hospital for Children (Shriners) to continue to employ physicians and allow the hospital to bill insurers for the services rendered to patients with insurance coverage.

Dr. Duruisseau made a motion that the Board support SB1274; s/Chang

Dr. GnanaDev did voice concern that this should only be applicable for Shriners.

Ms. Simoes explained that this bill has been crafted to only apply to Shriners.

Ms. Yaroslavsky called for the vote. Motion carried.

- **SB 1338** (Kehoe) Abortion
  This bill was recently significantly amended in policy committee and would now only allow a nurse practitioner, certified nurse midwife or physician assistant who has completed training through the Heath Workforce Pilot Project No. 171, to be authorized to continue to perform abortions by aspiration techniques. The staff suggested the Board not need to take a position on this bill at this time.

- **SB 1416** (Rubio) Medical Residency Training Program Grants
  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 would be required to be appropriated by the Legislature. The bill was amended to require OSHPD, in consultation with the California Healthcare Workforce Policy Committee, to develop criteria for distribution of available moneys in the fund by December 31, 2013. This bill would also require OSHPD to give priority to programs that meet particular specifications.

Dr. Duruisseau made a motion that the Board support SB 1416; s/Diego; motion carried.

- **SB 1483** (Steinberg) Physician Health Program
  This bill is sponsored by the California Medical Association, the California Hospital Association, the California Psychiatric Association, and the California Society of Addiction Medicine. 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. The bill would require the DCA to select a contractor to implement the PHP, and the 14 Member Committee would serve as the evaluator of the PHP. The PHP would provide for confidential participation by the physicians who have a qualifying illness and are not on probation with the Board. The PHP would refer physicians (participants) to monitoring programs through written

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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.

Staff presented some major concerns with this bill. One area of concern is the program is currently located in the Medical Practice Act. Also, the bill does not identify a state agency to have oversight of the Committee and the PHP, and there is no funding source identified to support the PHP and the Committee. 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, which is counter to positions that the Board has taken in the past. In addition, the Board may be responsible for funding this bill through increased licensing fees; the Board has previously opposed bills that would have created similar programs that were funded by increased fees without any oversight or control of the expenditures by some state entity.

There are also concerns related to the definition of "physician and surgeon" in this bill, as it includes medical students and residents 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.

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. Staff did meet with the sponsors to discuss these issues. The sponsors relayed that they were okay with moving the provisions of this bill out of the Medical Practice Act and into the general code sections. It was communicated to Board staff that this bill will eventually be amended to include language that will fund the PHP and the Committee through a $40 fee on all licensees, similar to the $25 fee on licensees that funds the Stephen M. Thompson Loan Repayment Program.

Staff suggested an opposed unless amended 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 does not increase licensing or renewal fees.

Dr. GnanaDev made a motion that the Board support SB 1483 if amended; s/Schipske

The Board discussed that in concept they support the effort of wellness in healthcare providers. There are still many unclear points of information that need to be addressed in this bill before the Board can make an informed decision.

A motion was made by Dr. Bishop to table this bill for further discussion at the next Board meeting; s/Chang

Public comment was provided for this agenda item.

James Conway of the Pacific Assistance Group urged the Board to support this bill. Mr. Conway spoke that what he encounters constantly from hospitals and the well being committees is confusion and questions about direction. They would like for the Board to have a defined

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position on this. Mr. Conway would like the Board to support the creation of a viable California early intervention program.

Julie D'Angelo Fellmeth from the Center for Public Interest Law (CPIL) informed the Board that she supported the motion to table this bill. It appears that this bill is still a work in progress and there are too many items that still need to be amended. There were several things in the bill that Ms. D'Angelo Fellmeth did wish to point out. First it does not create a diversion program and it does not prevent the Board from continuing to investigate and take disciplinary actions against substance abusing physicians, even if they go into the program that eventually gets created by this bill. The second any program created by this bill must adhere to the uniform standards that were developed by the Substance Abuse Coordination Committee of the DCA pursuant to Senate Bill 1441. So far this bill does clearly require any program that gets created by this bill to adhere to those standards. Finally, it is felt that the program should report to the Board if a physician who is a participant in the program violates the contract he or she signed. The language is not there yet and it was urged that the Board should not take a position until July.

Randall Hagar of the California Psychiatric Association appeared before the Board on behalf of the sponsors. There are still pieces that need to be combined and integrated. Mr. Hagar stated that he appreciated this process and the motion on the table and would be happy to answer any questions that the Board might have.

Yvonne Choong of the California Medical Association (CMA) suggested that the Board consider either supporting in concept or taking a neutral position. This is being envisioned as an entity that would help to coordinate all of the many aspects involved in somebody's recovery; the treatment, the monitoring, not directly delivering those services but making sure they are delivered appropriately and that there is some central point of contact both for the Board, employers, and hospitals to know that when a physician says that they are in recovery, they are getting services from reputable sources.

Michele Monserratt-Ramos from Consumers Union CA Safe Patient Network stated that the lack of funding was a concern and there was an item that needed to be refined regarding what should be reported to the Board and what would not be reported to the Board. Ms. Monserratt-Ramos stated that this process of selected reporting is not reasonable for the Board or for consumers. She wished that the Board would oppose SB 1483.

Bernard Karmatz encouraged the Board to take a support position with the understanding that these amendments are just at the brink of being brought forward and all of the issues of concern to the Board will be addressed.

Ms. Yaroslavsky called for the vote. Motion carried, with Ms. Schipske voting no.

- **SB 1488** (Yee) Traditional Chinese Medicine: Traumatologist Certification
  This bill would define Traditional Chinese Medicine (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 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. The Council would issue certificates for certified TCM

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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.

Staff is bringing this bill to the Board's attention because a member of the Board would be required to sit on the Council. Board staff suggested that the Board does not need to take a position on this bill at this time as there are issues that still need to be addressed to make this bill operational.

- **SCR 69** (Pavley) CA Autism Awareness Month
  This concurrent resolution would designate April 2012 as California Autism Awareness Month. This resolution would affirm the Legislature's commitment to autism spectrum disorder (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.

Staff suggested that the Board take a support position, 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.

Dr. Duruisseau made a motion that the Board support SCR 69; s/Low; motion carried.

Status of Pending Regulations:
Ms. Simoes requested that the Board review the regulation matrix that lists the status of all regulatory proposals in process.

Agenda Item 18 NPDB Feasibility
Ms. Kirchmeyer discussed that at the February 3, 2012 Board Meeting, a suggestion was made encouraging the Board to look into the cost benefit analysis of querying the National Practitioner Data Bank (NPDB) every two years, at the time of a physician's renewal. Staff completed an analysis of this suggestion and based upon the cost of the query and the insignificant number of hospital reports not received by the Board, Board staff recommended that this not be pursued because there is an alternative that has already been implemented.

Dr. GnanaDev made a motion to adopt the staff recommendation; s/Salomonson;

Public comment was provided for this agenda item.

Julie D'Angelo Fellmeth, from CPIL informed the Board that a valid source of information that the Board receives is from the NPDB. It contains licensing and disciplinary information from all states, hospital disciplinary action, and medical malpractice payout information. Because the Board does not query the NPDB with the exception of doctors who are being newly licensed and who are already licensed in another state, and occasionally during a disciplinary matter, the Board could be missing out on some critical information. It was conveyed that the Board should reconsider its decision.

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Ms. Yaroslavsky requested that staff bring back additional information on the NPDB to the July 2012 meeting. Ms. Kirchmeyer stated that she would bring to the meeting the statistics that were provided to the Board by the NPDB.

Dr. GnanaDev withdrew the motion.

Michele Monserratt-Ramos from the Consumers Union CA Safe Patient Network referred to the memo prepared by Board staff that identified 20 cases in which 805 reports made to the NPDB did not have a matching report made to the Board. It was suggested that the Board investigate why these 805 reports did not have an accompanying or matching reports. The Board was urged to take advantage of this important information source and should consider gathering this information on a pilot basis to learn what the benefits actually are.

Agenda Item 30 Enforcement Chief's Report

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

Ms. Whitney requested approval for 11 orders restoring license to clear status following completion of probation and five orders for license surrender during probation or administrative action.

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

B. Expert Utilization Report

Ms. Whitney reported that the Enforcement Program used 117 experts in the first quarter of 2012, 158 cases were sent to experts. There currently are a total of 1,125 experts and some of them will be attending the training on May 19, 2012.

C. Enforcement Program Update

On April 12, 2012, the HQE supervising DAGs met via video conference with the Board regional supervisors and management for a quarterly sharing of issues and resolutions. This was a productive meeting with some research assignments. The next scheduled meeting is in June.

The Enforcement Program has 16 vacancies but most of these investigator positions have an individual in the background process. There are two supervisor vacancies, one in Fresno and one in Pleasant Hill, due to the promotion of Teri Bennett, who was a Supervisor I and has now been promoted to the Northern Area Supervisor II position. The Program hopes that most backgrounds will be completed by June 30, 2012.

Also included in the report was the strategic plan goal for reducing the timelines and processing 50% or more of the Programs complaints within 50 days. The Program is not there yet, but will continue to strive to meet this goal.

A discussion continued regarding the number of average days it takes to complete a complaint investigation. One of the ways it will hopefully be reduced is to lower the number of days that the Board will be asking the medical experts to provide a review of a case. The Board will be asking for a review in two weeks instead of 30 days. In terms of the investigation, at the time of the report there were six offices that were under the 180 day average, which is in the statutory goal. It is believed that once vacancies are filled, all offices will be down to the average 180 day timeframe.

Dr. GnanaDev voiced concern with the length of time it takes to complete the investigation and what the options would be to take a physician out of practice if they were truly harming someone.

Ms. Whitney explained the Interim Suspension Order (ISO) is used in a case where a patient is being harmed.

Agenda Item 31 Vertical Enforcement Program Report
Mr. Carlos Ramirez provided a handout on the post accusation average timeframes and an analysis about the aspects of the case processing times.

Mr. Ramirez directed the Board to four recommendations that could prevent cases from accruing additional time:

1. Work with the Office of Administrative Hearings to initiate the hearings in Board cases within 180 day of receiving the request to set. This will possibly cut the time by 40 days.
2. Request that the Office of Administrative Hearings adopt a uniform statewide procedure for setting hearings in Board cases. Currently the system that is used in Sacramento and Los Angeles is far superior and has more formality than the other methods that are being used in San Francisco and San Diego.
3. Adopt the State Bar Disciplinary Model and create an in-house panel of Administrative Law Judges. It is an expensive option but it does provide the Board the option of hiring their own Administrative Law Judges to hear only Board cases.
4. Request that the Judicial Council modify its rules and reduce the waiting period to file a motion to dismiss for failure to prosecute a case to one year.

Agenda Item 10 Update of Strategic Plan Implementation
Ms. Kirchmeyer discussed the updates of the strategic plan.

Objective 1.1: Examine current continuing medical education (CME) structure, its effectiveness, the current California requirements, and opportunities for improvement.
There will be an extension of the due date on this objective. Statistics will be gathered to look into the current CME structure. Because of the lack of a licensing manager, these statistics have been deferred to the July 2012 Board meeting.

Ms. Yaroslavsky asked what the relevant importance is that rises the priority to an A level.

Ms. Kirchmeyer explained that priority level A was mandated or mandatory functions.

Objective 1.5: Conduct a comprehensive review of international schools.
The presentation of the history of international medical schools has been moved to the July Board meeting due to travel restrictions. Additionally, the update and revision of the application process has been moved due to the lack of staffing in the licensing unit.

Objective 2.7: Identify opportunities to better educate judges/hearing officers.
The examination of the disciplinary decisions to determine if they meet the Board's mission to protect the public will be deferred until this summer.

Goal 3: Consumer and Licensee Education: Increase Public and Licensee awareness of the

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Board, its mission, activities and services.
Several of these objectives have actually been updated but, they are going to move forward and go before the Education Committee. Mr. Wood is putting together a complete plan that will be reviewed and discussed at the upcoming Education Committee and these objectives will be updated after that plan has been approved by the Committee.

All other objectives in the plan are on target for completion or have been completed. Staff will continue to provide updates at each meeting on the progress of the objectives so the Board knows how it is meeting its goals and objectives.

Agenda Item 33 Agenda Items for July 19-20, 2012 Meeting in the Sacramento Area
The Licensing Committee will have a full presentation on SB 100 implementation and the full Board will respond to questions raised at the Licensing Committee meeting.

There will be a presentation of the PA scope of practice.

There will possibly be a presentation of critical care practitioners in medicine.

Staff will report back on the National Practitioner Data Bank.

Agenda Item 34 Adjournment

There being no further business, Dr. Duruisseau made a motion to adjourn; s/Salomonson; motion carried.

The meeting was adjourned at 3:50 p.m.

_____
Barbara Yaroslavsky, President

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

_____
Linda K. Whitney, Executive Director

DRAFT

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Memorandum

Date: July 10, 2012

To: Board Members

From: Kevin A. Schunke, UCD Telemedicine Project Manager

Subject: UCD Telemedicine Project

Assembly Bill 329, carried by Assembly Member Nakanishi in 2007, authorized the Medical Board of California to establish a pilot program to expand the practice of telemedicine in California. The purpose of the pilot is to develop methods, using telemedicine, to deliver health care to persons with a chronic disease. The pilot also shall develop information on the best practices for chronic disease management services and techniques and other health care information as deemed appropriate.

In the long term, the pilot strives for an outcome that documents improved methods of teaching personal health care maintenance to a patient with a chronic disease and, with this increased knowledge, it is hoped that objective lab data from the pilot will reflect the improvements in the patient's self-managed care of the disease.

The bill required the Board to make a report to the Legislature, with findings and recommendations, within one calendar year after the commencement date of the pilot. The report was to include an evaluation of the improvement and affordability of health care services and the reduction in the number of complications achieved by the pilot. However, as was explained in previous reports to the Legislature, the Board entered into a contract for a three-year pilot and has submitted reports in 2010 and 2011. Both of these annual reports have been presented to the Board and are posted on the Web site.

Dr. Jim Nuovo from the University of California, Davis is principle investigator of the team guiding this project. During the past two years, Dr. Nuovo and the members of his team presented a summary of the project to the Board and will attend the July 20, 2012 meeting to present the preliminary findings and experiences of the pilot. Since the contract ended on June 30, 2012, the data now is being reviewed and evaluated. The final report will be prepared during the fall of 2012, to include an evaluation of the entire pilot and to prepare evidence-based recommendations. That report will be forwarded once finalized.

If you have any questions about this agenda item, please contact me at (916) 263-2368 or via email at kevin.schunke@mbc.ca.gov.

Development of a Diabetes Self-Management Education Program Delivered via Telemedicine to Rural Communities in California 2009/2012

Welcome to Tulelake

AB329 (Nakanishi)

- The Assembly bill required the conduct of a pilot program to develop methods using a telemedicine model of delivering health care to those with chronic diseases and delivering other health information.

Acknowledgments

- Medical Board of California
- UCDHS Chronic Disease Management Program
- UCDHS Center for Healthcare Policy & Research
- UCDHS Center for Health & Technology

Acknowledgments

- Thomas Balsbaugh, MD
- Gisela Escalera
- Teresa Farley, BA
- Erin Griffin, PhD
- Stuart Henderson
- Julia Huerta, MPH
- Bridget Levich, RN, MSN, CDE
- Jim Nuovo, MD
- Mauricio Rodriguez
- Kevin Schunke
- Glee VanLoon, RD, CDE

WESTERN SIERRA
MEDICAL CLINIC
COMMUNITY HEALTH
CENTER
"SERVING THE COMMUNITY'S
MEDICAL AND DENTAL NEEDS."

Acknowledgments

- Sierra Family Medical Clinic
- Western Sierra Medical Clinic
- Eastern Plumas Healthcare
- Lassen Medical Group
- Tulelake Health Center
- Miners Family Health Center
- John C. Fremont Healthcare District
- Southern Trinity Health Service
- Jackson Rancheria Health Center

Project Goal

- To test a model for improving access to diabetes self-management training and resources via telemedicine technology for patients in rural communities in northern and central California.

Rationale

- The informed, activated patient in concert with the prepared, proactive healthcare team can improve outcomes.
  - From the Chronic Care Model: www.improvingchroniccare.org

Methods

- Provided a 2-hour class on diabetes to patients who received their care at these nine clinics.
- Assessed the impact of these classes on a variety of outcome measures.

00:00:00
-00:00:00

Methods

- Performed an extensive survey of the participants at these rural clinics:
  - Demographics
  - Self-Management Behavior
  - Knowledge About Diabetes
  - Confidence

Methods

- Assessed participants 6-8 weeks post-intervention.
- Performed chart audit.

Demographics

- 239 participants
- Average age = 63 years
- Women (61%); Men (39%)
- White (77%); Hispanic (9%); Native American (8%)
- High School (76%)
- Access to the Internet (68%)
- 93% either Medicare/Medical

Water Rotation

Demographics

- Over half had diabetes for more than 5 years.
- 85% had Type 2; 9% did not know the type of diabetes they have.

Demographics

- Medications:
  - Oral agents 61%
  - Insulin 9%
  - Insulin/Oral Agent 10%
  - No medications 20%

Demographics

- Most had the following co-morbid conditions:
  - Hypertension 56%
  - Hyperlipidemia 40%
  - DJD 37%

My Diabetes Care

- Participants were asked 20 questions about how often they received diabetes-specific care over the past 6 months at their doctor's office.
  - Scale: "1" = None of the time.
  - Scale: "5" = Always

My Diabetes Care

- The average scores were in the range of 2.5 to 3.6.

Self-Care and Confidence

- A series of questions about self-care and confidence were asked.

Self-Care and Confidence

- There was a statistically significant reduction in feeling overwhelmed with diabetes from the pre-test to the 6/8 week follow-up period.
- 18.8% felt overwhelmed at the pre-intervention survey; 5.4% felt overwhelmed at the 6/8 week post-intervention survey ($p < 0.01$).

Self-Care and Confidence

- Statistically significant changes were observed for the number of days participants did at least 30 minutes of exercise and the number of days participants checked their feet per week.
  - Exercise pre-intervention mean = 3.4 days; post-intervention mean = 3.9 days ($p < 0.01$)
  - Foot check pre-intervention mean = 4.2 days; post-intervention mean = 5.6 days ($p < 0.01$)

Knowledge About Diabetes

- There were a series of questions designed to assess the participants knowledge of diabetes:
  - How much do you know about?
    - The effect of carbohydrates on your blood sugar?
    - Reading food labels?
    - Portion size?
    - The benefits of exercise?
    - The importance of checking your feet?
    - The benefits of longterm blood sugar management?

Knowledge

- There were significant changes from the pre-test to the post-test in these knowledge areas that persisted through the 6/8 week follow-up period ($p < 0.01$).

Summary of Findings

- Self-confidence improved.
- Knowledge improved.
- Self-care behavior improved.
- These findings came from a 2-hour class and they persisted over a 6 to 8 week follow-up period.

Tulelake Super Market

Impact on Outcomes/Costs

- Patients with DM on average incur costs that are 2.4X more than age-matched cohort.

Impact on Costs/Outcomes

- Foot pathology is the most common complication of DM leading to hospitalization.
- Foot pathology accounts for approximately 1/3rd of the costs for diabetes care.

Estimated Costs

- Uncomplicated Foot Ulcer
  - $2000-$4000
- Complicated Foot Ulcer
  - $15000-$25,000
- Amputation
  - $107000-$145000

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

July 10, 2012

To: Members, Medical Board of California

From: Virginia Herold
Executive Officer
California State Board of Pharmacy

Subject: Emergency Contraception Protocol of the Medical Board of California with the California State Board of Pharmacy:
Proposed Amendments to Title 16, Section 1746 – Emergency Contraception Protocol

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Background

Business and Professions Code Section 4052.3 authorizes a pharmacist to initiate emergency contraception therapy in accordance with either (1) standardized procedures or protocols developed by the pharmacist and an authorized prescriber, as specified; or (2) standardized procedures or protocols developed and approved by both the Medical Board of California and the Board of Pharmacy, as specified.

The current state protocol was developed by the Medical Board in 2004 and was adopted by the Board of Pharmacy as a regulation later that same year. Title 16 CCR § 1746 became operative on December 2, 2004. Since that time, there have been changes in the availability of emergency contraception medicine, the manufacturers who produce the medication. The protocol also has a typographical error that requires correction (mcg instead of mg).

In October 2011, the board voted to initiate a proposed rulemaking to update the board's emergency contraception protocol at Title 16 Section 1746, to reflect the language and protocol approved by the Medical Board of California in July 2011. The board noticed the proposed regulation on January 6, 2012, and the 45-day public comment period concluded on February 20, 2012. The board received one comment during that period (**Attachment 1**). Both Shannon Smith Crowley, the Medical Board's technical expert and Kathleen Hill-Besinque, the California Pharmacists Association, technical expert, agreed there was no need to accept the written comment submitted.

Specifically, at the May 1, 2012 Board of Pharmacy Meeting, Dr. Besinque appeared before the board to answer questions related to the proposed protocol Thereafter, the board voted to reject the comments received during the 45-day public comment period.

Following the May 2012 Board Meeting, Dr. Besinque provided the board with suggested modifications to the Table of Dedicated Emergency Contraception (at Section 1746 (b)(11)) to provide clarity on the administration of the two-tablet regimes.

Attachment 2 contains a copy of the revised EC Protocol contained in section 1746, showing these modifications in the Table of Dedicated Emergency Contraception.

This version is being considered by the Board of Pharmacy at its next meeting on July 17-18, 2012.

At this Medical Board Meeting

The next step is for the Medical Board of California to consider the 45-day comment. If the Medical Board does not accept this comment, and if the Medical Board approves the final version of the protocol provided in **Attachment 2**, the Board of Pharmacy will finalize the rulemaking.

Following the adoption of a new emergency contraception protocol, the board will then need to update its patient information fact sheet. This fact sheet is required by Section 4052.3(e) of the Business and Professions Code and is provided to the patient by the pharmacist using the protocol to dispense emergency contraception. The Medical Board will have a chance to review the fact sheets as well.

Board of Pharmacy
Modified Language

To Amend § 1746 in Article 5 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

§ 1746. Emergency Contraception

(a) A pharmacist furnishing emergency contraception pursuant to Section ~~4052(a)(8)~~ 4052.3.(a)(2) of the Business and Professions Code shall follow the protocol specified in subdivision (b) of this section.

(b) Protocol for Pharmacists Furnishing Emergency Contraception (EC).

~~(1) Authority: Section 4052 of the California Business and Professions Code authorizes a pharmacist to furnish emergency contraception pursuant to the protocols specified in Business and Professions Code section 4052.3. Use of the following protocol satisfies that requirement.~~

(1) Authority: Section 4052.3(a)(2) of the California Business and Professions Code authorizes a pharmacist to furnish emergency contraception pursuant to a protocol approved by the California State Board of Pharmacy and the Medical Board of California. Use of the protocol specified in this section satisfies that requirement.

(2) Purpose: To provide timely access to emergency contraceptive medication ~~within required limits~~ and ensure that the patient receives adequate information to successfully complete therapy.

(3) Procedure: When a patient requests emergency contraception, the pharmacist will ask and ~~state~~ communicate the following:

> Are you allergic to any medications?
>
> Timing is an essential element of the product's effectiveness. EC should be taken as soon as possible after unprotected intercourse. Treatment may be initiated up to five days (120 hours) ~~of~~ after unprotected intercourse. ~~EC effectiveness declines gradually over five days and EC use will not interfere with an established pregnancy.~~
>
> EC use will not interfere with an established or implanted pregnancy.
>
> If more than 72 hours have elapsed since unprotected intercourse, the use of ella™ (ulipristal) may be more effective than levonorgestrel. Other options for EC include consultation with your physician regarding insertion of an IUD.

(4) The pharmacist shall provide ~~the~~ a fact sheet and review any questions the patient may have regarding EC. In addition, the pharmacist shall collect the information required for a patient medication record required by Section 1707.1 of Title 16 of the California Code of Regulations.

Fact Sheet: The pharmacist will provide the patient with a copy of the current EC fact sheet approved by the Board of Pharmacy as required by Business and Professions Code Section ~~4052(b)(3)~~ 4052.3(e).

(5) Referrals and Supplies: If emergency contraception services are not immediately available at the pharmacy or the pharmacist declines to furnish pursuant to conscience clause, the pharmacist will refer the patient to another emergency contraception provider. The pharmacist shall comply with all state mandatory reporting laws, including sexual abuse laws.

(6) The pharmacist may provide up to 12 non-spermicidal condoms to each Medi-Cal and Family PACT client who obtains emergency contraception.

(7) Advanced provision: The pharmacist may dispense emergency contraception medication for a patient in advance of the need for emergency contraception.

(8) EC Product Selection: The pharmacist will provide emergency contraception medication ~~compatible with product information~~ from the list of products specified in this protocol. This list must be kept current and maintained in the pharmacy. Along with emergency contraception products, the list will include adjunctive medications indicated for nausea and vomiting associated with taking EC containing estrogen. Patients will be provided information concerning dosing and potential adverse effects.

(9) Documentation: Each prescription authorized by a pharmacist will be documented in a patient medication record as required by law.

(10) Training: Prior to furnishing emergency contraception, pharmacists who participate in ~~the~~ this protocol must have completed a minimum of one hour of continuing education specific to emergency contraception.

~~(11) Brands and Doses of Oral Contraceptive Tablets Used for Emergency Contraception.~~

~~(11) Brands and Doses of Oral Contraceptive Tablets Used for Emergency Contraception.~~

~~Dedicated Emergency Contraception~~

~~Brand~~	~~Manufacturer~~	~~Tablets per Dose~~	~~Ethinyl Estradiol per Dose (mg)~~	~~Levonorgestrel per Dose (mg)**~~
		~~One Dose Regimen~~		
~~Plan B~~	~~Women's Capital Corporation~~	~~2 tablets~~	~~0~~	~~1.5~~
		~~Two Dose Regimens~~		
~~Plan B~~	~~Women's Capital Corporation~~	~~1 tablet per dose~~	~~0~~	~~0.75~~
~~Preven~~	~~Gynétics~~	~~2 tablets per dose~~	~~100~~	~~0.50~~
~~Oral Contraceptive Pills~~				
~~Brand~~	**~~Manufacturer~~**	**~~Tablets per Dose (two doses 12 hours apart*)~~**	**~~Ethinyl Estradiol per Dose (mg)~~**	**~~Levonorgestrel per Dose (mg)**~~**
~~Levora~~	~~Watson~~	~~4 white tablets~~	~~120~~	~~0.60~~
~~Ovral~~	~~Wyeth~~	~~2 white tablets~~	~~100~~	~~0.50~~
~~Ogestrel~~	~~Watson~~	~~2 white tablets~~	~~100~~	~~0.50~~
~~Nordette~~	~~Wyeth~~	~~4 light-orange tablets~~	~~120~~	~~0.60~~
~~Tri-Levlen~~	~~Berlex~~	~~4 yellow tablets~~	~~100~~	~~0.50~~
~~Alesse~~	~~Wyeth~~	~~5 pink tablets~~	~~100~~	~~0.50~~
~~Aviane~~	~~Duramed~~	~~5 orange tablets~~	~~100~~	~~0.50~~
~~Triphasil~~	~~Wyeth~~	~~4 yellow tablets~~	~~120~~	~~0.50~~
~~Levlen~~	~~Berlex~~	~~4 light-orange tablets~~	~~120~~	~~0.60~~
~~Trivora~~	~~Watson~~	~~4 pink tablets~~	~~120~~	~~0.50~~
~~Levlite~~	~~Berlex~~	~~5 pink tablets~~	~~100~~	~~0.50~~
~~Lo/Ovral~~	~~Wyeth~~	~~4 white tablets~~	~~120~~	~~0.60~~
~~Low-Ogestrel~~	~~Watson~~	~~4 white tablets~~	~~120~~	~~0.60~~
~~Ovrette~~	~~Wyeth~~	~~20 yellow tablets~~	~~0~~	~~0.75~~

~~* The progestin in Ovral, Lo/Ovral, and Ovrette is norgestrel, which contains two isomers, only one of which (levonorgestrel) is bioactive; the amount of norgestrel in eachdoes is twice the amount of levonorgestrel~~

(11) Medications Used for Emergency Contraception

Dedicated Approved Products for Emergency Contraception

Brand	Dose	Ethinyl Estradiol per dose (mcg)	
One Dose Regimen			
Plan B™ One-Step	1 tablet	0	1.5mg levonorgestrel
ella™	1 tablet	0	30mg ulipristal
Two Tablet ~~Dose~~ Regimens			
Next Choice™	2 tablets at once (1.5mg total dose) or 1 tablet (0.75mg) followed by 1 tablet (0.75mg) 12 hours later ~~1 tablet per dose~~	0	*Each tablet is 0.75 mg* ~~1.5mg~~ levonorgestrel
Levonorgestrel	2 tablets at once (1.5mg total dose) or 1 tablet (0.75mg) followed by 1 tablet (0.75mg) 12 hours later	*0*	*Each tablet is 0.75 mg levonorgestrel*

Oral Contraceptive Pills

Brand	Tablets per Dose (two doses 12 hours apart*)	Ethinyl Estradiol per dose (mcg)	Levonorgestrel per dose (mg)*
Alesse	5 pink tablets	100	0.50
Aviane	5 orange tablets	100	0.50
Levlen	4 light-orange tablets	120	0.60
Levlite	5 pink tablets	100	0.50
Levora	4 white tablets	120	0.60
Lo/Ovral	4 white tablets	120	0.50
Low-Ogestrel	4 white tablets	120	0.60
Nordette	4 light-orange tablets	120	0.60
Ogestrel	2 white tablets	100	0.50
Ovral	2 white tablets	100	0.50
Tri-Levlen	4 yellow tablets	100	0.50
Triphasil	4 yellow tablets	120	0.50
Trivora	4 pink tablets	120	0.50
Ovrette	20 yellow tablets	0	0.75

*The progestin in Ovral, Lo/Ovral, and Ovrette is norgestrel, which contains two isomers, only one of which (levonorgestrel) is bioactive; the amount of norgestrel in each dose is twice the amount of levonorgestrel.

In addition to the products specified in this paragraph, generic equivalent products may be furnished. Estrogen containing regimens are not preferred and should be used only when the other options are not available.

(12) Anti-nausea Treatment Options for use with Emergency Contraception

Anti-Nausea Treatment Options For Use With Emergency Contraception

Drug	Dose	Timing of Administration
Non-prescription Drugs		
Meclizine hydrochloride (Dramamine II, Bonine)	One or two 25 mg tablets	1 hour before first EC dose; Repeat if needed in 24 hours
Diphenhydramine hydrochloride (Benadryl)	One or two 25 mg tablets or capsules.	1 hour before first EC dose; repeat as needed every 4-6 hours
Dimenhydrinate (Dramamine)	One or two 50 mg tablets or 4-8 teaspoons liquid	30 minutes to 1 hour before first ~~ECP~~ EC dose; repeat as needed every 4-6 hours
Cyclizine hydrochloride (Marezine)	One 50 mg tablet	30 minutes before first EC dose; repeat as needed every 4-6 hours

Note: Authority cited: Section 4005, Business and Professions Code. Reference: Sections 4052 and 4052.3, Business and Professions Code. Authority cited: Section 4005, Business and Professions Code. Reference: Sections 4052 and 4052.3, Business and Professions Code.

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>
> EC use will not interfere with an established or implanted pregnancy.
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> If more than 72 hours have elapsed since unprotected intercourse, the use of ella™ (ulipristal) may be more effective than levonorgestrel. Other options for EC include consultation with your physician regarding insertion of an IUD.

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Fact Sheet: The pharmacist will provide the patient with a copy of the current EC fact sheet approved by the Board of Pharmacy as required by Business and Professions Code Section ~~4052(b)(3)~~ 4052.3(e).

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Triphasil	4 yellow tablets	120	0.50
Trivora	4 pink tablets	120	0.50
Ovrette	20 yellow tablets	0	0.75

Changes to the originally proposed language are shown as follows:

Deleted text is shown by double strike-through, thus: ~~deleted language~~

New or added text is shown by double underline, thus: added language

*The progestin in Ovral, Lo/Ovral, and Ovrette is norgestrel, which contains two isomers, only one of which (levonorgestrel) is bioactive; the amount of norgestrel in each dose is twice the amount of levonorgestrel.

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Amanda Davis, Pharm.D.
10972 Campus Street
Loma Linda, CA 92354

February 16, 2012

California Board of Pharmacy
1625 North Market Boulevard, N219
Sacramento, CA 95834

To Carolyn Klein and the Board of Pharmacy:

I am writing in regards to the proposed amendment to § 1746 of Article 5 of Division 17 of Title 16 of the California Code of Regulations regarding emergency contraception, specifically, subdivision (b)(3). There are several erroneous, unclear, and problematic statements that I believe must be addressed before this amendment is to take effect.

First, with the advent of ulipristal acetate on the market as an alternative emergency contraceptive, it is important to differentiate between the two types of emergency contraception when counseling patients. Although they are used for the same purpose, they have very different properties. Because of this, I suggest that you strike the phrase "EC use will not interfere with an established or implanted pregnancy." and replace it with, "Progesterone-based emergency contraception will not interfere with an established pregnancy," or any similar phrase that would exclude ulipristal. Considering the current scientific evidence regarding ulipristal, it would be incorrect tell a patient, implicitly or explicitly, that this medication cannot disrupt an established pregnancy. Such evidences can be found in animal studies on guinea pigs (1), rats (2), and macaque monkeys (3) where ulipristal acetate was found to be capable of inducing abortion. Human studies have found that the corpus luteum, which is necessary for maintaining pregnancy in early gestation, can undergo luteolysis after doses as low as 1 mg of ulipristal acetate are taken (4). Additionally, the official assessment report published by the European Medicines Agency for ellaOne (the trade name for ella in Europe) states that, "Ulipristal acetate prevents progesterone from occupying its receptor, thus the gene transcription normally turned on by progesterone is blocked, and the proteins necessary to begin **and maintain** pregnancy are not synthesized" (5). It is for these reasons that I recommend that the statement be changed from a blanket statement concerning all emergency contraception to a more directed statement concerning only progesterone-based emergency contraceptives. This is something that might also be applied to the EC fact sheet for patients.

Second, I would like to suggest that you strike the point, "If more than 72 hours have elapsed since unprotected intercourse, the use of ella™ (ulipristal) may be more effective than levonorgestrel. Other options for EC include consultation with your physician regarding insertion of an IUD." and replacing it with the phrase, "If more than 72 hours have elapsed since unprotected intercourse, consult with your physician to discuss other options for EC." There are three reasons why the current phrasing is problematic:

1. Ulipristal is only approved for EC up to 120 hours post unprotected intercourse; therefore, recommending the use of ulipristal "more than 72 hours" after intercourse would only be accurate if less than 120 hours has elapsed since the event. The proposed phrasing does not specify this and may provide confusing or inaccurate information to the patient.
2. If more than 72 hours have elapsed since unprotected intercourse, whether it be 5 days or 10 days, the ONLY other option a patient has is to consult with their doctor. We cannot provide ella at the pharmacy without a prescription, so it would be more beneficial to recommend that they see their physician immediately.
3. Since ulipristal has abortifacient properties and is likely able to cause a drug-induced abortion in the early stages of gestation, the recommendation of this particular product to patients is morally problematic. Like levonorgestrel, ulipristal is capable of preventing pregnancy, and if this was its only mechanism of action, then it might be appropriate to recommend this product in the pharmacy; however, given the abortifacient nature of this drug, we should be weary to casually recommend this medication to patients without even counseling them on its mechanism of action or even ascertaining their views on abortion. The pharmacy is no place to impose such a grave and life-altering decision on women. The California medical board and board of pharmacy should reconsider standing behind this drug when many of the pharmacists in this state do not stand behind it at all.

Thank you for taking the time to read through and consider my comments on this amendment. My hope and goal is for women to receive informed and accurate information from their pharmacists on emergency contraception and for pharmacists to feel confident in the medications that they are recommending to their patients.

Sincerely,

Amanda Davis, Pharm.D.

References

1. Poyser NL, Forcelledo ML. A comparison of the pregnancy-terminating potencies of three anti-progestins in guinea-pigs, and the effects of sulprostone. Prostaglandins Leukotrienes and Essential Fatty Acids (1994) 50; 245-247.

2. Teutsch G, Philibert D. History and perspectives of antiprogestins from the chemist's point of view. Hum Reprod. 1994 Jun;9 Suppl 1:12-31.

3. Tarantal AF, Hendrickx AG, Matlin SA, et al. Effects of two anti-progestins on Early Pregnancy in the long-tailed macaque. Contraception. 1996;54:107-115.

4. Passaro MD, *et al*. Luteal phase dose-response relationships of the antiprogestin CDB-2914 in normally cycling women. *Human Reproduction*. 2003; 18(9): 1820-1827.

5. CHP Assessment Report for ellaOne. European Medicines Agency: *Evaluation of Medicines for Human Use.* Doc.Ref.: EMEA/261787/2009.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	July 5, 2012
ATTENTION:	Medical Board of California
SUBJECT:	Special Faculty Permit Review Committee Recommendation
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing

RECOMMENDED ACTION:

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

BACKGROUND AND ANALYSIS:

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

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

The SFPRC is comprised of two Board members, one who is a physician and surgeon and one who is a public member, and one representative from each of the medical schools in California. The SFPRC reviews and makes recommendations to the Board regarding the applicants applying pursuant to Section 2168.1 of the B&P.

At its June 14, 2012 meeting, the SFPRC reviewed the qualifications of three applicants: One from the University of California Los Angeles, David Geffen School of Medicine (UCLA-DGSOM), the University of California Irvine, School of Medicine (UCI-SOM); and the University of California San Francisco, School of Medicine (UCSF-SOM).

HASAN YERSIZ, M.D., UCLA- DGSOM - SFP APPLICANT:

Note: Neil Parker, M.D., Senior Associate Dean Student Affairs and Graduate Medical Education, presented UCLA-DGSOM's request for Hasan Yersiz, M.D. at the January 23, 2012, SFPRC meeting. The SFPRC requested additional information and a proctoring plan to be presented at the next SFPRC meeting (June 14, 2012).

Neil Parker, M.D., Senior Associate Dean Student Affairs and Graduate Medical Education, presented UCLA-DGSOM's request for Hasan Yersiz, M.D. to receive a SFP and the qualifications of Dr. Yersiz. Dr. Parker recommends Dr. Yersiz for the SFP based on his clinical research in split-liver transplantation. Dr. Yersiz leads the Dumont-UCLA Transplant Center in all aspects of multi-organ procurement procedures, and he holds the primary responsibility for training residents and fellows in the surgical techniques utilized in organ procurement. UCLA-

DGSOM has determined that Dr. Yersiz is the most qualified individual to bring these skills to the Dumont-UCLA Transplant Center.

Dr. Yersiz was awarded the prestigious international award by the Medical Students International Coordination in 1980. Dr. Yersiz's research has been published in leading international scientific journals, including: Transplantation; and Annals of Surgery.

The Board previously granted Dr. Yersiz a 2111 appointment from May 8, 1992 until May 8, 1995. Dr. Yersiz went back to Turkey in 1994 to work as an Assistant Professor at the University of Istanbul until returning to UCLA-DGSOM in September 1995. UCLA-DGSOM reapplied to the Board for another 2111 appointment in September 1995, which was approved on November 2, 1995 and was valid until November 2, 1998.

The Board previously granted Dr. Yersiz a 2113 faculty position, which was valid from July 31, 1998 until July 31, 2003. The Board received a request from UCLA-DGSOM requesting an extension of Dr. Yersiz's 2113 faculty position, which was denied by the Board based on B&P § 2113 (d)(1)(2), which only allows a registrant to hold the faculty position for a total of five years.

Dr. Yersiz has held the title of Health Sciences Clinical Professor of Surgery at Dumont-UCLA Transplant Center in the Division of Liver & Pancreas Transplantation, at UCLA-DGSOM since July 1, 2011. Dr. Yersiz has also held several other positions at UCLA-DGSOM, in the department of Liver and Pancreas Transplant Program, Visiting Assistant Researcher 1992, Visiting Associate Researcher 1995; Assistant Clinical Professor of Surgery 1998; Assistant Adjunct Professor of Surgery 2003; Associate Adjunct Professor Surgery 2004; Adjunct Professor of Surgery 2007. On November 8, 2011, UCLA-DGSOM approved an academic title change for Dr. Yersiz to Professor of Clinical Surgery. Dr. Yersiz's expertise has allowed him to provide consultations for several liver transplantation committees, along with providing training to numerous fellows.

Dr. Yersiz's application is complete except for the final fee for the permit. The fee will be requested from UCLA-DGSOM if the Board agrees with the SFPRC's recommendation for approval.

PIETRO GALASSETTI, M.D., UCI-SOM - SFP APPLICANT:
F. Allan Hubbell, M.D., Executive Vice Dean, School of Medicine, Professor of Medicine, Public Health, and Nursing Science, presented UCI-SOM's request for Pietro Galassetti, M.D., to receive a SFP and presented the qualifications of Dr. Galassetti. Dr. Galassetti's area of expertise is pediatrics, specifically in the area of in-vivo metabolic procedures.

Dr. Hubbell indicated that Dr. Galassetti holds the following titles of Associate Professor, Step IV, in Line (50%) and Associate Professor in Residence, (50%) in the Department of Pediatrics at UCI-SOM since March 1, 2011. Dr. Galessetti has also held the position at UCI-SOM as the Director of the Bionutrition/Metabolism Core, General Clinical Research Center in 2002. Dr. Galassetti has been awarded research awards from Southern Society of Clinical Investigations and the Outstanding Young Investigator Award from the Association for Patient-Oriented Research in 2001. Dr. Galassetti is the recipient of a prestigious NIH K24 mid-career award that recognizes both scientific innovation and outstanding mentorship in clinical/translational research. Dr. Galassetti's research has been published

in scientific journals and he has served as a reviewer for over 30 different scientific journals. Dr. Galassetti's expertise will provide invaluable contributions to the academic, clinical and research at UCI-SOM, along with providing training to numerous fellows. UCI-SOM has indicated Dr. Galessetti fills a great need in the School of Medicine to lead the development of a pediatric obesity clinical and research program.

UCI-SOM submitted a 2113 application on Dr. Galassetti's behalf that was approved by the Board, effective January 31, 2003. Dr. Galassetti held this faculty position until the Board received the Notice of Termination requesting to cancel the registration effective February 1, 2006. Dr. Galassetti did not apply for a California license while he held this position; he never took and passed Step 3 of the United States Medical Licensing Examination. Dan M. Cooper, M.D., Associate Dean for Translational Science, Professor and Chair, Department of Pediatrics, UCI-SOM, indicated the reason Dr. Galassetti did not take Step 3 was due to administrative delays and not receiving his certificate from the Educational Commission for Foreign Medical Graduates in a timely manner. Dr. Cooper has indicated that Dr. Galassetti is still planning to take Step 3.

Dr. Cooper provided to the SFPRC a proctoring plan for Dr. Galassetti that will be implemented, if the Board approves Dr. Galassetti for a SFP. Dr. Cooper indicated that Dr. Galassetti's professional efforts will be subdivided between 50-60% clinical research, 25-35% mentoring, and 10-20% patient care.

Dr. Galassetti's application is complete except for the final fee for the permit. The fee will be requested from UCI-SOM if the Board agrees with the SFPRC recommendation for approval.

MARIA ROBERTA CILIO, M.D., UCSF-SOM- SFP APPLICANT:
Neal Cohen, M.D., MS, MPH, Vice Dean, presented UCSF-SOM's request for Maria Roberta Cilio M.D., Ph.D to receive a special faculty permit and presented the qualifications of Dr. Cilio. Dr. Cohen indicated that Dr. Cilio is a recognized world leader in neonatal neurophysiology.

Dr. Cohen indicated Dr. Cilio has held the title of Visiting Professor at UCSF-SOM in the Department of Neurology since September 2011. Dr. Cilio's previous two positions at UCSF-SOM were Visiting Associate Professor 2008 and Associate Adjunct Professor 2009. Dr. Cilio was awarded the Presidential Chair award from UCSF-SOM in 2011, which calls for her to develop and implement an interdisciplinary program in neonatal neurophysiology. Dr. Cilio is the project leader and principal investigator for prestigious multicenter research grants with the European Commission and the Italian Ministry of Health for rare neonatal neurological disorders and the genetic basis of neonatal seizures.

Dr. Cilio is a clinical child neurologist with two distinct subspecialties within Child Neurology Epilepsy and Neonatal Neurology. Her knowledge of neonatal EEG and her combined clinical skills in neurology and neurophysiology render her ideal in bridging the gap between clinicians and neurophysiologists. Dr. Cilio will utilize her education, clinical, and research approach with the specific goals of diffusing basic concepts of neonatal, neurophysiology, and epilepsy throughout the UCSF community.

Dr. Cilio's application is complete except for the final fee for the permit. The fee will be requested from UCSF-SOM if the Board agrees with the SFPRC recommendation for approval.

SPECIAL FACULTY PERMIT REVIEW COMMITTEE FINDINGS:
The SFPRC initially reviewed Dr. Yersiz's application on January 23, 2012 and requested UCLA-DGSOM provide to the Board a proctoring plan that will include the method of supervision, a clinical assessment, the applicant qualifications, and the intended scope of practice. UCLA-DGSOM provided this information, which was reviewed by SFPRC on June 14, 2012.

The SFPRC recommended approval of Dr. Yersiz for a SFP at UCLA-DGSOM. The approval includes the requirement for follow-up documentation to be provided by UCLA at the time of renewal that confirms the proctoring plan was implemented and completed satisfactorily, a report to the Board on what privileges were requested and granted to Dr. Yersiz, and whether there was appropriate proctoring for the privileges.

The SFPRC recommended approval of Dr. Galassetti for a SFP at UCI-SOM. The approval includes the requirement for follow-up documentation to be provided by UCI-SOM at the time of renewal that confirms the proctoring plan was implemented and completed satisfactorily, a report to the Board on what privileges were requested and granted to Dr. Galassetti, and whether there was appropriate proctoring for the privileges.

The SFPRC recommended approval of Dr. Cilio for a SFP at UCSF-SOM, contingent upon receipt of follow-up documentation from UCSF regarding why a great need exists to fill the appointment as a SFP holder. The Board received the requested follow-up documentation from UCSF-SOM`. Therefore, SFPRC recommends approval for Dr. Cilio.

FISCAL CONSIDERATIONS:
None

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	June 20, 2012
ATTENTION:	Medical Board of California
SUBJECT:	Special Faculty Permit Review Committee University of California, Irvine School of Medicine Committee Member Change Request
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing

RECOMMENDED ACTION:

Board approve University of California, Irvine School of Medicine's (UCI) request to change its Special Faculty Permit Committee (SFPRC) member from F. Allan Hubbell, M.D., M.S.P.H., Executive Vice Dean to Wadie Najm, M.D., Associate Dean for Academic Affairs/Clinical.

BACKGROUND AND ANALYSIS:

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

The Board has received a written request (attached) from UCI requesting to change its SFPRC member from F. Allan Hubbell, M.D., M.S.P.H. Executive Vice Dean to Wadie Najm, M.D., Associate Dean for Academic Affairs/Clinical.

FISCAL CONSIDERATIONS:

None

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Ralph V. Clayman, MD
Dean, School of Medicine
Professor, Dept of Urology
University of California Irvine

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(949) 824-2676 Fax

May 25, 2012

Medical Board of California
Attention: Philip Egeston
2005 Evergreen Street
Suite 1200
Sacramento, CA 95815

Dear Mr. Egeston:

I hereby nominate Dr. Wadie Najm as the new representative to the Special Faculty Permit Review Committee from the University of California, Irvine. Dr. Allan Hubbell will be retiring effective July 1st, 2012.

Sincerely yours,

Ralph V. Clayman, M.D.
Dean, School of Medicine
Professor of Urology

cc: Wadie Najm, M.D.
Associate Dean for Academic Affairs/Clinical

ATTENTION: Members, Medical Board of California
SUBJECT: Presentation on History and Scope of Practice of Physician Assistants
STAFF CONTACT: Kevin A. Schunke

BACKGROUND:

The Physician Assistant Committee (PAC) of the Medical Board of California serves and protects consumers of California through licensing, approving physician assistant (PA) training programs, and enforcement of the laws governing the Physician Assistant Practice Act. PAs are highly skilled professions who, under the supervision of a physician and surgeon, provide patient services ranging from primary medicine to very specialized surgical care.

The Board heard a scope of practice regulatory proposal from PAC Chair, Robert Sachs, at the May 2012 meeting. Members requested a presentation on PAs to better understand their scope of practice in order to make informed decisions on future issues related to PAs.

A presentation will be made to discuss the history of PAs, the PAC's relationship with the Board, and the scope of practice of PAs.

Elberta Portman has served as Executive Officer of the PAC since 2007. Prior to that, she was a manager at the Medical Board of California in the Complaint Processing and Discipline Coordination Units and was a Diversion Case Manager in 2000.

Beth Grivett, PA-C, is a PA specializing in family medicine. She graduated with a BS in kinesiology from UCLA and received her certificate in Physician Assistant Studies from USC. Beth has been a PA for 17 years and currently works for a medical group in Orange County. She has worked extensively with both the American Academy of Physician Assistants and the California Academy of Physician Assistants and has been instrumental in helping improve the practice act for PAs in California by working on legislative and regulatory changes on behalf of PAs. She recently released the second edition of her book, ***So You Want to be a Physician Assistant***.

Physician Assistant Committee

Medical Board of California Meeting

July 20, 2012

Legislative Intent

In its concern with the growing shortage and geographic maldistribution of health care services in California, the Legislature established the PAC in 1975.

The purpose is to encourage the more effective utilization of the skills of physicians…by enabling them to delegate health care tasks to qualified PAs

Who We Are

- The PAC is a 9 member regulatory board within the Department of Consumer Affairs and comprised of:
- 1 physician who is a member of the MBC
- 4 public members
- 4 PA members

What We Do

- Regulate over 8,500 licensees
- License PAs
- Approve PA programs
- Investigate complaints
- Discipline licensees who violate PA laws and regulations
- Manage a drug & alcohol diversion program

Mission Statement

- Protect and serve consumers through licensing, education and objective enforcement of the PA laws and regulations

#1 Priority - Consumer Protection

PAC/MBC Relationship

- SP and PA relationship
- MBC provides PAC with complaint and investigation services
- Provides IT services
- MBC physician as PAC member
- Scope of Practice regulations

California Physician Assistant

Medical Board of California
July, 2012

Beth Grivett, PA-C

Family Medicine, Premier Physicians Medical Group, South Orange County, CA

Past President, CA Academy of Physician Assistants

Past Legislative Chair, CAPA

Past President, Student Academy of American Academy of Physician Assistants

What is a PA?

- Health care professionals licensed to provide health care services with physician supervision
- Provide a broad range of diagnostic and therapeutic services
- Primary and specialty care in medical and surgical practice settings in rural and urban areas
- Duties may include educational, research, and administrative activities

Origins of the Profession

- Born on the battlefields of Vietnam
- Major future health "manpower" shortage predicted in the 1960s
- Retraining highly skilled corpsmen as "physician extenders" seen as one solution
- First class of PAs graduated from Duke University on October 6, 1967
- 156 accredited PA training programs in the United States; 9 in California
- 85,000 PAs in practice nationally; 8,500 in CA

PA Education

- Historically competency based rather than degree based
- Significant preparation with college pre-requisites required
- Average training 24 months in length
- First year (12 months) is didactic classroom instruction
  - Anatomy
  - Biochemistry
  - Pathophysiology
  - Microbiology
  - Pharmacology
  - Physical Diagnosis

PA Education

- Second phase of training (14-20 months) in supervised clinical clerkships (over 2,000 hours of supervised clinical practice prior to graduation)
- Rotations in:
  - Family medicine
  - Obstetrics and gynecology
  - Internal medicine
  - Pediatrics
  - Emergency Medicine
  - Surgery and surgery specialties (orthopedics)
  - Psychiatry

PA Education

- Master's degree has become the entry level degree
- Why is this important in CA?
  - Stanford
  - San Joaquin College
  - Riverside College
  - Loma Linda
  - UC Davis
  - USC
  - Western
  - Touro
  - Samuel Merritt
- Seeking Accreditation
  - Southern CA College of Optometry
  - Chapman
  - Charles Drew

Initial Licensure

To obtain the initial CA License, a PA must be certified by the National Commission on Certification of Physician Assistants (NCCPA)

To obtain certification, a PA

- Must be a graduate of an accredited PA program
- Must pass the national exam administered by the NCCPA

To Maintain Certification

- Must log 100 hours of continuing medical education (CME) every 2 years
- Must sit for recertification exam every 6 years (will be every 10 years)

- CA does not require maintenance of certification
  - 50 hours Category 1 CME every 2 years

Typical PA Duties

- History and physical examinations
- Order and interpret laboratory tests
- Develop and initiate treatment plans
- Patient education
- Write prescriptions (drug orders)
- Perform minor outpatient surgical procedures
- First assist at surgery
- Research, administration, and education

California PA Demographics

- Approximately 8,500 licensed PAs in California
- Less than 50% practice in "primary care" specialties

- Approximately 55 applicants are licensed each month

California Laws Governing Physician-PA Practice

- Any licensed physician in good standing with the MBC may supervise a licensed PA – no additional paperwork required
- Physician and PA must have a "Delegation of Services Agreement" on file at each practice location
- Physician may delegate those duties that are within the physician's scope of practice

California Laws Governing Physician-PA Practice

- Delegated Autonomy
- PA is an "agent" of the Physician
  - PA orders are treat by regulation as if they were given by the physician
- Supervising Physician (SP) can supervise up to four PAs at any one time
- PAs can perform duties and procedures customary to the practice of their SP

Supervision Requirements

- Physician must be on site or available via telecommunication
- Physician and PA must establish guidelines for supervision. Must include:
  - Adoption of protocols (texts accepted)
  - Charts with Schedule II medications require physician signature within 7 days
  - 5% chart signature and review

Reimbursement

- Services are generally reimbursed to the physician at the physician rate for services performed by a PA
- Medicare deducts 15% from the physician rate for most services when performed by a PA

Healthcare Reform

- Preventive Services
- Chronic Condition Management
- Annual Wellness Visits for Medicare
- Case Management
- Quality Metrics
- Patient Satisfaction

Questions ?

Delegation of Services Agreements – Change in Regulations

Recently, Title 16, Division 13.8, Article 4, section 1399.540 has been amended to include several requirements for the delegation of medical services to a physician assistant. There are four specific changes with this amendment:

Background:
The Delegation of Services Agreement (DSA) is a document used by supervising physicians and physician assistants to meet requirements of Section 1399.540. The DSA is the foundation of the relationship between a supervising physician and the physician assistant, and specifies the names of the supervising physicians and what types of medical services the physician assistant is allowed to perform, how they are performed, how the patient charts will be reviewed and countersigned, and what type of medications the physician assistant will transmit on behalf of the supervising physician.

Regulatory Requirements:

1) A physician assistant may provide medical services, which are delegated in writing by a supervising physician who is responsible for patients, cared for by the physician assistant. The physician assistant may only provide services which he or she is competent to perform, which are consistent with their education, training and experience, and which are delegated by the supervising physician.

2) The delegation of services agreement is the name of the document, which delegates the medical services. More than one supervising physician may sign the delegation of services agreement only if each supervising physician has delegated the same medical services. A physician assistant may provide medical services pursuant to more than one delegation of services agreement.

3) The Physician Assistant Committee or their representative may require proof or demonstration of competence from any physician assistant for any medical services performed.

4) If a physician assistant determines a task, procedure or diagnostic problem exceeds his or her level of competence, and then the physician assistant shall either consult with a physician or refer such cases to a physician.

Question: What if a physician assistant works for more than one supervising physician at a hospital or clinic? Do we need to have separate DSAs for each supervising physician?

Answer: The PAC has had questions regarding how the DSA would be written if a physician assistant works for more than one supervising physician at a hospital or clinic. If the duties and medical services performed are consistent with each supervising physician, then one DSA can be written to include several supervising physicians. Each supervising physician must sign and date the DSA, along with the signature of the physician assistant.

Question: What if a physician assistant works for one supervising physician who is an ob-gyn, and also works for an ortho supervising physician, and both are at the same clinic or hospital?

Answer: If the duties and medical services provided by the physician assistant differ from one supervising physician to another, then it is recommended that a separate DSA be written for each supervising physician. However, one DSA could be used, but it would need to be separated with which duties are allowed under each supervising physician. Again, signatures and dates from all parties must be included on the DSA.

Question: What if the physician assistant works at several different clinics – can one DSA be written?

Answer: A separate DSA should be made for each hospital or clinic, regardless of how many supervising physicians the physician assistant works with.

Alternatively, a physician assistant may have a DSA that specifies what services can be provided at a specific site.

Question: How long should I retain my DSA?

Answer: You should retain the DSA as long as it is valid. Additionally, it is recommended that you keep a copy of your DSA for at least one to three years after it is no longer the current DSA in case you need to reference the document. However, there is no legal requirement to retain the DSA once it is no longer valid and current.

DELEGATION OF SERVICES AGREEMENT
BETWEEN
A SUPERVISING PHYSICIAN AND A PHYSICIAN ASSISTANT
and
SUPERVISING PHYSICIAN'S RESPONSIBILITY FOR SUPERVISION OF A PHYSICIAN ASSISTANT

Title 16, Section 1399.540 of the Physician Assistant Regulations states, in part, "A physician assistant may only provide those medical services which he or she is competent to perform and which are consistent with the physician assistant's education, training, and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant. b) The writing which delegates the medical services shall be known as a delegation of services agreement. A delegation of services agreement shall be signed and dated by the physician assistant and each supervising physician. A delegation of services agreement may be signed by more than one supervising physician only if the same medical services have been delegated by each supervising physician. A physician assistant may provide medical services pursuant to more than one delegation of services agreement."

The following two sample documents are attached to assist you with meeting this legal requirement:

- Delegation of Services Agreement (DSA) Between Supervising Physician and Physician Assistant; and,
- Supervising Physician's Responsibility for Supervision of Physician Assistant Agreement.

These are sample documents. They are for your convenience, information, and use. Please feel free to duplicate or modify them as appropriate and consistent with law.

If you choose not to use the sample documents, please be aware that you are still required by law to execute a DSA with your supervising physician. The DSA must be signed and dated by you and your supervising physician. The original or a copy of this document should be maintained at all practice sites where the physician assistant practices, and should be readily accessible. It is recommended that you retain prior DSAs for one to three years after the DSA is no longer current or valid.

While every practicing physician assistant is required to have a DSA, you are **not** required to submit it to the Physician Assistant Committee. If requested, you must make a copy of your DSA available to any authorized agent of the Medical Board of California, the Osteopathic Medical Board of California, or the Physician Assistant Committee who may request it.

Failure to have a current DSA constitutes a violation of the Physician Assistant Regulations and is grounds for disciplinary action against a physician assistant's license. In addition, failure by the physician assistant and supervising physician to comply with the supervision requirements specified in the Physician Assistant Regulations and in the Delegation of Services Agreement is ground for disciplinary action.

THE ATTACHED DOCUMENTS DO NOT NEED TO BE RETURNED TO THE PHYSICIAN ASSISTANT COMMITTEE

SAMPLE
DELEGATION OF SERVICES AGREEMENT BETWEEN SUPERVISING PHYSICIAN AND PHYSICIAN ASSISTANT (Title 16, CCR, Section 1399.540)

PHYSICIAN ASSISTANT _____
(Name)

Physician assistant, graduated from the _____
(Name of PA Training Program)

physician assistant training program on _____.
(Date)

He/she took (or is to take) the licensing examination for physician assistants recognized by the State of California (e.g., Physician Assistant National Certifying Examination or a specialty examination given by the State of California) on _____.
(Date)

He/she was first granted licensure by the Physician Assistant Committee on _____, which expires on _____, unless renewed.
(Date) (Date)

SUPERVISION REQUIRED. The physician assistant named above (hereinafter referred to as PA) will be supervised in accordance with the written supervisor guidelines required by Section 3502 of the Business and Professions Code and Section 1399.545 of the Physician Assistant Regulations. The written supervisor guidelines are incorporated with the attached document entitled, "Supervising Physician's Responsibility for Supervision of Physician Assistants."

AUTHORIZED SERVICES. The PA is authorized by the physician whose name and signature appear below to perform all the tasks set forth in subsections (a), (d), (e), (f), and (g) of Section 1399.541 of the Physician Assistant Regulations, when acting under the supervision of the herein named physician. (In lieu of listing specific lab procedures, etc. the PA and *supervising* physician may state as follows: "Those procedures specified in the practice protocols or which the supervising physician specifically authorizes.")

The PA is authorized to perform the following laboratory and screening procedures:

_____

_____

The PA is authorized to assist in the performance of the following laboratory and screening procedures:

_____

_____

The PA is authorized to perform the following therapeutic procedures:

_____

_____

The PA is authorized to assist in the performance of the following therapeutic procedures:

_____

_____

The PA is authorized to function as my agent per bylaws and/or rules and regulations of (name of hospital):

_____

_____

a) The PA is authorized to write and sign drug orders for Schedule: II, III, IV, V without advance approval (circle authorized Schedule(s). The PA has taken and passed the drug course approved by the PAC on _____ (attach certificate). DEA #:_____.
Date

or

b) The PA is authorized to write and sign drug orders for Schedule: II, III, IV, V with advance patient specific approval (circle authorized Schedule(s). DEA #:_____.

CONSULTATION REQUIREMENTS. The PA is required to always and immediately seek consultation on the following types of patients and situations (e.g., patient's failure to respond to therapy; physician assistant's uncertainty of diagnosis; patient's desire to see physician; any conditions which the physician assistant feels exceeds his/her ability to manage, etc.)

_____
(List Types of Patients and Situations)

_____

MEDICAL DEVICES AND PHYSICIAN'S PRESCRIPTIONS. The PA may transmit by telephone to a pharmacist, and orally or in writing on a patient's medical record or a written prescription drug order, the supervising physician's prescription in accordance with Section 3502.1 of the Business and Professions Code.

The supervising physician authorizes the delegation and use of the drug order form under the established practice protocols and drug formulary. _____ YES _____ NO

The PA may also enter a drug order on the medical record of a patient at _____
(Name of Institution)
in accordance with the Physician Assistant Regulations and other applicable laws and regulations.

Any medication handed to a patient by the PA shall be authorized by the supervising physician's prescription and be prepackaged and labeled in accordance with Sections 4076 of the Business and Professions Code.

PRACTICE SITE. All approved tasks may be performed for care of patients in this office or clinic located at _____ (Address / City) and, in _____ (Address / City) hospital(s) and _____ (Name of Facility) skilled nursing facility (facilities) for care of patients admitted to those institutions by physician(s) _____ (Name/s)) .

EMERGENCY TRANSPORT AND BACKUP. In a medical emergency, telephone the 911 operator to summon an ambulance.

The _____ (Name of Hospital) emergency room at _____ (Phone Number) is to be notified that a patient with an emergency problem is being transported to them for immediate admission. Give the name of the admitting physician. Tell the ambulance crew where to take the patient and brief them on known and suspected health condition of the patient.
Notify _____ (Name of Physician) at _____ (Phone Number/s)) immediately (or within _____ minutes).

PHYSICIAN ASSISTANT DECLARATION
My signature below signifies that I fully understand the foregoing Delegation of Services Agreement, having received a copy of it for my possession and guidance, and agree to comply with its terms without reservations.

_____ Date

_____ Physician's Signature (Required)

_____ Physician's Printed Name

_____ Date

_____ Physician Assistant's Signature (Required)

_____ Physician Assistant's Printed Name

SAMPLE ONLY

SUPERVISING PHYSICIAN'S RESPONSIBILITY FOR SUPERVISION OF PHYSICIAN ASSISTANT

SUPERVISOR _____, M.D./D.O. is licensed to practice in California as a physician and surgeon with medical license number _____. Hereinafter, the above named physician shall be referred to as the supervising physician.

SUPERVISION REQUIRED. The physician assistant (PA) named in the attached Delegation of Services Agreement will be supervised by the supervising physician in accordance with these guidelines, set forth as required by Section 3502 of the Business and Professions Code and Section 1399.545 of the Physician Assistant Regulations, which have been read by the physician whose signature appears below.

The physician shall review, countersign, and date within seven (7) days the medical record of any patient cared for by the physician assistant for whom the physician's prescription for Schedule II medications was transmitted or carried out.

REPORTING OF PHYSICIAN ASSISTANT SUPERVISION. Each time the physician assistant provides care for a patient and enters his or her name, signature, initials, or computer code on a patient's record, chart or written order, the physician assistant shall also enter the name of his or her supervising physician who is responsible for the patient. When the physician assistant transmits an oral order, he or she shall also state the name of the supervising physician responsible for the patient.

MEDICAL RECORD REVIEW. One or more of the following mechanisms, as indicated below, by a check mark (x), shall be utilized by the supervising physician to partially fulfill his/her obligation to adequately supervise the actions of the physician assistant named _____.
(Name of PA)

_____ Examination of the patient by a supervising physician the same day as care is given by the PA.

_____ The supervising physician shall review, audit, and countersign every medical record written by the PA within _____ of the encounter.
(Number of Days May- Not Exceed 30 Days)

_____ The physician shall audit the medical records of at least 5% of patients seen by the PA under any protocols which shall be adopted by the supervising physician and the physician assistant. The physician shall select for review those cases which by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

_____ Other mechanisms approved in advance by the Physician Assistant Committee may be used. Written documentation of those mechanisms is located at _____.
(Give Location)

_____ INTERIM APPROVAL. For physician assistants operating under interim approval, the supervising physician shall review, sign, and date the medical records of all patients cared for by the physician assistant within seven (7) days if the physician was on the premises when the physician assistant diagnosed or treated the patient. If the physician was not on the premises at that time, he or she shall review, sign, and date such medical records within 48 hours of the time the medical services were provided.

BACK UP PROCEDURES: In the event this supervising physician is not available when needed, the following physician(s) has (have) agreed to be a consultant(s) and/or to receive referrals:

_____ Phone: _____
(Printed Name and Specialty)

_____ Phone: _____
(Printed Name and Specialty)

PROTOCOLS NOTE: This document **does not** meet the regulation requirement to serve as a protocol. Protocols, if adopted by the supervising physician, must fully comply with the requirements authorized in Section 3502 (c) (1) of the Business and Professions Code.

_____ _____
Date Physician's Signature

THIS DOCUMENT IS NOT TO BE RETURNED TO THE PAC
SAMPLE ONLY

DELEGATION OF SERVICES AGREEMENT BETWEEN SUPERVISING PHYSICIAN AND PHYSICIAN ASSISTANT AND WRITTEN SUPERVISION GUIDELINES

This Delegation of Services Agreement ("Agreement") is entered into between [_____ _____, *M.D. ("Supervising Physician")*] [*the physicians whose signatures appear below, each of which shall be referred to herein as "Supervising Physician"*], and _____ _____, *PA* ("PA"), in order to fulfill the purposes set forth below.

1. **Purpose**. The purpose of this Agreement is to comply with the requirements of Title 16, Article 4, of the California Code of Regulations, hereinafter referred to as the "Physician Assistant Regulations." Section 1399.540 of the Physician Assistant Regulations states, in pertinent part, that "A physician assistant may only provide those medical services which he or she is competent to perform and which are consistent with the physician assistant's education, training and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant." In this Agreement, Supervising Physician hereby delegates the performance of certain medical services to PA. Section 1399.545 of the Physician Assistant Regulations sets forth requirements for supervision by a supervising physician when a PA is caring for patients. This Agreement shall set forth such requirements to be followed by Supervising Physician.

2. **Qualifications**. PA is licensed by the California Physician Assistant Committee. Supervising Physician is licensed by the Medical Board of California or the Osteopathic Medical Board of California and is qualified to act as a supervising physician. PA and Supervising Physician are familiar with the requirements governing the performance of medical services by PAs, and the supervision of PAs by supervising physicians, as set forth in the Physician Assistant Regulations.

3. **Authorized Services**.

(a) PA is authorized by Supervising Physician to perform all the tasks set forth in subsections (a), (b), (c), (d), (e), (f), and (g) of Section 1399.541 of the Physician Assistant Regulations, subject to the limitations and conditions described in this Agreement or established by Supervising Physician in any applicable protocols or otherwise. [*PA is also authorized to perform certain surgical procedures as specified by Supervising Physician in accordance with Section 1399.541(i) of the Physician Assistant Regulations.*]

(b) As required by Section 1399.540 of the Physician Assistant Regulations, PA may only provide those medical services which he or she is competent to perform and which are consistent with PA's education, training and experience. PA shall consult with Supervising Physician or another qualified health care practitioner regarding any task, procedure or diagnostic problem which PA determines exceeds his or her level of competence, or shall refer such cases to Supervising Physician or another appropriate practitioner.

(c) PA shall perform delegated medical services under the supervision of the Supervising Physician as specified in the Physician Assistant Regulations, this Agreement, any applicable practice protocols, and the specific instructions of Supervising Physician.

(d) As required by Section 1399.546, each time a PA provides care for a patient and enters his or her name, signature, initials or computer code on the patient's record or written order, PA shall also enter the name of the Supervising Physician responsible for the patient.

4. **Drug Orders.**

(a) PA may administer or provide medication to a patient, or issue a drug order, orally or in writing in a patient's chart or drug order form, subject to the conditions and limitations as set forth in Section 3502.1 of the Business and Professions Code, this Agreement, any applicable protocols as described in subsection (b) below, or the specific instructions of Supervising Physician. Such medications may include Controlled Substances in schedules III through V. PA may sign for the request and receipt of samples of drugs specified in the protocols described in subsection (b) below.

(b) Drug orders shall be based on protocols established or adopted by the Supervising Physician. According to the California Code of Regulations Sections: 1399.541(h), 1399.610 and 1399.612, a PA may administer, provide or issue a drug order for Schedule II through V controlled substances without a patient specific approval if the PA completes an approved controlled substance course and his or her Supervising Physician delegates this authority to them. Each drug delegated in this class must be included in the office specific formulary. The undersigned Supervising Physician and PA agree that this PA has met this course requirement [redacted]nd is in possession of a certificate of completion on file in this office. This document therefore authorizes such use as described in paragraph (b).

(c) Supervising Physician shall review, countersign, and date the medical record of any patient for whom PA issues or carries out a drug order for a Schedule II Controlled Substance within seven (7) days..

5. **Emergency Transport and Backup.**

(a) In a medical emergency requiring the services of a hospital emergency room, the patient shall be directed or transported to the **Emergency Room**, the telephone number of which is When indicated, PA or practice personnel shall telephone the 911 Operator to summon an ambulance.

(b) In the event Supervising Physician is not available when needed, PA may call and/or refer patients to other authorized physicians as designated by the Supervising Physician, or as otherwise deemed appropriate by PA.

6. **Supervising Physician's Responsibilities.**

(a) Supervising Physician shall remain electronically available at all times while PA is performing medical services, unless another approved supervising physician who has signed a Delegation of Services Agreement for PA is so available.

(b) To the extent required by Section 4(c) above, Supervising Physician shall review, countersign and date within seven (7) days the medical record of any patient for whom PA issues or carries out a drug order for a Schedule II Controlled Substance. For other patients, Supervising Physician shall utilize one or more of the following mechanisms to supervise PA, as required by Section 1399.545 of the Physician Assistant Regulations *(Check one or more of the following, as applicable)*:

_____ Examination of the patient by Supervising Physician the same day as care is given by PA

_____ Supervising Physician shall review, audit and countersign every medical record written by PA within _____ days *(no more than thirty (30) days)* of the encounter.

____X____ Supervising Physician shall audit the medical records of at least ten percent (10%) of the patients managed by PA under protocols which shall be adopted by Supervising Physician and PA, pursuant to Section 1399.545(e)(3) of the Physician Assistant Regulations. Supervising Physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent, in his or her judgment, the most significant risk to the patient.

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7. **Protocols.** This Agreement does not constitute the protocols required by Section 3502.1 of the Business and Professions Code or, if applicable, Section 1399.545(e)(3) of the Physician Assistant Regulations. Such protocols are on file at the practice site and may incorporate by reference appropriate medical texts.

8. **No Third Party Beneficiaries.** This Agreement shall not be construed as creating rights in or obligations to any third party. It is the intent of the parties solely to fulfill the requirements of the Physician Assistant Regulations for a Delegation of Services Agreement and for the mechanisms to be used by Supervising Physician in supervising PA.

_____ Dated: _____

PHYSICIAN ASSISTANT

_____ Dated: _____

SUPERVISING PHYSICIAN

Delegation of Services Agreement

DELEGATION OF SERVICES AGREEMENT BETWEEN
SUPERVISING PHYSICIANS AT M

This Delegation of Services Agreement ("Agreement") is entered into between [redacted] MD; [redacted] MD; [redacted] MD; [redacted] MD; [redacted] MD; [redacted] MD, [redacted], MD; [redacted] MD *("Supervising Physicians")* and [redacted] PA-C *("PA")*, in order to fulfill the purposes set forth below.

1. **Purpose.** The purpose of this Agreement is to comply with the requirements of Title 16, Article 4, of the California Code of Regulations, hereinafter referred to as the "Physician Assistant Regulations." Section 1399.540 of the Physician Assistant Regulations states, in pertinent part, that "A physician assistant may only provide those medical services which he or she is competent to perform and which are consistent with the physician assistant's education, training and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant." In this Agreement, Supervising Physicians hereby delegate the performance of certain medical services to PA. Section 1399.545 of the Physician Assistant Regulations sets forth requirements for supervision by a supervising physician when a PA is caring for patients. This Agreement shall set forth such requirements to be followed by Supervising Physicians.

2. **Qualifications.** PA is licensed by the California Physician Assistant Committee. Supervising Physician has been granted approval by the Medical Board of California or the Osteopathic Medical Board of California to act as a supervising physician. PA and Supervising Physician are familiar with the requirements governing the performance of medical services by PAs, and the supervision of PAs by supervising physicians, as set forth in the Physician Assistant Regulations.

3. **Authorized Services.**

(a) PA is authorized by Supervising Physicians to perform all the tasks set forth in subsections (a), (b), (c), (d), (e), (f), and (g) of Section 1399.541 of the Physician Assistant Regulations, subject to the limitations and conditions described in this Agreement or established by Supervising Physician in any applicable protocols or otherwise

(b) As required by Section 1399.540 of the Physician Assistant Regulations, PA may only provide those medical services which he or she is competent to perform and which are consistent with PA's education, training and experience. PA shall consult with Supervising Physicians or another qualified health care practitioner regarding any task, procedure or diagnostic problem which PA determines exceeds his or her level of competence, or shall refer such cases to Supervising Physicians or another appropriate practitioner.

(c) PA shall perform delegated medical services under the supervision of the Supervising Physicians as specified in the Physician Assistant Regulations, this Agreement, any applicable practice protocols, and the specific instructions of Supervising Physicians.

(d) As required by Section 1399.546, each time a PA provides care for a patient and enters his or her name, signature, initials or computer code on the patient's record or written order, PA shall also enter the name of the Supervising Physician responsible for the patient.

4. **Drug Orders.**

(a) PA may administer or provide medication to a patient, or issue a drug order, orally or in writing in a patient's chart or drug order form, subject to the conditions and limitations as set forth in Section 3502.1 of the Business and Professions Code, this Agreement, any applicable protocols as described in subsection (b) below, or the specific instructions of Supervising Physicians. Such medications may include Controlled Substances in schedules III through V. PA may sign for the request and receipt of samples of drugs specified in the protocols described in subsection (b) below.

(b) Drug orders shall either be based on protocols established or adopted by Supervising Physicians, or shall be approved by Supervising Physicians for the specific patient prior to being issued or carried out.

(c) PA has successfully completed an approved controlled substances course in accordance with Section 1399.541 (h) and 1399.610 and is authorized by Supervising Physicians to administer, provide or issue a drug order for Controlled Substances in Schedule II through V, without advance approval by the Supervising Physicians, provided such drug is included in the protocols. PA has made the course certificate of completion available for inspection by the supervising physician. [redacted]

(d) Supervising Physician shall review, countersign, and date the medical record of any patient for whom PA issues or carries out a drug order for a Schedule II Controlled Substance within seven (7) days.

5. **Emergency Transport and Backup.**

(a) In a medical emergency requiring the services of a hospital emergency room, the patient shall be directed or transported to the nearest Emergency Room. When indicated, PA or practice personnel shall telephone the 911 Operator to summon an ambulance.

(b) In the event Supervising Physician is not available when needed, PA may call and/or refer patients to other authorized physicians as designated by the Supervising Physician, or as otherwise deemed appropriate by PA.

6. **Supervising Physician's Responsibilities.**

(a) Supervising Physicians shall remain electronically available at all times while PA is performing medical services, unless another approved supervising physician who has signed a Delegation of Services Agreement for PA is so available.

(b) Supervising Physician shall audit the medical records of at least five percent (5%) of the patients managed by PA under protocols which shall be adopted by Supervising Physician and PA, pursuant to Section 1399.545(e)(3) of the Physician Assistant Regulations. Supervising Physician shall select for review those cases which by diagnosis, problem,

treatment or procedure represent, in his or her judgment, the most significant risk to the patient.

7. **Protocols.** This Agreement does not constitute the protocols required by Section 3502.1 of the Business and Professions Code or, if applicable, Section 1399.545(e)(3) of the Physician Assistant Regulations. Such protocols are on file at the practice site and may incorporate by reference appropriate medical texts.

8. **No Third Party Beneficiaries.** This Agreement shall not be construed as creating rights in or obligations to any third party. It is the intent of the parties solely to fulfill the requirements of the Physician Assistant Regulations for a Delegation of Services Agreement and for the mechanisms to be used by Supervising Physician in supervising PA.

_____ Dated: _____
PHYSICIAN ASSISTANT

_____ Dated: _____
MD - SUPERVISING PHYSICIAN

_____ Dated: _____
MD - SUPERVISING PHYSICIAN

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MD - SUPERVISING PHYSICIAN

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MD - SUPERVISING PHYSICIAN

_____ Dated: _____
MD - SUPERVISING PHYSICIAN

Protocols for Physician Assistant Practice

As outlined in Sections 1399.541 and 1399.545 of the Physician Assistant Regulations, and Section 3502 of the Physician Assistant Practice Act, the undersigned have adopted the following medical books as the protocols and formulary for the physician assistant practice of medicine. The physician assistant(s) affirms that the following standard texts will constitute the body of information that he or she will consult on a regular basis for clarification of medical issues. A consensus derived from these sources will serve as his or her protocols and formulary in the absence of a patient-specific consultation with a supervising physician. The protocols set forth in these medical books, which shall be kept at the practice site available for reference at all times, shall provide:

(1) Guidelines for the subjective and objective data that should be obtained from patients for each of the diseases included within them;

(2) Guidelines for the management of patients with any of the included diseases; and

(3) The formulary of drugs that may be administered or ordered by the physician assistant. Controlled substances require advance approval from the supervising physician unless the PA has completed an approved course and has delegated authorization, documented in the Delegation of Services Agreement, to provide controlled substances without prior approval. The indications and contraindications for use of the drugs included in the above formulary are found in the Physician's Desk Reference (PDR), which is included in these protocols.

As an agent of the supervising physician, the physician assistant is authorized to provide, administer or order a service, drug, device or procedure specified in these protocols. Except as provided below, the physician assistant may initiate treatment or orders for the patient care services indicated in the protocols specified in these medical books without prior consultation with the supervising physician.

Physician consultation or referral is indicated for the management of patients that have diseases which are not included in the protocols set forth in these medical books and regarding any patient, task, procedure or diagnostic problem that the physician assistant determines exceeds his level of competence. Also, prior approval of the supervising physician is required before issuing or carrying out any drug order for a drug that is not specified in the applicable treatment protocol.

Nothing herein shall be deemed as limiting the discretion of the Physician Assistant, with input from the supervising physician when needed, to exercise professional judgment in the treatment of patients. Deviation from the protocols and guidelines shall not, by itself, be deemed a deviation from the standard of care.

Unless otherwise indicated, all chapters of the following texts shall be included in these protocols.

1. Bonica's Management of Pain (Loeser)
2. Interventional Pain Management (Waldman)
3. ~~Intrathecal Drug Therapy for Spasticity and Pain (Gianino et al.)~~
4. Harrison's Principles of Internal Medicine (Fauci)
5. Current Medical Diagnosis and Treatment (Lange)
6. Saunders Manual of Medical Practice (Rakel)
7. International Spinal Intervention Society Practice Guidelines

8. Official Disabilty Guidelines
9. American College of Occupational and Environmental Medicine Guidelines

Declaration: Our signatures below signify that we fully understand the forgoing protocols for physician assistant practice and agree with its terms without reservation.

Signed [redacted] Date: [redacted] Signed: [redacted]

Signe [redacted] Date: [redacted]

DELEGATION OF SERVICES AGREEMENT BETWEEN SUPERVISING PHYSICIAN AND PHYSICIAN ASSISTANT AND WRITTEN SUPERVISION GUIDELINES

This Delegation of Services Agreement ("Agreement") is entered into between [redacted], MD, and [redacted], MD ("Supervising Physician"), and [redacted] PA-C ("PA"), in order to fulfill the purposes set forth below.

1. **Purpose.** The purpose of this Agreement is to comply with the requirements of Title 16, Article 4, of the California Code of Regulations, hereinafter referred to as the "Physician Assistant Regulations." Section 1399.540 of the Physician Assistant Regulations states, in pertinent part: "A physician assistant may only provide those medical services which he or she is competent to perform and which are consistent with the physician assistant's education, training and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant. The writing which delegates the medical services shall be known as a delegation of services agreement. A delegation of services agreement shall be signed and dated by the physician assistant and each supervising physician. A delegation of services agreement may be signed by more than one supervising physician only if the same medical services have been delegated by each supervising physician. A physician assistant may provide medical services pursuant to more than one delegation of services agreement."

In this Agreement, Supervising Physician hereby delegates the performance of certain medical services to PA. Section 1399.545 of the Physician Assistant Regulations sets forth requirements for supervision by a supervising physician when a PA is caring for patients. This Agreement shall set forth such requirements to be followed by Supervising Physician.

2. **Qualifications.** PA is licensed by the California Physician Assistant Committee. Supervising Physician is licensed by the Medical Board of California or the Osteopathic Medical Board of California and is qualified to act as a supervising physician. PA and Supervising Physician are familiar with the requirements governing the performance of medical services by PAs, and the supervision of PAs by supervising physicians, as set forth in the Physician Assistant Regulations.

3. **Authorized Services.**

(a) PA is authorized by Supervising Physician to perform all the tasks set forth in subsections (a), (b), (c), (d), (e), (f), and (g) of Section 1399.541 of the Physician Assistant Regulations, subject to the limitations and conditions described in this Agreement or established by Supervising Physician in any applicable protocols or otherwise. PA is also authorized to perform certain surgical procedures as specified by Supervising Physician in accordance with Section 1399.541(i) of the Physician Assistant Regulations.

(b) As required by Section 1399.540 of the Physician Assistant Regulations, PA may only provide those medical services which he or she is competent to perform and which are consistent with PA's education, training and experience. PA shall consult with Supervising Physician or another qualified health care practitioner regarding any task, procedure or diagnostic problem which PA determines exceeds his or her level of competence, or shall refer such cases to Supervising Physician or another appropriate practitioner.

(c) PA shall perform delegated medical services under the supervision of the Supervising Physician as specified in the Physician Assistant Regulations, this Agreement, any applicable practice protocols, and the specific instructions of Supervising Physician.

(d) As required by Section 1399.546, each time a PA provides care for a patient and enters his or her name, signature, initials or computer code on the patient's record or written order, PA shall also enter the name of the Supervising Physician responsible for the patient.

(e) PA shall also be able to (1) order durable medical equipment for purposes of medicare billing and (2) approve, sign, modify, or add to a plan of treatment or plan of care for home health services

4. **Drug Orders.**

(a) PA may administer or provide medication to a patient, or issue a drug order, orally or in writing in accordance with the provisions of Section 3502.1 of the Business and Professions Code, this Agreement, any applicable protocols as described in subsection (b) below, or the specific instructions of Supervising Physician. Such medications may include Controlled Substances in schedules II through V. PA may sign for the request and receipt of samples of drugs specified in the protocols described in subsection (b) below.

(b) Drug orders shall either be based on protocols established or adopted by Supervising Physician, or shall be approved by Supervising Physician for the specific patient prior to being issued or carried out. Unless the PA has satisfied the requirements of Subsection (c) below, all drug orders for Controlled Substances shall be approved by Supervising Physician for the specific patient prior to being issued or carried out.

(c) PA has successfully completed an approved controlled substances course in accordance with Section 1399.541(h) and 1399.610 and is authorized by Supervising Physician to administer, provide or issue a drug order for Controlled Substances in Schedule II through V, without advance approval by the Supervising Physician, provided such drug is included in the protocols. PA has made the course certificate of completion available for inspection by the supervising physician. [redacted]

(d) Supervising Physician shall review, countersign, and date the medical record of any patient for whom PA issues or carries out a drug order for a Schedule II Controlled Substance within seven (7) days.

5. **Emergency Transport and Backup.**

(a) In a medical emergency requiring the services of a hospital emergency room, the patient shall be directed or transported to the [redacted] or [redacted] Emergency Rooms. When indicated, PA or practice personnel shall telephone the 911 Operator to summon an ambulance.

(b) In the event Supervising Physician is not available when needed, PA may call and/or refer patients to other authorized physicians as designated by the Supervising Physician, or as otherwise deemed appropriate by PA.

6. **Supervising Physician's Responsibilities.**

(a) Supervising Physician shall remain electronically available at all times while PA is performing medical services, unless another approved supervising physician who has signed a Delegation of Services Agreement for PA is so available.

(b) Supervising Physician shall utilize one or more of the following mechanisms to supervise PA, as required by Section 1399.545 of the Physician Assistant Regulations:

> Supervising Physician shall audit the medical records of at least five percent (5%) of the patients managed by PA under protocols which shall be adopted by Supervising Physician and PA, pursuant to Section 3502(c)(2) of the Business and Professions Code. Supervising Physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent, in his or her judgment, the most significant risk to the patient.

7. **Protocols.** This Agreement does not constitute the protocols required by Section 3502 or 3502.1 of the Business and Professions Code. Such protocols are on file at the practice site and may incorporate by reference appropriate medical texts.

8. **No Third Party Beneficiaries.** This Agreement shall not be construed as creating rights in or obligations to any third party. It is the intent of the parties solely to fulfill the requirements of the Physician Assistant Regulations for a Delegation of Services Agreement and for the mechanisms to be used by Supervising Physician in supervising PA.

[redacted] Dated: [redacted]

PHYSICIAN ASSISTANT

[redacted] Dated [redacted]

SUPERVISING PHYSICIAN

[redacted] Dated: [redacted]

SUPERVISING PHYSICIAN

Date: July 1, 2008

To: **Cardiothoracic Surgery Physician Assistants**

Re: **Delegation of Services Agreement Between Supervising Physician's Responsibility for Physician Assistants**

Title 16, Article 4, Section 1399.540 of Physician Assistant Regulations state in part: A Physician Assistant may only provide Medical Services for which he/she is competent to perform and which are consistent with the Physician Assistant's education, training, and experience and which have been delegated by the supervising physician who is responsible for the patients cared for by the Physician Assistant.

Section 3502 of the California Business and Professional Code describes further Physician Assistant Practice with regards to Written Drug Order, State of Emergency and Immunity from Liability (Good Samaritan Act).

As specified in AB3 Legislation to PA Regulations, the Physicians authorize Physician Assistant's to take required course and to write non-patient specific drug order.

(See Attached List) are licensed physicians who practice in the State of California

Supervisor Required: The Physician Assistant (PA) named in the attached Delegation of Services Agreement will be supervised by the supervising physician in accordance with these guidelines set forth as required under Section 1399.545 of Physician Assistant Regulations, which have been read by the physician assistants whose signatures are at the end of this document. The physicians shall review, countersign, and date within 7 days the medical records for any patient cared for by the physician assistant for whom the physician's prescription, or written drug order was transmitted. Each time a physician assistant provides care for an individual patient, he will enter his name, signature, and the name of the supervising physician. Supervising physicians shall review, audit, and countersign the medical records written by the PA within 30 days and/or will audit 5% of the medical records which have been managed under protocols by the physician assistant.

The Physician Assistant will use the following texts: The Physician Desk Reference, The Manual for Perioperative Care of Cardiac and Thoracic Surgery by Bojar, the Physician Assistant's Prescribing Reference book, which is published quarterly, Harrison's Textbook of Medicine, Conn Medical Therapeutics, The Washington Manual of Medical Therapeutics, Pocket Pharmaco Poeia, and any other pertinent text., EPOCRATES –

The responsibilities of the physician are listed in the [illegible] Surgery job description. The PA will function as described in the job description to include, but not limited to: first and second assisting in surgery; harvesting of saphenous vein; open or endoscopic harvesting of radial artery; insertion of arterial lines; insertion of SWAN GANZ, CVP, triple lumen lines, and thoracentesis; insertion of intra-aortic balloon pump; insertion and removal of chest tubes; removal of pacing wires; ICU and floor care; pre and postoperative evaluations of the patient including history and physicals, consults, pre and postoperative orders.

The physician and physician assistant will function as per the Bylaws and/or Rules and Regulations of the individual hospitals for which they have been awarded staff privileges.

Consultation requirements: The PA will see the initial consultation and discuss the patient's treatment plan and diagnosis with the physician who will be the consultant. The PA may write a written drug order form as established under the practice protocols, drug formulary, and physician assistant regulations. The practice site of the physician and physician assistants are listed on the back page.

Emergency transport and backup: The PA will immediately contact the physician on-call or the Cardiothoracic Fellow, depending upon the location of said emergency, should emergencies occur.

This Delegation of Services Agreement is understood by affixing the signature of the PA and the Supervising Physicians on the following pages.

All Physician Assistants with the Depar[illegible] Surgery will obtain and maintain DEA registration and are authorized to have written drug authority. They are also authorized under section 4061 of the Business and Profession code to order and request professional drug samples.

The following classes of medications are approved for use by physician assistants. They include: Analgesics, antimicrobials, cardiovascular medications including inotropes, or pressors, not limited to dopamine, dobutamine, adrenalin, aramine ephedrine, levophed, milrinone, neosynephriene, calcium channel blockers, ACE inhibitors, antihypertensives, beta-blockers, diuretics, volume expanders, thrombolytic pressors, nitrates, pulmonary medications, beta antagonists combinations, inhaled steroids, endocrine medications, corticosteroids, diabetics, gout related, thyroid related, GI medications including antiemetics, antiulcers, H2 antagonists, laxatives, proton pump inhibitors, hematologic agents, heparin, Lovenox, coumadin, neurology medications, Parkinson's anticholinergic to Parkinson's, dopaminergic, urology medications not limited to: Benign prostate hyperplasia, bladder agents.

The dosages of these medications will be followed within the approved text of the delegation of services agreement. Physician Assistants are specifically approved to write for pain medications in a hospital setting for morphine, Toradol, Vicodin, Tylenol #3, darvocettN-100 and other similar medications. They may not write for morphine or schedule two medications outside of the hospital setting. This formulary has been reviewed by the supervising physicians whose signatures appear on the last page of the Delegation of Services Agreement and also acknowledged by the physician assistants whose signatures is on the last page of the Delegation of Services Agreement.

1.
2.
3.

DELEGATION OF SERVICES AMENDMENT

PA IS AUTHORIZED TO PRESCRIBE SCHEDULE MEDICATION AS DEFINED BY AB3 LEGISLATION EFFECTIVE JANUARY 1 2008, IF THE PHYSICIAN ASSISTANT HAS COMPLETED THE REQUIRED EDUCATION COURSE.

GUIDELINES FOR PHYSICIAN AND PHYSICIAN ASSISTANT

1. IF A PHYSICIAN AND A PHYSICIAN ASSISTANT AGREE THEY THEIR PRACTICE SETTING WILL NOT HAVE PATIENT SPECIFIC PRIOR APPROVAL BY THE PHYSICIAN, THEN IT IS THE PHYSICIAN AND PHYSICIAN ASSISTANT RESPONSIBILITY TO MAINTAIN DOCUMENTATION OF THE EDUCATION COURSE COMPLETED BY THE PHYSICIAN ASSISTANT TO COMPLY WITH SECTION 3502.1, PARAGRAPH (C) PART (2) OF THE B&P CODE, AND TO HAVE AVAILABLE AT ALL PRACTICE SITES FOR INSPECTION BY THE PHYSICIAN ASSISTANT COMMITTEE OR IT'S DESIGNATED REPRESENTATIVE..

Physician Assistant

Cardiovascular and Thoracic Surgery
Management Protocols

Responsibilities:

I. *Review patient records to determine health status.*

A. Obtain health record from Medical Records
B. Review Diagnosis Sheets and Progress Records from previous admissions and clinic visits
C. Interview patient to ascertain present complaint
D. Present patient's present complaint and previous medical history to attending physician in a clear concise manner.

II. *Perform and record history and physical examination.*

A. Interview patient and obtain:
1. Chief complaint
2. History of present illness
   a. Identifying statement
   b. Chronological history of presenting complaint
c. Include any objective previously obtained data, such as cardiac catheterization data.
d. Brief differential diagnosis to include pertinent positives and negatives
   e. Any pertinent medications relating to present illness
   f. Reason for admission
3. Past medical history
   a. Previous medical history to include, hypertension. + -; tuberculosis + -; diabetes + -; malignancy + -; heart disease + -.
   b. Previous operations
   c. Allergies and immunizations
   d. Present medications and diet
4. Family history (may be in symbol form)
   a. Spouse's age and major medical problems
   b. Children's ages and major medical problems
   c. Parents' ages and major medical problems
   d. Siblings ages and major medical problems
   e. Predominant medical problems
5. Social history
   a. Occupations: if retired, why disabilities
   b. Domestic situation
   c. Tobacco history
   d. Alcohol and drug history
6. Review of systems
   a. Major systems review

B. Physical examination
Detailed physical examination is required on all hospital admissions and on all NEW patients seen in clinic.
C. Impression
Major problems list to include as number 1, the presenting diagnosis
D. History and physical examination is recorded

(on the general History and Physical Examination form and supplementary sheets are used if additional sheets are required.)

III. *Write routine admission and preoperative orders.*

Routine order will be written according to the attached copies.

IV. *Assist at Surgery*

A. Assist anesthesia in starting intravenous lines
B. Insert radial arterial monitoring line where applicable
C. Insert Foley catheter where applicable
D. Position patient for procedure
E. Prep patient with antiseptic solutions
F. Drape patient for surgery
G. First or second assist during operation at surgeon's discretion
H. Assist moving patient after surgery
I. Generally supervise and expedite activities in preparation for and between operations.

V. *Complete discharge summaries*

A. Discharge summaries will be dictated according to the outline which appears on all Dictaphones.
B. Access codes are provided
C. Discharge summaries are to be reviewed by the dictator and signed.
D. Discharge summaries are to be kept up to date.

VI. Start intravenous lines

A. Select appropriate size catheter.
B. Ask nurses to prepare intravenous fluid.
C. Prep skin with alcohol or benadine.
D. Insert catheter in upper extremity as far distal as possible.
E. Use local anesthesia for starting 16 gauge or larger catheters.
F. Secure catheter with sterile bandage and tape appropriately.
G. Ask nurse to regulate fluid according to your orders.

VII. Insert Foley catheters.

A. Obtain appropriate size catheter & insertion set.
B. Prepare and drape sterile field.
C. Insert catheter making sure there is urinary return before inflating balloon.
D. Attach catheter to appropriate sterile urinary drainage system.

VIII. Insert nasogastric tubes or feeding tubes.

A. Obtain appropriate size tube.
B. Obtain surgical lubricant.
C. Obtain small glass of water or clear liquid.
D. Cool tube in ice water or freezer to facilitate intubation if necessary.
E. Use gelatin capsule for inserting small flexible feeding tubes along with larger more rigid tube.
F. Ask patient to swallow small amounts of water while inserting tube.
G. Listen over epigastric area for proper placement of tube while injecting small amount of air in tube.
H. Secure tube to nose with adhesive tape, making sure that this is no pressure on nares.
I. Connect tube to appropriate drainage system.

IX. Perform electrocardiogram

A. Obtain ECG machine.
B. Attach leads to appropriate points.
C. Operate machine according to directions.

X. Perform thoracentesis.

A. Review appropriate X-ray with consultant.
B. Obtain appropriate instrument tray.
C. Prepare and drape sterile field.
D. Anesthetize skin and chest wall.
E. Obtain plasma evacuation bottle and tubing.
F. Insert needle into pleural space.
G. remove needle leaving catheter in place.
H. Attach 50 cc syringe and 3-way stopcock to catheter.
I. Obtain specimens in bottles provided.
J. Attach tubing from evacuation bottle to 3-way stopcock.
K. Evacuate effusion.
L. Remove catheter and apply sterile dressing.
M. Review post procedure X-ray with consultant.

XI. Remove chest tubes.

A. Review current X-ray with consultant.
B. Obtain three inch adhesive tape, sponges, vaseline gauze, suture removal set.
C. Remove dressing.
D. Cut securing stitch.
E. Hold vaseline gauze dressings over subcutaneous tract of tube.
F. remove chest tube on full inspiration as rapidly as possible.
G. Tape dressing in place.
H. Order appropriate X-rays.
I. Review post-extubation X-ray with consultant.
J. remove dressing after 48 hours.

XII. Remove monitoring lines.

A. Remove securing stitch and any dressings.
B. Remove line slowly.
C. Pressure dressings are applied over arterial puncture sites using gauze and elastoplast.

XIII. Irrigate chest tubes and Foley catheter.

A. Obtain sterile saline, irrigating syringe and irrigating bowl.
B. Prep chest tubes before interrupting connection.
C. Clamp chest tubes before interrupting connection.
D. Insert syringe in tube, unclamp tube as solution is injected and then reclamp.
E. Reconnect tube to drainage system.
F. Release Clamp.

XIV. Application of dressings and bandages.

All dressings will be changed and applied using sterile gloves and in certain cases with gowns and masks.

XV. *Administer specified medication.*

A. Will be ordered to be given by a nurse.
B. Instillation of medication into body cavity will be done according to the irrigation of chest tubes and Foley catheter technique.

XVI. *Administer intravenous fluids.*

This will be ordered to be fiven by a nurse.

XVII. *Administer transfusions of blood and blood components.*

A. This will be ordered to be given by a nurse.
B. Blood crossmatched, but with notation of specific problem with compatibility, will be transfused and signed by the physician's assistant/nurse practitioner.

XVIII. *Perform arterial punctures for arterial blood gases.*

A. Obtain kit for this purpose.
B. Prep skin with alcohol or betadine.
C. Obtain bag of ice for preservation of specimen.
D. Wash syringe with heparin solution provided.
E. Insert needle into artery.
F. Allow syringe to fill by arterial pressure.
G. Apply pressure over puncture site after needle is removed for at least five minutes.
H. Remove needle from syringe, evacuate are from syringe, cap end of syringe with cap provider.
I. Immediately place specimen in ice and send to laboratory.

XIX. *Insert central venous pressure line.*

A. Review with consultant need for central venous pressure line. Uldall catheter or TPN line.
B. Obtain appropriate instrument tray.
C. Prep and drape appropriate area for insertions.
D. Place patient in flat or preferably Trendelenburg position.
E. Anesthetize skin at side.
F. Insert needle into subclavian or internal jugular vein assuring good venous return.
G. Remove needle leaving catheter in place.
H. Thread CVP catheter through catheter in vein.
I. Aspirate for position.
J. Attach catheter to monitor, transducer or I.V.
K. Secure catheter with suture.
L. Apply sterile dressing.
M. Obtain appropriate X-ray for correct position.
N. Review post-insertion X-ray with consultant.

XX. *Control of external hemorrhage.*

Will be controlled by (1) direct pressure, (2) pressure point, (3) tourniquet or other measures

XXI. *Cardiopulmonary resuscitation.*

All physician assistants working in the departmentare required to be certified in basic life support.

XXII. *Aseptic and isolation technique.*

Hospital policies and procedures concerning techniques will be followed in all cases.

XXIII. *Suture skin incisions.*

This layer closure will be sutured using the specific technique employed by the attending physician.

XXIV. *Suture fascia.*

In most cases, fascia will be sutured under direct supervision of the attending surgeon. In other cases, this layer closure will be sutured using the specified technique employed by the attending physician.

XXV. *Perform tube thoracostomies.*

A. Review appropriate X-rays and patient's history with consultant.
B. Obtain chest tube laceration tray.
C. Obtain appropriate size chest tube.
D. Obtain appropriate collection-suction system.
E. Prepare skin and drape sterile field.
F. Anesthetize insertion site with local anesthesia.
G. Incise skin and chest wall in appropriate location.
H. Prepare a tube tract with blunt instrument or use a trocar with chest tube.
I. Connect chest tube to collection tubing.
J. Secure tube into position.
K. Dress wound.
L. review post-intubation X-rays with consultant.

XXVI. *Veinpunture.*

A. Obtain blood tubes needed.
B. Obtain vacutainer and needles or syringe and needle.
C. Prep skin with alcohol or betadine.
D. Insert needle in vein and withdraw blood.
E. Remove needle and apply sterile Band-Aid.

XXVII. Perform venous cutdown.

A. Review need for venous cutdown with consultant.
B. Obtain appropriate instrument tray.
C. Prepare and drape sterile field.
D. Anesthetize skin.
E. Make skin incision perpendicular to vein.
F. Dissect vein free.
G. Obtain proximal control with encircling ligature.
H. Insert catheter through skin and into controlled vein. Tie off vein distally only if required for homeostasis.
I. Attach catheter to I.V.
J. remove encircling ligature.
K. Secure catheter to skin with skin stitch.
L. Close wound.
M. Apply sterile dressing.

XVIII. Make incisions at operation.

All incisions at operation will be made at the discretion of and under direct supervision of the attending physician.

XXIX. Close sternum.

Closure of the sternum will be accomplished at the discretion and under the direct supervision of the attending physician.

XXX. Set-up and operation of volume controlled ventilator.

Respirator settings will be ordered according to formulas listed under Respiratory Care Protocol. Set-up and operation of the ventilator will be accomplished in conjunction with the Respitory Therapy Department.

XXXI. Set-up and operation of intra-aortic balloon pump.

This procedure will be done under direct physician supervision and in conjunction with the extracorporeal profusionists.

XXXII. Operation of Doppler measuring equipment.

A. Obtain Doppler and probe.
B. Place lubricating conducting gel over artery.
C. Place blood pressure cuff proximal to site.
D. Place probe over artery obtaining the best possible signal.
E. Inflate blood pressure to point at which Doppler signal is lost.
F. Ankle Arm Index is calculated by dividing ankle pressure by brachial artery pressure.

XXXIII. Remove endocractracheal tube postoperatively.

A. Obtain post-weaning arterial blood gases to meet following criteria:
   1. pH 7.35
   2. PCO_2 < 48 min.
   3. PO_2 > 60
   4. HCO_3 > 21
B. Perform spirometry mechanics to meet the following criteria:
   1. Tidal volume = at least 3 cc/kg
   2. Forced vital capacity = at least 10 cc/kg.
C. Communicate with attending physician if extubation criteria are questionable or unclear.
D. Suction trachea.
E. Remove endotracheal tube on full inspiration.
F. Apply mist mask at appropriate F10, setting
G. Extubation note with the above data now entered in progress note.

XXXIV. Arterial cutdown for monitoring.

A. Review with attending physician decision to perform cutdown.
B. Prepare and drape sterile field.
C. Anesthetize skin.
D. Incise skin.
E. Dissect artery to be cannulated and control with ligature.
F. Insert sheathed needle into artery through skin.
G. Connect to appropriate transducer.
H. Secure needle or catheter into position.
I. Close wound
J. Dress wound.

XXXV. Remove saphenous vein for coronary artery bypass. OPEN, OR ENDOSCOPIC

This procedure will always be done under direct supervision of the attending physician.

XXXVI. Percutaneous Arterial Catheterization.

A. Prepare and drape sterile field.
B. Anesthetize skin.
C. Puncture skin with one size larger needle than is to be used for arterial catheterization.
D. Insert sheathed needle into artery.
E. Connect to appropriate transducer.
F. remove air from line with syringe at stopcock.
G. Flush catheter with infusion bag solution.
H. Secure catheter and immobilize with armboard and appropriate dressing.

APPROVED BY:

[redacted]

M.D.

[redacted]

M.D.

[redacted]

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I.D.

[redacted]

I.D.

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[redacted]

Virtual Mentor
American Medical Association Journal of Ethics
May 2012, Volume 14, Number 5: 411-414.

POLICY FORUM

Physician Assistants and Their Role in Primary Care

James F. Cawley, MPH, PA-C

In the mid-1960s, the need for greater patient access to general medical services was a principal motivator for establishment of the physician assistant (PA) profession. Since then, PAs have effectively helped to deliver primary care services in many settings. But the supply of clinicians in this field remains a major issue. While the absolute number of primary care physicians, nurse practitioners, and physician assistants is expected to rise in the coming years, the increases are not expected to meet the demands of an aging population, changes in service use, and trends connected with a major expansion of insurance coverage. The best estimates continue to indicate that there will be significant shortages in primary care clinicians. According to the DHHS Agency for Healthcare Research and Quality, only about one-third (208,000) of American physicians practicing in 2009 [1], 43.4 percent (30,300) of PAs practicing in 2010, and 2 percent of nurse practitioners (NPs) practicing in 2010 worked in primary care [2]. It is believed that these numbers are insufficient to meet current and future demands for these services [3].

PAs: Definition and Scope of Practice

Physician assistants are health care professionals licensed to practice medicine with physician supervision. PAs conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventive health care, assist in surgery, and write prescriptions. A PA's practice may also include education, research, and administrative services [4].

Utilization in Practice

There appears to be increasing reliance on PAs and NPs to deliver primary care services. Recent data from the National Center for Health Statistics attests to this trend based on information from hospital outpatient departments. According to the data brief, hospital outpatient department visits handled by PAs and advanced practice nurses (including APNs and NPs) increased from 10 percent in 2000 and 2001 to 15 percent in 2008 and 2009 [1], indicating greater use of PAs and other nonphysicians, particularly in settings where a good deal of primary care is delivered.

The same study found that PAs also more often delivered care in clinics associated with nonteaching hospitals and handled a higher percentage of Medicaid, Children's Health Insurance Program (CHIP), and uninsured patients, as well as younger patients [1]. These data suggest that PAs are used to a greater degree in smaller facilities located in nonurban areas to serve populations that may otherwise be

medically underserved, trends that are consistent with the intentions of the profession's creators [1].

Of particular interest to some is the finding that PAs saw a higher percentage of preventive care visits (17 percent) than visits for routine chronic conditions or pre- and postsurgical care [1]. It has long been speculated that PAs (as well as NPs) have the potential to provide care that is more prevention-oriented than physician care, and it appears that they may be fulfilling this potential. Further delineation of this trend is warranted. Practicing preventive medicine may offer justification not only for the widespread use of PAs and NPs in primary care but also for policy changes leading to greater levels of reimbursement for preventive services by third-party health payors.

Longer-term trends point to a future for PAs and NPs as the principal front-line deliverers of primary care with physicians assuming more managerial and executive functions and a greater focus on inpatient specialty practice. One physician and professor of medicine at Yale School of Medicine recently observed that "in the decades ahead, it is likely that the main role of the generalist physician will be to supervise those providing primary care and to personally care for patients with complex illnesses who are hospitalized, an idea already well established as the hospitalist movement" [6].

In 2012, 34 percent of practicing PAs reported that their specialty was one of the primary care fields: family/general medicine (25 percent), general internal medicine (7 percent), or general pediatrics (2 percent) [5]. The percentages of PAs working in these primary care fields has been steadily declining, down from fully 50 percent in 1997 and 43.1 percent in 2002 [3]. Although the proportion of PAs choosing primary care has declined, the absolute number of PAs in primary care has continued to increase due to the rapid growth in the number of PAs overall. For example, while the number of PAs in primary care grew only about 45 percent between 1997 and 2006 (from about 16,000 to 23,000), the total number of PAs practicing in America doubled [5].

Increasingly popular specialties for PAs include general surgery/surgical subspecialties (25 percent), emergency medicine (12 percent), the subspecialties of internal medicine (11 percent), and dermatology (4 percent). More than 9 percent work in orthopedics; only 2 percent are in obstetrics/gynecology.

Education, Accreditation, and Certification

Because of the close working relationship they have with physicians, PAs are educated in graduate-level, medical-model programs designed to complement physician training. There are 164 accredited programs in the United States, the majority of which offer master's degrees. The Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) is the accrediting agency responsible for establishing the standards for U.S. PA education and for evaluating programs to ensure their compliance with the standards.

The curriculum is rigorous, comprising basic science, behavioral science, and clinical courses. The required content areas of the preclinical curriculum are anatomy, physiology, pathophysiology, pharmacology and pharmacotherapeutics, and genetic and molecular mechanisms of health and disease. The average U.S. PA program takes 26.5 continuous months of study to complete.

In essence, PA education more closely resembles a condensed version of medical school than does any other health professions curriculum. Clinical education is required in a variety of settings, including outpatient and inpatient settings as well as emergency and long-term care facilities, typically in academic teaching settings. Inpatient clinical rotations are usually conducted in an experiential team format consisting of PA students, medical students, and residents, led by a staff attending physician. The required areas for clinical education are emergency medicine, family medicine, general internal medicine, general surgical care (including operative experiences), geriatrics, pediatrics, prenatal care, and women's health.

Economic Aspects

Data from the Medical Group Management Association's (MGMA) 2009 Physician Compensation and Production Survey supply estimates of the amount of care provided annually by primary care clinicians [7]. (The MGMA statistics reflect productivity at larger group practices, which are not necessarily representative of productivity in smaller group settings [7].) Each year, PAs in family practice have 42 percent of ambulatory encounters with patients (physicians have the other 58) [7]. Using relative value units (RVUs; indicators of service effort used for Medicare reimbursement) that reflect personnel time and level of skill involved with care, PAs have almost as many RVUs as family practitioners (48 percent, to physicians' 52). Use of average, annual patient encounters as the productivity measure may be leading to underestimation of the contribution of PAs because, though in some practices the PA might provide the majority of the care during a patient visit with the physician participating only at the end (e.g., to prescribe medication), these encounters are typically coded as physician encounters [7].

These numbers suggest that hiring a PA in a large practice could be the equivalent of having 0.73 to 0.96 of a full-time (FTE) family practice physician. For general internal medicine and geriatrics, the percentages are somewhat lower (ranging from 70 to 85 percent [7])—perhaps reflecting the complexity of adult cases. For NPs, average annual ambulatory visits and RVUs are lower, possibly reflecting greater use of NPs for administrative and other non-patient-care activities. Although primary care practices differ in how they use certified nurse practitioners (NP-Cs) within a team, these numbers suggest that an NP-C offsets the work of 70 percent to 90 percent of an FTE primary care physician, on average. Additional research on the implications of greater use of NPs and PAs on demand for physicians would be useful.

Conclusions

PAs are likely to continue to be used increasingly in a wide variety of medical practice settings in American medicine, including primary care. They have been shown to be clinically versatile and cost-effective clinicians, extending the services of physician practices and improving delivery of care to underserved populations, and have thus become an important component of the U.S. health care workforce.

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MEDICAL BOARD STAFF REPORT

ATTENTION: Members, Medical Board of California
SUBJECT: Report on Physicians Experience with Electronic Health Records
STAFF CONTACT: Kimberly Kirchmeyer, Deputy Director

BACKGROUND

The Department of Health Care Services has a program called the Medi-Cal Electronic Health Record or EHR Incentive Program which provides eligible Medi-Cal providers with $21,250 during the first year of the program for adopting, implementing, or upgrading a certified electronic health record in their practices. In subsequent years, providers who demonstrate "meaningful use" of their EHRs by reporting on a set of objectives and clinical quality measures will receive $8,500 yearly for up to 5 years. Over the life of the program providers can receive a total of $63,750 in incentive payments from Medi-Cal. An email blast was sent to physicians notifying them of this program and its deadlines for application.

The Board also partnered with the University of California at San Francisco to assist the Department of Health Care Services in being able to baseline or provide a starting point for usage of electronic health records statewide. The UCSF drafted a survey that was sent out to physicians along with their renewal notice. This survey was separate from the Board's physician survey and asked questions regarding electronic health records. The information gathered from this survey by UCSF was used to draft a report for the Department. This report will provide the Department with the data they can use to see how this program impacts the use of EHR in the future. The Department of Health Care Services and UCSF is presenting its report at this July 2012 meeting.

Janet Coffmann, MAA, MPP, Ph.D., Assistant Adjunct, UCSF will be making a presentation on this report. Professor Coffman is an associate professor at the Philip R. Lee Institute for Health Policy Studies and the Department of Family and Community Medicine at the UCSF. She has been engaged in health workforce policy and research for over 20 years. Professor Coffman's other research interests include health insurance, access to care for vulnerable populations, and innovations in management of chronic illnesses. She serves as principal analyst for medical effectiveness for the California Health Benefits Review Program, a program of the University of California that responds to requests from the California State Legislature to provide independent analysis of the medical, cost, and public health impacts of proposed health insurance benefit mandates and repeals. In addition she directs an initiative at UCSF that aims to enhance capacity for UCSF students, residents, fellows, and faculty to conduct research using large, secondary datasets. She previously worked for the United States Senate Committee on Veterans Affairs, the San Francisco Department of Public Health, and the UCSF Center for the Health Professions. Dr. Coffman received a master's degree in public policy and a doctoral degree in health services and policy analysis from the University of California, Berkeley.

Full report can be obtained at: http://www.chcf.org/publications/2012/06/meaningful-use-ehrs-physicians

On the Road to Meaningful Use of EHRs: A Survey of California Physicians

Janet M. Coffman, MA, MPP, PhD
University of California, San Francisco

July 20, 2012

Outline

- Background
- Methods
- Findings
- Implications

Background

- The HITECH Act authorizes Medicare and Medicaid (Medi-Cal in California) to make incentive payments to hospitals and clinicians for meaningful use of electronic health records (EHRs)

- Total payments of $27 billion over 10 years
  - $2 to $3 billion for California hospitals and health professionals
  - As much as $44,000 (Medicare) or $63,750 (Medicaid) per clinician

Background

- Broader adoption of EHRs has potential to
  - Improve prevention and early diagnosis
  - Improve management of chronic conditions
  - Improve communication among providers
  - Reduce medical errors
  - Reduce duplication of diagnostic tests
  - Reduce expenditures

Background

- Concerns about EHRs during initial implementation and beyond
  - Not designed with physicians' needs in mind
  - Distract from provider-patient interactions
  - Disrupt work flow
  - Increase errors
  - Reduce quality of care

Methods

- Supplemental questionnaire sent at the time of biennial physician licensure renewal to MDs with renewal dates from June 1 through July 31, 2011
- MDs could respond on paper or online
- Supplemental survey results combined with information from the mandatory survey and the Medical Board's core license file database

Meaningful Use Objectives Measured

Core Objectives

Collect patient demographics

Take clinical notes

Generate patient problem list

Order/transmit prescriptions electronically

Generate list of medications

Generate list of medication allergies

Generate routine reports for quality indicators

Transmit information electronically to/from providers to whom patients are referred

Menu Objectives

View or receive lab test results

Generate lists of patients by condition

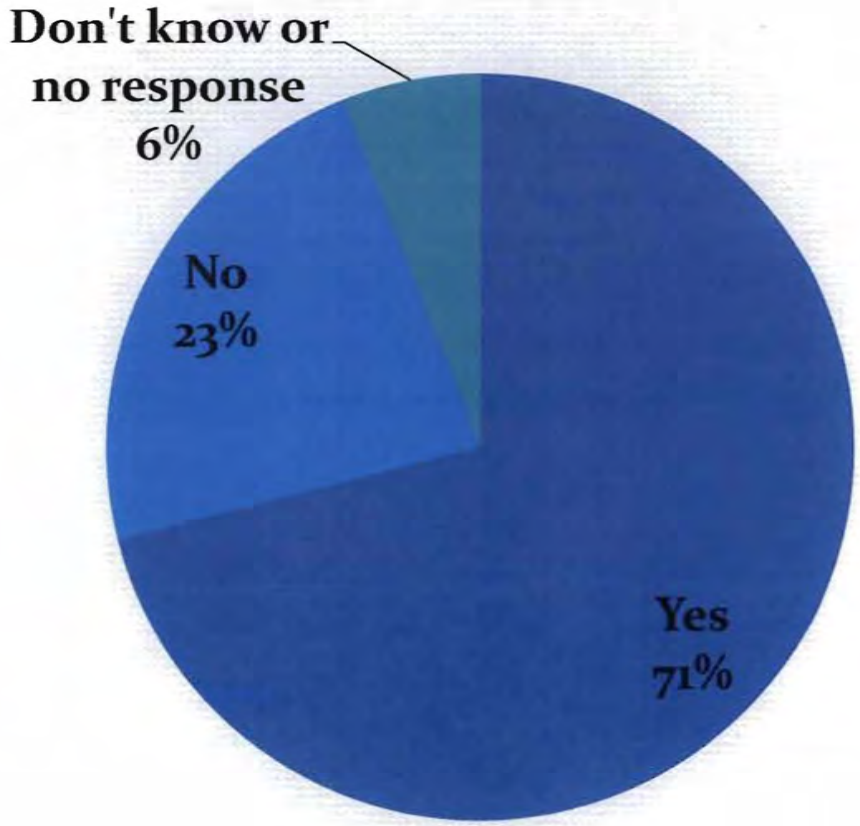
Transmit data to immunization registries

Provide patients access to own records

Response Rate

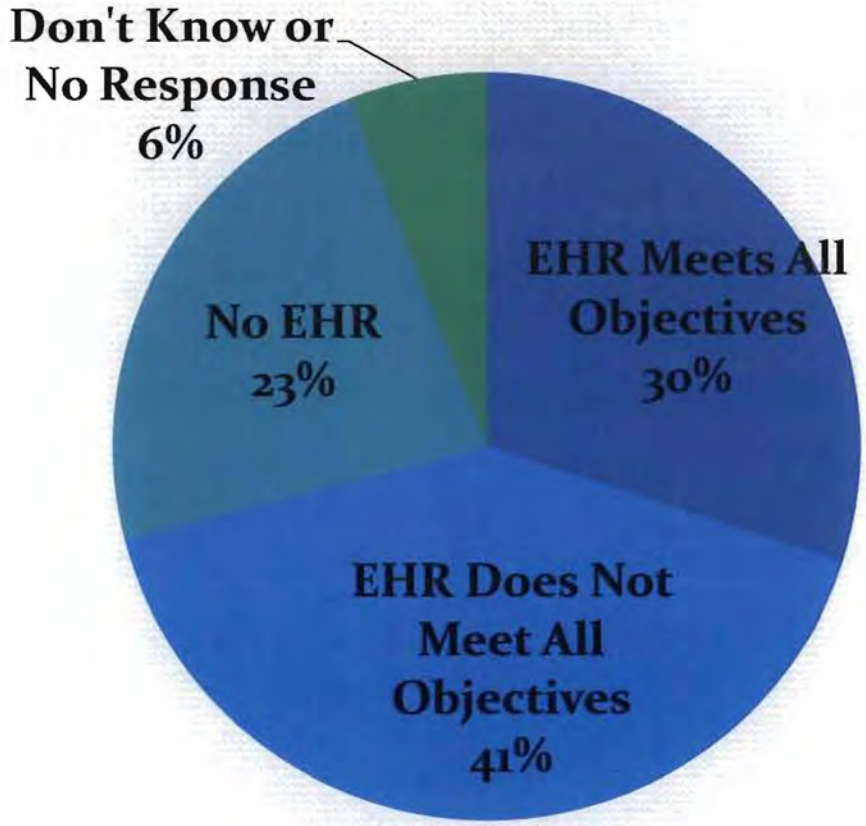
	Number	Percent
Number with license renewal due in June or July 2011	10,353	
Number with practice zip code in California and provide at least 1 hour of patient care per week	7,931	77%
Completed EHR supplemental survey	**5,384**	**68%**

Physicians with Any EHR
(n = 5384)



Physicians with EHRs that Meet All 12 Meaningful Use Objectives

(n = 5384)

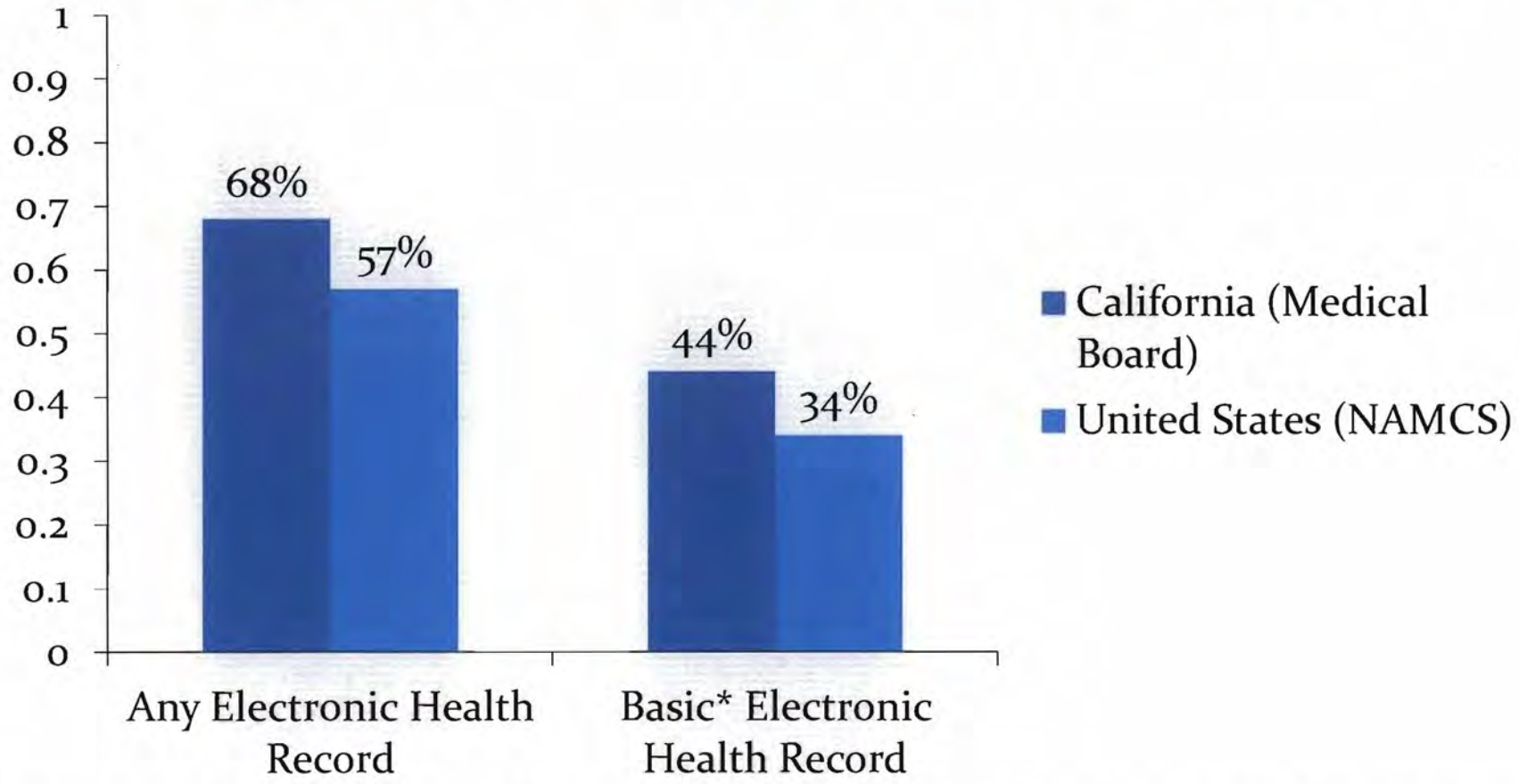


Availability of Specific EHR Functions

- Most Frequently Available
  - Take clinical notes (60%)
  - Generate list of medication allergies (60%)
  - Generate list of medications (59%)
  - View/receive lab test results (59%)

- Least Frequently Available
  - Provide patients access to own records (40%)
  - Transmit data to immunization registries (41%)
  - Generate routine reports of quality indicators (45%)

California Compared to the US



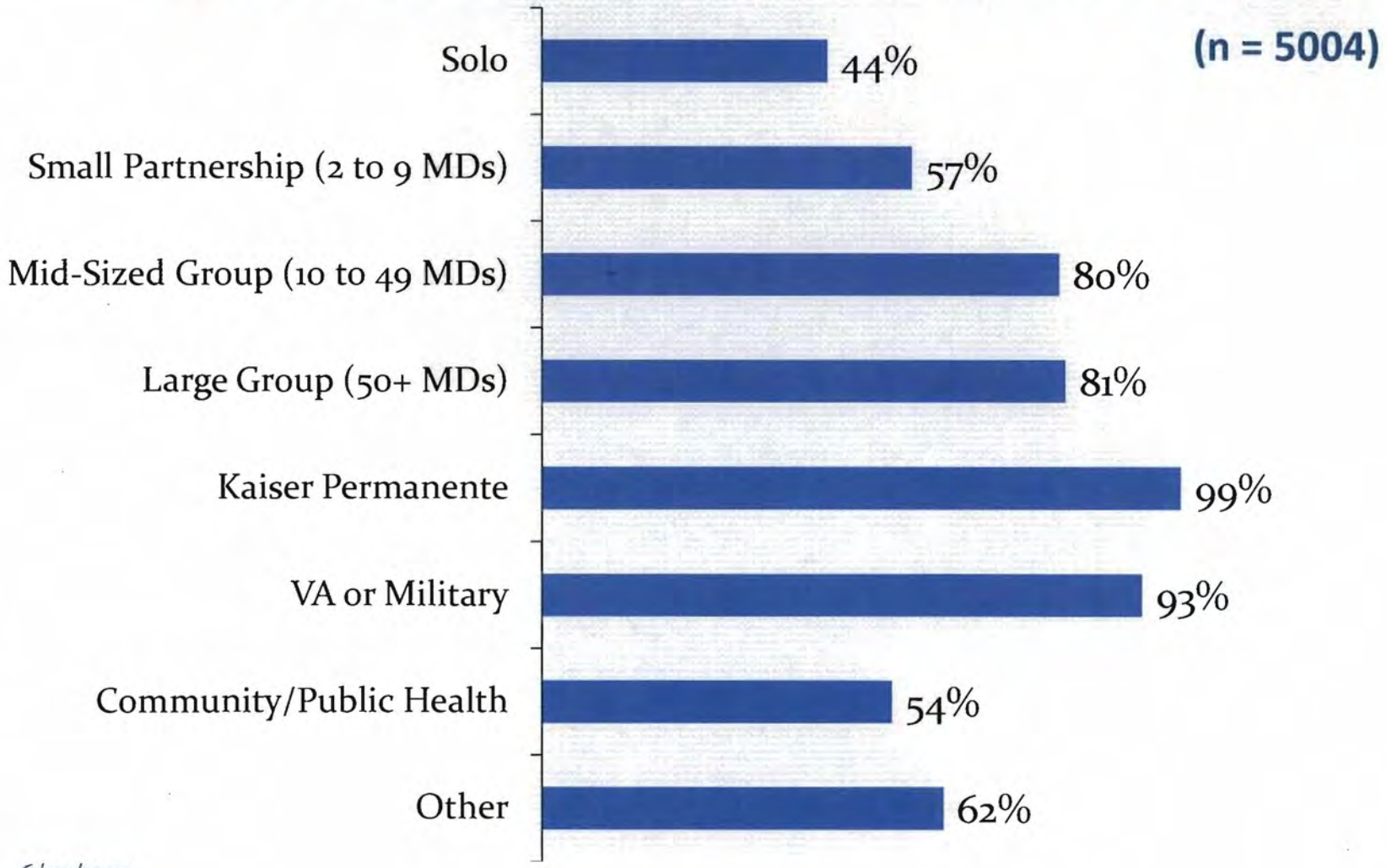
* Defined as an EHR that can collect demographics, take clinical notes, list patient problems, list medications, list medication allergies, order/transmit prescriptions, view lab tests results, view imaging test results.

Factors Associated with Having an EHR

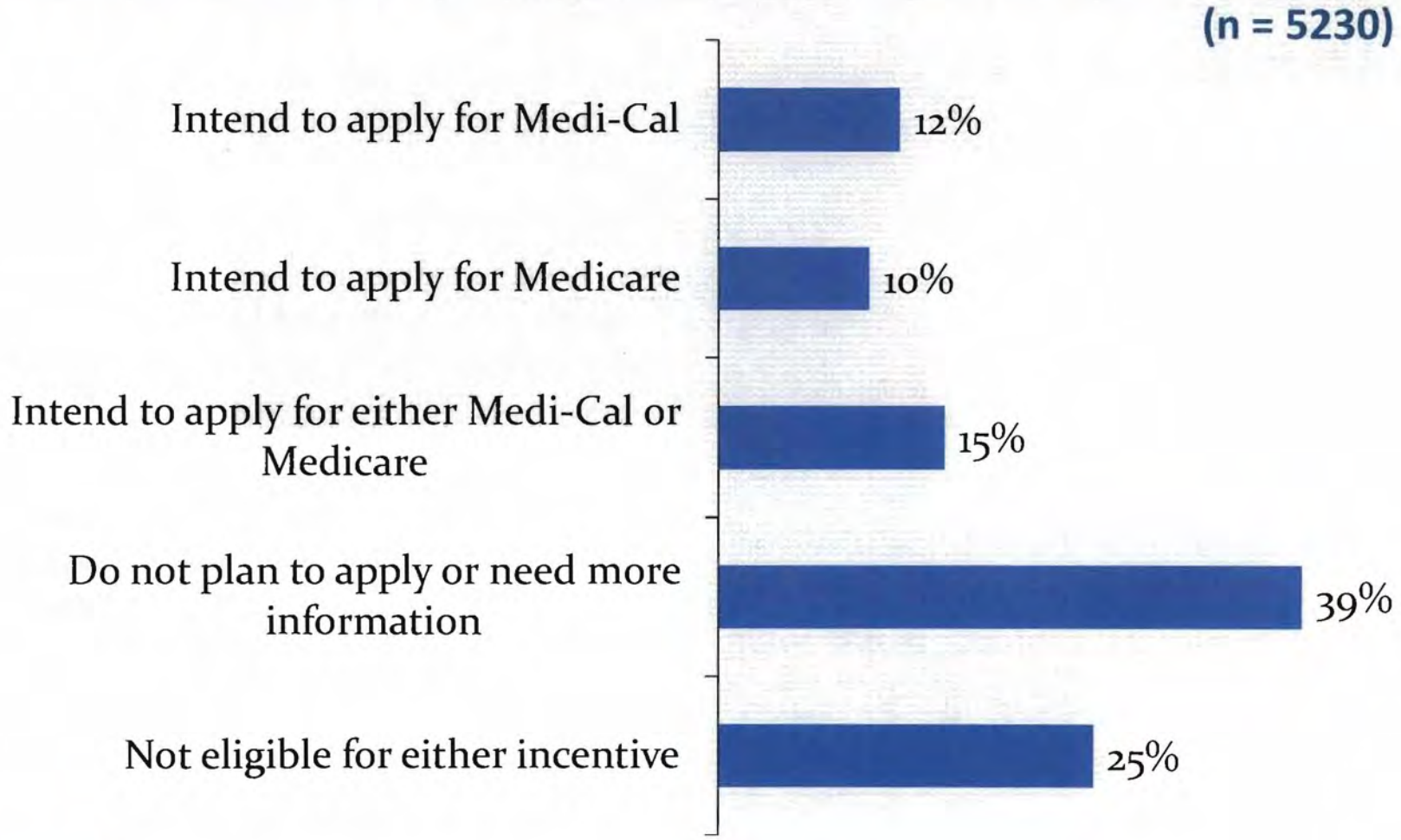
- Higher rates of EHR availability among
  - Physicians in large practices
  - Hospital-based physicians
  - Urban physicians
  - Younger physicians

- Practice size has the largest effect

EHR Availability by Practice Type



Plans Regarding EHR Incentive Payments



Eligibility for Medi-Cal EHR Incentive Payments

- An estimated 17% of physicians with active California licenses are eligible for Medi-Cal incentive payments

- Eligible physicians are more likely to
  - Practice in community/public clinics
  - Practice in rural areas
  - Be primary care physicians

Limitations

- Data are self-reported
- Not all physicians completed the survey
- Some responses were incomplete or implausible
- Did not include other health professionals eligible for Medi-Cal HIT incentive payments

Implications

- Need for ongoing education and outreach about Medicare and Medi-Cal incentive payments
- Involve DHCS, CMS, Regional Extension Centers, Medical Board, and others
- Emphasize the importance of using certified EHRs
- Place highest priority on outreach to
  - Community/public clinics
  - Small practices
- Survey again in 2013 to assess the impact of incentives

Acknowledgements

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Questions???

LEGISLATIVE PACKET

MEDICAL BOARD MEETING

JULY 20, 2012
SACRAMENTO, CA

MEDICAL BOARD OF CALIFORNIA
TRACKER – LEGISLATIVE BILL FILE
July 10, 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	Enrolled	Sponsor	3/21/12
AB 1548	Carter	Cosmetic Surgery: Employment of Physicians	Enrolled	Support	3/22/12
AB 1621	Halderman	Physicians & Surgeons: Prostate Cancer	Enrolled	Support	
AB 1896	Chesbro	Tribal Health Programs: Health Care Practitioners	Enrolled	No Position	3/27/12
AB 2561	Hernandez	Certified Surgical Tech.	Sen. Approps	Neutral	6/26/12
AB 2570	Hill	Licensees: Settlement Agreements	Sen. Approps	Support	
SB 122	Price	International Medical Schools	Asm. Approps		7/2/12
SB 616	DeSaulnier	CURES	Asm. 3rd Reading	Reco: Support	6/27/12
SB 924	Price, Walters & Steinberg	PTs: Direct Access: Professional Corporations	Asm. Approps	Oppose Unless Amended	6/18/12
SB 1095	Rubio	Pharmacy: Clinics	Asm. Approps	Support	6/25/12
SB 1236	Price	Healing Arts Boards	Asm. Approps	Reco: Support	6/18/12
SB 1237	Price	Professions & Vocations: Regulatory Boards (VEP Sunset Extension)	Asm. Approps	Reco: No Position	7/5/12
SB 1274	Wolk	Healing Arts: Hospitals: Employment	Asm. Approps	Support	4/26/12
SB 1416	Rubio	Medical Residency Training Program Grants	Asm. Approps	Support	5/29/12
SB 1483	Steinberg	Physician Health Program	Asm. Approps	Reco: Neutral if Amended	7/2/12
SB 1575	B&P Comm.	Omnibus – B&P Health	Asm. Approps	Sponsor	6/28/12

Pink – Sponsored Bill, Blue – For Discussion, Green – No Discussion Needed

SPONSORED BILLS

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 has been sent to enrollment.

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

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1575
Author: Committee on Business, Professions, and Economic Development
Bill Date: June 28, 2012, amended
Subject: Omnibus
Sponsor: Committee, Medical Board, and other health boards
Position: Support MBC Provisions

STATUS OF BILL:

This bill is in the Assembly Appropriations 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.

Recent amendments do not impact the provisions in the bill related to the Board.

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: Board of Behavioral Sciences
Medical Board of California

OPPOSITION: None on file

AMENDED IN ASSEMBLY JUNE 28, 2012

AMENDED IN ASSEMBLY JUNE 20, 2012

AMENDED IN ASSEMBLY JUNE 12, 2012

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 1640, *1715.5,* 1934, 1950.5, 2021, 2064, 2184, 2220, 2424, 2516, 2518, 2570.13, 2904.5, 3057.5, 3742, 3750, 3750.5, 4209, 4980.04, 4980.34, 4980.397, 4980.398, 4980.399, 4980.40, 4980.43, 4980.44, 4980.48, 4980.50, 4980.78, 4980.80, 4984.01, 4984.4, 4984.7, 4984.72, 4989.16, 4989.42, 4992.05, 4992.07, 4992.09, 4992.1, 4996.1, 4996.3, 4996.4, 4996.6, 4996.28, 4999.22, 4999.32, 4999.45, 4999.46, 4999.50, 4999.52, 4999.53, 4999.55, 4999.57, 4999.58, 4999.59, 4999.62, 4999.63, 4999.64, 4999.76, 4999.90, 4999.100, 4999.106, and 4999.120 of, to add Sections 1902.2, 1942, 1958.1, and 4300.1 to, and to repeal Section 1909.5 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) 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 approved 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.

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.

Existing law authorizes the Dental Board of California to issue a special permit to persons meeting certain requirements, including furnishing satisfactory evidence of having graduated from a dental college.

This bill would allow that requirement to also be met through completion of an accredited advanced education program.

The bill would delete obsolete references.

(2) 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) 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) Existing law, the Occupational Therapy Practice Act, requires the California Board of Occupational Therapy to ensure proper supervision of occupational therapy assistants and aides. An aide is required to be supervised by an occupational therapist.

This bill would also provide for an aide to be supervised by an occupational therapy assistant.

(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

(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. 8.~~

SEC. 9. 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. 9.~~

SEC. 10. 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. 10.~~

SEC. 11. 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. 11.~~

SEC. 12. 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. 12.~~

SEC. 13. 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

2011/2012
LEGISLATION

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

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.

(10) Naturopathic doctors.
(g) Marriage and family therapy 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.
(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.
(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 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

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 enrolled (it has been sent to the Governor).

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
California Medical Association
Medical Board of California
Physicians Coalition for Injectable Safety

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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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
Position: Support

STATUS OF BILL:

This bill has been enrolled (it has been sent to the Governor).

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.

The Board took a support position on this bill because 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.

FISCAL: None

SUPPORT: California Chapter of the American College of Emergency Physicians
California Hospital Association
Medical Board of California
Northern CA Chapter of the American College of Surgeons

OPPOSITION: None on File

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.

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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)
Position: None

STATUS OF BILL:

This bill has been sent to enrollment.

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)

OPPOSITION: None on file

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.*

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2561
Author: Hernandez
Bill Date: June 26, 2012
Subject: Certified Surgical Technologists
Sponsor: California State Assembly Association of Surgical Technologists
Position: Neutral

STATUS OF BILL:

This bill is in the Senate 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.

The recent amendments would replace the term "healing arts licensee" with "health care practitioner" and would specify that this bill would not prohibit a health care practitioner from performing a task or function within his or her scope of practice. The amendments would define "health care practitioner".

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.

The June 26th amendments revise the bill to specify that it does not prohibit or limit any health care practitioner from performing a task for function within his or her scope of practice. It also would define "health care practitioner" as any person who engages in acts that are the subject of licensure or regulation.

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 and the Board has taken a neutral position on this bill.

FISCAL: None

SUPPORT: California State Assembly Association of Surgical Technologists (Sponsor)

OPPOSITION: None on File.

AMENDED IN SENATE JUNE 26, 2012

AMENDED IN ASSEMBLY APRIL 26, 2012

AMENDED IN ASSEMBLY MARCH 29, 2012

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 2561

Introduced by Assembly Member Roger Hernández

February 24, 2012

An act to add Article 25 (commencing with Section 2525.20) to 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. 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 for a person to use the title "certified surgical technologist" unless the person meets certain educational requirements~~,~~ and holds a certification by a specified entity.

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 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) "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 *the* entities described in Section 2525.24.

(b) "Surgical technology" means intraoperative 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 for a person to use the title "certified surgical technologist" in this state unless the person satisfies the following requirements:

(1) The person has successfully completed a nationally accredited educational program for surgical technologists or a training program for surgical technology provided by the United States Army, Navy, Air Force, Marine Corps, Coast Guard, or Public Health Service.

(2) The person 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 credentialing organization.

(b) A violation of this section shall not be subject to Section 2314.

2525.30. 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.

2525.31. This article does not prohibit or limit any ~~healing arts licensee described in this division~~ *health care practitioner* from performing a task or function within ~~the~~ *his or her* scope of ~~the healing art licensee's license~~ *practice*, nor shall it be construed as

1 such. *For purposes of this section, "health care practitioner"*
2 *means any person who engages in acts that are the subject of*
3 *licensure or regulation under this division or under any initiative*
4 *act referred to in this division.*
5 2525.32. This article does not apply to any of the following:
6 (a) A registered nurse licensed pursuant to Chapter 6
7 (commencing with Section 2700) or a vocational nurse licensed
8 pursuant to Chapter 6.5 (commencing with Section 2840).
9 (b) An individual employed by a health care facility whose
10 primary functions include the cleaning or sterilization of supplies,
11 instruments, equipment, or operating rooms.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2570
Author: Hill
Bill Date: February 24, 2012, introduced
Subject: Licensees: Settlement Agreements
Sponsor: Author
Position: Support

STATUS OF BILL:

This bill is in the Senate 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.

The Board has taken a support position on this bill because it 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: Board of Behavioral Sciences
Center for Public Interest Law
Medical Board of California

OPPOSITION: None on file

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 122 (PRICE)
International Medical Schools

This Item will be discussed as part of the Licensing Committee Update, Agenda Item 14.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 616
Author: DeSaulnier
Bill Date: June 27, 2012, amended
Subject: Controlled Substances: Reporting
Sponsor: Author

STATUS OF BILL:

This bill is on the Assembly Third Reading File.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would establish the Controlled Substance Utilization Review and Evaluation System (CURES) Fund, which would consist of contributions collected from organizations for purposes of funding the CURES program, to be administered by the Department of Justice (DOJ).

ANALYSIS:

The CURES Program is currently housed in DOJ and is a state database of dispensed prescription drugs that have a high potential for misuse and abuse. CURES provides for electronic transmission of specified prescription data to DOJ. In September 2009, DOJ launched the CURES Prescription Drug Monitoring Program (PDMP) system allowing pre-registered users, including licensed health care prescribers eligible to prescribe controlled substances, pharmacists authorized to dispense controlled substances, law enforcement, and regulatory boards, including the Medical Board of California (Board), to access patient controlled substance history information through a secure Web site.

According to a DOJ, there is currently no permanent funding to support the CURES/ PDMP program. The California Budget Act of 2011 eliminated all General Fund support of CURES/PDMP, which included funding for system support, staff support and related operating expenses. To perform the minimum critical functions and to avoid shutting down the program, DOJ opted to assign five staff to perform temporary dual job assignments on a part-time basis. Although some tasks are being performed, the program is faced with a constant backlog (e.g., four-week backlog on processing new user applications, six-week response time on emails, twelve week backlog on voicemails, etc.)

The only funding currently available to DOJ for CURES is through renewable contracts with five separate regulatory boards (including the Board) and one grant. While DOJ has been able to successfully renew contracts with the boards and receive grant funding this year, these sources of funding are not permanent and may not be available in future years and cannot be used to fund staff positions. In addition, these

funding sources are insufficient to operate and maintain the PDMP system, make necessary enhancements or fully fund a PDMP modernization effort.

This bill would make findings and declarations related to the importance of CURES and would establish the CURES Fund that would consist of all funds contributed by organizations for the purpose of funding the CURES Program. This bill would make the money in the CURES Fund available for allocation to DOJ, upon appropriation by the Legislature, for the purposes of funding the CURES Program.

The Board believes CURES is a very important enforcement tool and an effective aid for physicians to use to prevent "doctor shopping". Although the Board currently helps to fund CURES at a cost of $150,000 this year, these funds cannot be used for staffing. The Board is aware of the issues DOJ is facing related to insufficient staffing and funding for CURES/PDMP, and due to the importance of this program, is suggesting that the Board support any effort to get CURES more fully funded in order for the PDMP to be at optimum operating capacity.

FISCAL: None to the Board.

SUPPORT: DOJ

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY JUNE 27, 2012

AMENDED IN ASSEMBLY JUNE 26, 2012

AMENDED IN SENATE JANUARY 4, 2012

AMENDED IN SENATE APRIL 26, 2011

AMENDED IN SENATE MARCH 22, 2011

SENATE BILL No. 616

Introduced by Senator DeSaulnier

February 18, 2011

An act to amend Section 11165 of the Health and Safety Code, relating to controlled substances.

LEGISLATIVE COUNSEL'S DIGEST

SB 616, as amended, DeSaulnier. Controlled substances: reporting.

Existing law classifies certain controlled substances into designated schedules. Existing law requires the Department of Justice to maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe or dispense these controlled substances.

Existing law requires dispensing pharmacies and clinics to report, on a weekly basis, specified information for each prescription of Schedule II, Schedule III, or Schedule IV controlled substances, to the department, as specified.

This bill would ~~require that dispensing pharmacies and clinics report that information to the department twice a week~~ *establish the CURES Fund within the state treasury to receive contributions to be allocated,*

upon appropriation by the Legislature, to the Department of Justice for the purposes of the CURES program, and would make related findings and declarations.

Vote: majority. Appropriation: no. Fiscal committee: ~~yes~~ *no*. 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) The Controlled Substance Utilization Review and Evaluation*
4 *System (CURES) is a valuable investigative, preventive, and*
5 *educational tool for law enforcement, regulatory boards,*
6 *educational researchers, and the health care community. Recent*
7 *budget cuts to the Attorney General's Division of Law Enforcement*
8 *have resulted in insufficient funding to support the CURES*
9 *Prescription Drug Monitoring Program (PDMP). The PDMP is*
10 *necessary to ensure health care professionals have the necessary*
11 *data to make informed treatment decisions and to allow law*
12 *enforcement to investigate diversion of prescription drugs. Without*
13 *a dedicated funding source, the CURES PDMP is not sustainable.*
14 *(b) Each year the CURES program responds to more than*
15 *60,000 requests from practitioners and pharmacists regarding all*
16 *of the following:*
17 *(1) Helping identify and deter drug abuse and diversion of*
18 *prescription drugs through accurate and rapid tracking of Schedule*
19 *II, II, and IV controlled substances.*
20 *(2) Helping practitioners make better prescribing decisions.*
21 *(3) Helping reduce misuse, abuse, and trafficking of those drugs.*
22 *(c) Schedules II, III, and IV, controlled substances have had*
23 *deleterious effects on private and public interests, including the*
24 *misuse, abuse, and trafficking in dangerous prescription*
25 *medications resulting in injury and death. It is the intent of the*
26 *Legislature to work with stakeholders to fully fund the operation*
27 *of the CURES program which seeks to mitigate those deleterious*
28 *effects, and which has proven to be a cost-effective tool to help*
29 *reduce the misuse, abuse, and trafficking of those drugs.*
30 ~~SECTION 1~~
31 *SEC. 2.* Section 11165 of the Health and Safety Code is
32 amended to read:

11165. (a) To assist law enforcement and regulatory agencies in their efforts to control the diversion and resultant abuse of Schedule II, Schedule III, and Schedule IV controlled substances, and for statistical analysis, education, and research, the Department of Justice shall, contingent upon the availability of adequate funds from the Contingent Fund of the Medical Board of California, the Pharmacy Board Contingent Fund, the State Dentistry Fund, the Board of Registered Nursing Fund, ~~and~~ the Osteopathic Medical Board of California Contingent Fund, *and the CURES Fund,* maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of, and Internet access to information regarding, the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe or dispense these controlled substances.

(b) The reporting of Schedule III and Schedule IV controlled substance prescriptions to CURES shall be contingent upon the availability of adequate funds from the Department of Justice. The department may seek and use grant funds to pay the costs incurred from the reporting of controlled substance prescriptions to CURES. Funds shall not be appropriated from the Contingent Fund of the Medical Board of California, the Pharmacy Board Contingent Fund, the State Dentistry Fund, the Board of Registered Nursing Fund, the Naturopathic Doctor's Fund, or the Osteopathic Medical Board of California Contingent Fund to pay the costs of reporting Schedule III and Schedule IV controlled substance prescriptions to CURES.

(c) CURES shall operate under existing provisions of law to safeguard the privacy and confidentiality of patients. Data obtained from CURES shall only be provided to appropriate state, local, and federal persons or public agencies for disciplinary, civil, or criminal purposes and to other agencies or entities, as determined by the Department of Justice, for the purpose of educating practitioners and others in lieu of disciplinary, civil, or criminal actions. Data may be provided to public or private entities, as approved by the Department of Justice, for educational, peer review, statistical, or research purposes, provided that patient information, including any information that may identify the patient, is not compromised. Further, data disclosed to any

individual or agency as described in this subdivision shall not be disclosed, sold, or transferred to any third party.

(d) For each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance, as defined in the controlled substances schedules in federal law and regulations, specifically Sections 1308.12, 1308.13, and 1308.14, respectively, of Title 21 of the Code of Federal Regulations, the dispensing pharmacy or clinic shall provide the following information to the Department of Justice ~~twice a week~~ *on a weekly basis* and in a format specified by the Department of Justice:

(1) Full name, address, and the telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the ultimate user.

(2) The prescriber's category of licensure and license number; federal controlled substance registration number; and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility.

(3) Pharmacy prescription number, license number, and federal controlled substance registration number.

(4) NDC (National Drug Code) number of the controlled substance dispensed.

(5) Quantity of the controlled substance dispensed.

(6) ICD-9 (diagnosis code), if available.

(7) Number of refills ordered.

(8) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

(9) Date of origin of the prescription.

(10) Date of dispensing of the prescription.

(e) The CURES Fund is hereby established within the State Treasury. The Cures Fund shall consist of all funds contributed by organizations for the purposes of funding the CURES program. Money in the CURES Fund shall, upon appropriation by the Legislature, be available for allocation to the Department of Justice for the purposes of funding the CURES program.

O

AB 924

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 924
Author: Price, Walters, and Steinberg
Bill Date: June 18, 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 Appropriations 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.

This bill was recently amended to allow a podiatrist to sign off on the plan of care and perform the examination required by this bill. The notice that the PT must provide the patient was also amended to include podiatrists, as well as make a technical amendment.

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, osteopathic physician, or podiatrist, 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, osteopathic physician, or podiatrist.

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 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, or from a person holding a certificate to practice podiatric medicine

from the California Board of Podiatric Medicine and acting within his or her scope of practice, 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:
California Physical Therapy Association (Sponsor)
California Advocates for Nursing Home Reform
California Senior Legislature
Numerous Individuals

OPPOSITION:
California Association of Joint Powers Authorities
California Chiropractic Association
California Medical Association
California Orthopaedic Association
California Society of Anesthesiologists
Medical Board of California (unless amended)

AMENDED IN ASSEMBLY JUNE 18, 2012

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 Senators Price, Walters, and Steinberg
(Coauthors: Assembly Members Chesbro, Fong, Knight, Morrell, and Wieckowski)

February 18, 2011

An act to amend Sections 2406 and 2690 of, and to add 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 healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 924, as amended, Price. Physical therapists: direct access to services: professional corporations.

(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.

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, and, with the patient's written authorization, to notify the patient's *primary* 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 30 business days or 12 visits, whichever occurs first, unless the physical therapist receives a specified authorization from a person with a physician and surgeon's certificate *or from a person with a podiatric medicine certificate and acting within his or her scope of practice*. 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.

(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 that is authorized to render professional services, as
9 defined in Sections 13401 and 13401.5 of the Corporations Code,
10 so long as that corporation and its shareholders, officers, directors,
11 and employees rendering professional services who are physicians
12 and surgeons, psychologists, registered nurses, optometrists,
13 podiatrists, chiropractors, acupuncturists, naturopathic doctors,
14 physical therapists, occupational therapists, or, in the case of a
15 medical corporation only, physician assistants, marriage and family
16 therapists, or clinical social workers, are in compliance with the
17 Moscone-Knox Professional Corporation Act, the provisions of
18 this article, and all other statutes and regulations now or hereafter
19 enacted or adopted pertaining to the corporation and the conduct
20 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 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 that
27 is authorized to render professional services, as defined in Sections
28 13401 and 13401.5 of the Corporations Code, shall disclose to its
29 patients, orally and in writing, when initiating any physical therapy
30 treatment services, that the patient may seek physical therapy
31 treatment services from a physical therapy provider of his or her
32 choice who may not necessarily be employed by the medical or
33 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
36 license issued pursuant to the Knox-Keene Health Care Service
37 Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340)
38 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. 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 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 *primary* 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, *or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice,* 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, *or by the person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice.* 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), (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) 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, *or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice,* 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, *or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice,* 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. 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 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 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:

(a) Medical corporation.

(1) Licensed doctors of podiatric medicine.

(2) Licensed psychologists.

(3) Registered nurses.

(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.

(12) Licensed physical therapists.

(13) 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.
(10) Licensed professional clinical counselors.
(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.
(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.

1 (8) Naturopathic doctors.
2 (p) Physical therapy corporation.
3 (1) Licensed physicians and surgeons.
4 (2) Licensed doctors of podiatric medicine.
5 (3) Licensed acupuncturists.
6 (4) Naturopathic doctors.
7 (5) Licensed occupational therapists.
8 (6) Licensed speech-language pathologists.
9 (7) Licensed audiologists.
10 (8) Registered nurses.
11 (9) Licensed psychologists.
12 (10) Licensed physician assistants.
13 SEC. 8. No reimbursement is required by this act pursuant to
14 Section 6 of Article XIII B of the California Constitution because
15 the only costs that may be incurred by a local agency or school
16 district will be incurred because this act creates a new crime or
17 infraction, eliminates a crime or infraction, or changes the penalty
18 for a crime or infraction, within the meaning of Section 17556 of
19 the Government Code, or changes the definition of a crime within
20 the meaning of Section 6 of Article XIII B of the California
21 Constitution.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1095
Author: Rubio
Bill Date: June 25, 2012, amended
Subject: California Outpatient Pharmacy Safety and Improvement Act
Sponsor: California Ambulatory Surgery Association (CASA)
Position: Support

STATUS OF BILL:

This bill is in Assembly 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.

The recent amendments are technical in nature and do not affect the Board's analysis.

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.

The June 25th amendments change the wording in existing law and combine subdivision (b) and (d) into a newly amended subdivision (b). The amendments also take out the notwithstanding language in subdivision (b). These amendments were taken at the request of the Board of Pharmacy and are technical in nature.

The Board has taken a support position on this bill because it 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. **The recent amendments do not change the Board's support position or the reasons for that position.**

FISCAL: None

SUPPORT: CASA (Sponsor)
Aspen Surgery Center
Golden Triangle SurgiCenter
Medical Board of California
Millennium Surgery Center, Inc.
Physicians Plaza Surgical Center
Southwest Surgical Center
Surgical Care Affiliates

OPPOSITION: None on file

AMENDED IN ASSEMBLY JUNE 25, 2012

SENATE BILL No. 1095

Introduced by Senator Rubio
(Coauthor: Senator Wyland)

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 amended, 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~~ *in order to operate.* The bill would specify that the board is authorized to inspect only *an outpatient setting, an ambulatory surgical care center, or* a *surgical* 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. 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 (b) ~~Notwithstanding any provision of this chapter, a~~ *A* clinic
21 *licensed by the board* may purchase drugs at wholesale for
22 administration or dispensing, under the direction of a physician

and surgeon, to patients registered for care at the clinic, as provided in subdivision (c). *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.* The clinic shall keep records of 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.

(c) The drug distribution service of a clinic shall be limited to the use of drugs for administration to the patients of the 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.

(d) No clinic shall 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.~~

(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 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.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1236
Author: Price
Bill Date: June 18, 2012, amended
Subject: Healing Arts Boards
Sponsor: Author

STATUS OF BILL:

This bill is in the Assembly Business, Professions and Consumer Protection Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill is the sunset bill for the Physician Assistant Committee (PAC). This bill would rename this committee the Physician Assistant Board (PAB), and would make it its own Board, not a committee of the Medical Board of California (Board). This analysis will only include the relevant sections of the bill in the Business and Professions Code (BPC) that are related to the PAB.

ANALYSIS:

In addition to making the PAC its own board, this bill would extend the sunset date of the PAB to January 1, 2017. This bill would also create a retired license status for Physician Assistants. Lastly, this bill would revise the makeup of the members of the PAB. Upon expiration of the current Medical Board Member, this bill would require a member to be appointed to the PAB that is also a member of the Board, but that member shall serve as an ex officio, nonvoting member whose functions will include reporting to the Board on the actions or discussion of the PAB.

Board staff is suggesting that the Board take a support position on this bill. Although the PAC currently resides within the Board, the PAC acts independently on many of its mandates. The Board would continue to perform investigative services for the new PAB; the Board and PAC currently have a cooperative working relationship. This bill would maintain close ties with the Board and PAB, by requiring a Medical Board Member to sit on the PAB and provide reports to the Board.

FISCAL: None to MBC

SUPPORT: Board of Podiatric Medicine and PAC

OPPOSITION: None on file

POSITION: Recommendation: Support Provisions related to the PAC/PAB

AMENDED IN ASSEMBLY JUNE 18, 2012

AMENDED IN SENATE APRIL 17, 2012

SENATE BILL No. 1236

Introduced by Senator Price

February 23, 2012

An act to amend Sections 800, 801.01, 802.1, 802.5, 803, 803.1, 803.5, 803.6, 805, 2335, 2460, 2465, 2470, 2472, 2475, 2477, 2484, 2493, 2496, 2497.5, 3501, 3502, 3502.1, 3502.3, 3502.5, 3504, 3504.1, 3505, 3506, 3507, 3508, 3509, 3509.5, 3510, 3511, 3512, 3513, 3514.1, 3516, 3516.5, 3517, 3518, 3519, 3519.5, 3520, 3521, 3521.1, 3521.2, 3521.5, 3522, 3523, 3524, 3524.5, 3526, 3527, 3529, 3530, 3531, 3533, 3534, 3534.1, 3534.2, 3534.3, 3534.4, 3534.5, 3534.6, 3534.7, 3534.9, 3534.10, 3535, 3537.10, 3537.20, 3537.30, 3537.50, 3540, 3546 of, and to add ~~Sections~~ *Section* 3521.3 ~~and 3521.4~~ to, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 1236, as amended, Price. Healing arts boards.

(1) Existing law provides for the certification and regulation of podiatrists by the California Board of Podiatric Medicine within the jurisdiction of the Medical Board of California. Under existing law, the California Board of Podiatric Medicine will be repealed on January 1, 2013. Existing law requires that boards scheduled for repeal be reviewed by the Joint Sunset Review Committee of the Legislature.

This bill would extend the operation of the California Board of Podiatric Medicine until January 1, 2017. The bill would specify that the board is subject to review by the appropriate policy committees of the Legislature. The bill would revise provisions regarding the examination of applicants for certification to practice podiatric medicine.

(2) Existing law establishes the Physician Assistant Committee within the jurisdiction of the Medical Board of California and provides for its membership, operation, duties, and powers with respect to licensure and regulation of physician assistants, including requirements for the payment of license renewal fees. Under existing law, the committee will be repealed on January 1, 2013.

This bill would rename the committee as the Physician Assistant Board, make various conforming changes relative to this change in designation, and extend the operation of the board until January 1, 2017. The bill would revise the composition of the board and would specify ~~exemptions to the requirements for the payment of license renewal fees. The bill would specify~~ that the board is subject to review by the appropriate policy committees of the Legislature. *The bill would allow the board to establish, by regulation, a system for placement of a licensee on retired status, as specified.*

(3) Existing law specifies reports to be made and procedures to be followed when a coroner receives information, as specified, that a death may be the result of a physician and surgeon's, or podiatrist's gross negligence or incompetence, and in connection with disciplinary actions against those licensees.

This bill would expand those provisions to include conduct of a physician assistant.

(4) Existing law requires a physician and surgeon, osteopathic physician and surgeon, and a doctor of podiatric medicine to report to his or her licensing board the occurrence of an indictment or information charging a felony against the licensee or the conviction of the licensee of a felony or misdemeanor. Under existing law the failure of those licensees to submit the required report is a crime.

This bill would impose that requirement on a physician assistant. Because a violation of this requirement by a physician assistant would be a crime, this bill would impose a state-mandated local program.

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

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

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

(d) In any judicial action for the recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(e) (1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one year period for those unpaid costs.

(f) All costs recovered under this section shall be deposited in the Board of Podiatric Medicine Fund as a reimbursement in either the fiscal year in which the costs are actually recovered or the previous fiscal year, as the board may direct.

SEC. 21. Section 3501 of the Business and Professions Code is amended to read:

3501. (a) As used in this chapter:

(1) "Board" means the Physician Assistant Board.

(2) "Approved program" means a program for the education of physician assistants that has been formally approved by the ~~committee~~ *board.*

(3) "Trainee" means a person who is currently enrolled in an approved program.

(4) "Physician assistant" means a person who meets the requirements of this chapter and is licensed by th~~e committee~~ *board.*

(5) "Supervising physician" means a physician and surgeon licensed by the Medical Board of California or by the Osteopathic Medical Board of California who supervises one or more physician assistants, who possesses a current valid license to practice medicine, and who is not currently on disciplinary probation for improper use of a physician assistant.

(6) "Supervision" means that a licensed physician and surgeon oversees the activities of, and accepts responsibility for, the medical services rendered by a physician assistant.

(7) "Regulations" means the rules and regulations as set forth in Chapter 13.8 (commencing with Section 1399.500) of Title 16 of the California Code of Regulations.

(8) "Routine visual screening" means uninvasive nonpharmacological simple testing for visual acuity, visual field defects, color blindness, and depth perception.

(9) "Program manager" means the staff manager of the diversion program, as designated by the executive officer of the ~~Medical Board of California~~ *board*. The program manager shall have background experience in dealing with substance abuse issues.

(10) "Delegation of services agreement" means the writing that delegates to a physician assistant from a supervising physician the medical services the physician assistant is authorized to perform consistent with subdivision (a) of Section 1399.540 of Title 16 of the California Code of Regulations.

(11) "Other specified medical services" means tests or examinations performed or ordered by a physician assistant practicing in compliance with this chapter or regulations of the Medical Board of California promulgated under this chapter.

(b) A physician assistant acts as an agent of the supervising physician when performing any activity authorized by this chapter or regulations ~~promulgated by the board~~ *adopted* under this chapter.

SEC. 22. Section 3502 of the Business and Professions Code is amended to read:

3502. (a) Notwithstanding any other provision of law, a physician assistant may perform those medical services as set forth by the regulations ~~of the Medical Board of California~~ *adopted under this chapter* when the services are rendered under the supervision of a licensed physician and surgeon who is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting that supervision or prohibiting the employment of a physician assistant.

(b) Notwithstanding any other provision of law, a physician assistant performing medical services under the supervision of a physician and surgeon may assist a doctor of podiatric medicine who is a partner, shareholder, or employee in the same medical group as the supervising physician and surgeon. A physician assistant who assists a doctor of podiatric medicine pursuant to this subdivision shall do so only according to patient-specific orders from the supervising physician and surgeon.

The supervising physician and surgeon shall be physically available to the physician assistant for consultation when such assistance is rendered. A physician assistant assisting a doctor of

podiatric medicine shall be limited to performing those duties included within the scope of practice of a doctor of podiatric medicine.

(c) (1) A physician assistant and his or her supervising physician and surgeon shall establish written guidelines for the adequate supervision of the physician assistant. This requirement may be satisfied by the supervising physician and surgeon adopting protocols for some or all of the tasks performed by the physician assistant. The protocols adopted pursuant to this subdivision shall comply with the following requirements:

(A) A protocol governing diagnosis and management shall, at a minimum, include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be provided to the patient.

(B) A protocol governing procedures shall set forth the information to be provided to the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the followup care.

(C) Protocols shall be developed by the supervising physician and surgeon or adopted from, or referenced to, texts or other sources.

(D) Protocols shall be signed and dated by the supervising physician and surgeon and the physician assistant.

(2) The supervising physician and surgeon shall review, countersign, and date a sample consisting of, at a minimum, 5 percent of the medical records of patients treated by the physician assistant functioning under the protocols within 30 days of the date of treatment by the physician assistant. The physician and surgeon shall select for review those cases that by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

(3) Notwithstanding any other provision of law, the Medical Board of California or board may establish other alternative mechanisms for the adequate supervision of the physician assistant.

(d) No medical services may be performed under this chapter in any of the following areas:

(1) The determination of the refractive states of the human eye, or the fitting or adaptation of lenses or frames for the aid thereof.

(2) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, or orthoptics.

(3) The prescribing of contact lenses for, or the fitting or adaptation of contact lenses to, the human eye.

(4) The practice of dentistry or dental hygiene or the work of a dental auxiliary as defined in Chapter 4 (commencing with Section 1600).

(e) This section shall not be construed in a manner that shall preclude the performance of routine visual screening as defined in Section 3501.

SEC. 23. Section 3502.1 of the Business and Professions Code is amended to read:

3502.1. (a) In addition to the services authorized in the regulations adopted by the Medical Board of California, and except as prohibited by Section 3502, while under the supervision of a licensed physician and surgeon or physicians and surgeons authorized by law to supervise a physician assistant, a physician assistant may administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device pursuant to subdivisions (c) and (d).

(1) A supervising physician and surgeon who delegates authority to issue a drug order to a physician assistant may limit this authority by specifying the manner in which the physician assistant may issue delegated prescriptions.

(2) Each supervising physician and surgeon who delegates the authority to issue a drug order to a physician assistant shall first prepare and adopt, or adopt, a written, practice specific, formulary and protocols that specify all criteria for the use of a particular drug or device, and any contraindications for the selection. Protocols for Schedule II controlled substances shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is being administered, provided, or issued. The drugs listed in the protocols shall constitute the formulary and shall include only drugs that are appropriate for use in the type of practice engaged in by the supervising physician and surgeon. When issuing a drug order, the physician assistant is acting on behalf of and as an agent for a supervising physician and surgeon.

(b) "Drug ~~order"~~ *order,"* for purposes of this section, means an order for medication that is dispensed to or for a patient, issued and signed by a physician assistant acting as an individual practitioner within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription or order of the supervising physician, (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by physician assistants pursuant to authority granted by their supervising physicians and surgeons, and (3) the signature of a physician assistant on a drug order shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

(c) A drug order for any patient cared for by the physician assistant that is issued by the physician assistant shall either be based on the protocols described in subdivision (a) or shall be approved by the supervising physician and surgeon before it is filled or carried out.

(1) A physician assistant shall not administer or provide a drug or issue a drug order for a drug other than for a drug listed in the formulary without advance approval from a supervising physician and surgeon for the particular patient. At the direction and under the supervision of a physician and surgeon, a physician assistant may hand to a patient of the supervising physician and surgeon a properly labeled prescription drug prepackaged by a physician and surgeon, manufacturer as defined in the Pharmacy Law, or a pharmacist.

(2) A physician assistant may not administer, provide, or issue a drug order to a patient for Schedule II through Schedule V controlled substances without advance approval by a supervising physician and surgeon for that particular patient unless the physician assistant has completed an education course that covers controlled substances and that meets standards, including pharmacological content, approved by the ~~committee~~ *board.* The education course shall be provided either by an accredited continuing education provider or by an approved physician assistant training program. If the physician assistant will administer, provide, or issue a drug order for Schedule II controlled substances, the course shall contain a minimum of three hours exclusively on

Schedule II controlled substances. Completion of the requirements set forth in this paragraph shall be verified and documented in the manner established by the ~~committee~~ *board* prior to the physician assistant's use of a registration number issued by the United States Drug Enforcement Administration to the physician assistant to administer, provide, or issue a drug order to a patient for a controlled substance without advance approval by a supervising physician and surgeon for that particular patient.

(3) Any drug order issued by a physician assistant shall be subject to a reasonable quantitative limitation consistent with customary medical practice in the supervising physician and surgeon's practice.

(d) A written drug order issued pursuant to subdivision (a), except a written drug order in a patient's medical record in a health facility or medical practice, shall contain the printed name, address, and ~~phone~~ *telephone* number of the supervising physician and surgeon, the printed or stamped name and license number of the physician assistant, and the signature of the physician assistant. Further, a written drug order for a controlled substance, except a written drug order in a patient's medical record in a health facility or a medical practice, shall include the federal controlled substances registration number of the physician assistant and shall otherwise comply with the provisions of Section 11162.1 of the Health and Safety Code. Except as otherwise required for written drug orders for controlled substances under Section 11162.1 of the Health and Safety Code, the requirements of this subdivision may be met through stamping or otherwise imprinting on the supervising physician and surgeon's prescription blank to show the name, license number, and if applicable, the federal controlled substances *registration* number of the physician assistant, and shall be signed by the physician assistant. When using a drug order, the physician assistant is acting on behalf of and as the agent of a supervising physician and surgeon.

(e) The medical record of any patient cared for by a physician assistant for whom the physician assistant's Schedule II drug order has been issued or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven days.

(f) All physician assistants who are authorized by their supervising physicians to issue drug orders for controlled

substances shall register with the United States Drug Enforcement Administration (DEA).

(g) The board shall consult with the Medical Board of California and report during its sunset review required by Division 1.2 (commencing with Section 473) the impacts of exempting Schedule III and Schedule IV drug orders from the requirement for a physician and surgeon to review and countersign the affected medical record of a patient.

SEC. 24. Section 3502.3 of the Business and Professions Code is amended to read:

3502.3. (a) Notwithstanding any other provision of law, in addition to any other practices that meet the general criteria set forth in this chapter or the Medical Board of California's regulations for inclusion in a delegation of services agreement, a delegation of services agreement may authorize a physician assistant to do any of the following:

(1) Order durable medical equipment, subject to any limitations set forth in Section 3502 or the delegation of services agreement. Notwithstanding that authority, nothing in this paragraph shall operate to limit the ability of a third-party payer to require prior approval.

(2) For individuals receiving home health services or personal care services, after consultation with the supervising physician, approve, sign, modify, or add to a plan of treatment or plan of care.

(b) Nothing in this section shall be construed to affect the validity of any delegation of services agreement in effect prior to the enactment of this section or those adopted subsequent to enactment.

SEC. 25. Section 3502.5 of the Business and Professions Code is amended to read:

3502.5. Notwithstanding any other provision of law, a physician assistant may perform those medical services permitted pursuant to Section 3502 during any state of war emergency, state of emergency, or state of local emergency, as defined in Section 8558 of the Government Code, and at the request of a responsible federal, state, or local official or agency, or pursuant to the terms of a mutual aid operation plan established and approved pursuant to the California Emergency Services Act (Chapter 7 (commencing with Section 8550) of Division 1 of Title 2 of the Government Code), regardless of whether the physician assistant's approved

supervising physician is available to supervise the physician assistant, so long as a licensed physician is available to render the appropriate supervision. "Appropriate supervision" shall not require the personal or electronic availability of a supervising physician if that availability is not possible or practical due to the emergency. The local health officers and their designees may act as supervising physicians during emergencies without being subject to approval by the Medical Board of California. At all times, the local health officers or their designees supervising the physician assistants shall be licensed physicians and surgeons. Supervising physicians acting pursuant to this section shall not be subject to the limitation on the number of physician assistants supervised under Section 3516.

No responsible official or mutual aid operation plan shall invoke this section except in the case of an emergency that endangers the health of individuals. Under no circumstances shall this section be invoked as the result of a labor dispute or other dispute concerning collective bargaining.

SEC. 26. Section 3504 of the Business and Professions Code is amended to read:

3504. There is established a Physician Assistant ~~board~~ *Board* within the jurisdiction of the Medical Board of California. The board consists of nine members. This section 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. Notwithstanding any other provision of law, the repeal of this section renders the board subject to review by the appropriate policy committees of the Legislature.

SEC. 27. Section 3504.1 of the Business and Professions Code is amended to read:

3504.1. Protection of the public shall be the highest priority for the Physician Assistant Board in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.

SEC. 28. Section 3505 of the Business and Professions Code is amended to read:

3505. The members of the board shall include four physician assistants, one physician and surgeon who is also a member of the Medical Board of California, and four public members. Upon the expiration of the term of the member who is a member of the

Medical Board of California, that position shall be filled by a physician assistant. *Upon the expiration of the term of the member who is a member of the Medical Board of California, above, there shall be appointed to the board a physician and surgeon who is also a member of the Medical Board of California who shall serve as an ex officio, nonvoting member and whose functions shall include reporting to the Medical Board of California on the actions or discussions of the board.* Following the expiration of the term of the member described above, the board shall include five physician assistants, *one physician and surgeon,* and four public members.

Each member of the board shall hold office for a term of four years expiring on January 1st, and shall serve until the appointment and qualification of a successor or until one year shall have elapsed since the expiration of the term for which the member was appointed, whichever first occurs. No member shall serve for more than two consecutive terms. Vacancies shall be filled by appointment for the unexpired terms.

The Governor shall appoint the licensed members qualified as provided in this section and two public members. The Senate Rules Committee and the Speaker of the Assembly shall each appoint a public member.

SEC. 29. Section 3506 of the Business and Professions Code is amended to read:

3506. Each member of the board shall receive a per diem and expenses as provided in Section 103.

SEC. 30. Section 3507 of the Business and Professions Code is amended to read:

3507. The appointing power has power to remove from office any member of the board, as provided in Section 106.

SEC. 31. Section 3508 of the Business and Professions Code is amended to read:

3508. (a) The board may convene from time to time as deemed necessary by the board.

(b) Notice of each meeting of the board shall be given at least two weeks in advance to those persons and organizations who express an interest in receiving notification.

(c) The board shall receive permission of the director to meet more than six times annually. The director shall approve meetings that are necessary for the board to fulfill its legal responsibilities.

SEC. 32. Section 3509 of the Business and Professions Code is amended to read:

3509. It shall be the duty of the board to:

(a) Establish standards and issue licenses of approval for programs for the education and training of physician assistants.

(b) Make recommendations to the Medical Board of California concerning the scope of practice for physician assistants.

(c) Make recommendations to the Medical Board of California concerning the formulation of guidelines for the consideration of applications by licensed physicians to supervise physician assistants and approval of such applications.

(d) Require the examination of applicants for licensure as a physician assistant who meet the requirements of this chapter.

SEC. 33. Section 3509.5 of the Business and Professions Code is amended to read:

3509.5. The board shall elect annually a chairperson and a vice chairperson from among its members.

SEC. 34. Section 3510 of the Business and Professions Code is amended to read:

3510. The board may adopt, amend, and repeal regulations as may be necessary to enable it to carry into effect the provisions of this chapter; provided, however, that the Medical Board of California shall adopt, amend, and repeal such regulations as may be necessary to enable ~~it~~ *the board* to implement the provisions of this chapter under its jurisdiction. All regulations shall be in accordance with, and not inconsistent with, the provisions of this chapter. Such regulations shall be adopted, amended, or repealed in accordance with the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 35. Section 3511 of the Business and Professions Code is amended to read:

3511. Five members shall constitute a quorum for transacting any business. The affirmative vote of a majority of those present at a meeting of the board shall be required to carry any motion. *The physician and surgeon who serves as an ex officio member shall not be counted for purposes of a quorum.*

SEC. 36. Section 3512 of the Business and Professions Code is amended to read:

3512. (a) Except as provided in Sections 159.5 and 2020, the board shall employ within the limits of the Physician Assistant Fund all personnel necessary to carry out the provisions of this chapter including an executive officer who shall be exempt from civil service. The Medical Board of California and board shall make all necessary expenditures to carry out the provisions of this chapter from the funds established by Section 3520. The board may accept contributions to effect the purposes of this chapter.

(b) This section 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.

SEC. 37. Section 3513 of the Business and Professions Code is amended to read:

3513. The board shall recognize the approval of training programs for physician assistants approved by a national accrediting organization. Physician assistant training programs accredited by a national accrediting agency approved by the board shall be deemed approved by the board under this section. If no national accrediting organization is approved by the board, the board may examine and pass upon the qualification of, and may issue certificates of approval for, programs for the education and training of physician assistants that meet board standards.

SEC. 38. Section 3514.1 of the Business and Professions Code is amended to read:

3514.1. (a) The board shall formulate by regulation guidelines for the consideration of applications for licensure as a ~~physician's~~ *physician* assistant.

(b) The board shall formulate by regulation guidelines for the approval of ~~physician's~~ *physician* assistant training programs.

SEC. 39. Section 3516 of the Business and Professions Code is amended to read:

3516. (a) Notwithstanding any other provision of law, a physician assistant licensed by the board shall be eligible for employment or supervision by any physician and surgeon who is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting that employment or supervision.

(b) No physician and surgeon shall supervise more than four physician assistants at any one time, except as provided in Section 3502.5.

(c) The Medical Board of California may restrict a physician and surgeon to supervising specific types of physician assistants including, but not limited to, restricting a physician and surgeon from supervising physician assistants outside of the field of specialty of the physician and surgeon.

SEC. 40. Section 3516.5 of the Business and Professions Code is amended to read:

3516.5. (a) Notwithstanding any other provision of law and in accordance with regulations established by the Medical Board of California, the director of emergency care services in a hospital with an approved program for the training of emergency care physician assistants, may apply to the Medical Board of California for authorization under which the director may grant approval for emergency care physicians on the staff of the hospital to supervise emergency care physician assistants.

(b) The application shall encompass all supervising physicians employed in that service.

(c) Nothing in this section shall be construed to authorize any one emergency care physician while on duty to supervise more than four physician assistants at any one time.

(d) A violation of this section by the director of emergency care services in a hospital with an approved program for the training of emergency care physician assistants constitutes unprofessional conduct within the meaning of Chapter 5 (commencing with Section 2000).

(e) A violation of this section shall be grounds for suspension of the approval of the director or disciplinary action against the director or suspension of the approved program under Section 3527.

SEC. 41. Section 3517 of the Business and Professions Code is amended to read:

3517. The board shall require a written examination of physician assistants in the manner and under the rules and regulations as it shall prescribe, but the examination shall be conducted in that manner as to ensure that the identity of each applicant taking the examination will be unknown to all of the examiners until all examination papers have been graded. Except as otherwise provided in this chapter, or by regulation, no physician assistant applicant shall receive approval under this chapter without

first successfully passing an examination given under the direction of the board.

Examinations for licensure as a physician assistant may be required by the board under a uniform examination system, and for that purpose the board may make those arrangements with organizations furnishing examination material as may, in its discretion, be desirable. The board shall, however, establish a passing score for each examination. The licensure examination for physician assistants shall be held by the board at least once a year with such additional examinations as the board deems necessary. The time and place of examination shall be fixed by the board.

SEC. 42. Section 3518 of the Business and Professions Code is amended to read:

3518. The board shall keep current, two separate registers, one for approved supervising physicians and one for licensed ~~physician's~~ *physician* assistants, by specialty if applicable. These registers shall show the name of each licensee, his or her last known address of record, and the date of his or her licensure or approval. Any interested person is entitled to obtain a copy of the register in accordance with the Information Practices Act of 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code) upon application to the board together with a sum as may be fixed by the board, which amount shall not exceed the cost of this list so furnished.

SEC. 43. Section 3519 of the Business and Professions Code is amended to read:

3519. The board shall issue under the name of the Medical Board of California a license to all physician assistant applicants who meet all of the following requirements:

(a) Provide evidence of successful completion of an approved program.

(b) Pass any examination required under Section 3517.

(c) Not be subject to denial of licensure under Division 1.5 (commencing with Section 475) or Section 3527.

(d) Pay all fees required under Section 3521.1.

SEC. 44. Section 3519.5 of the Business and Professions Code is amended to read:

3519.5. (a) The board may issue under the name of the Medical Board of California a probationary license to an applicant subject

to terms and conditions, including, but not limited to, any of the following conditions of probation:

(1) Practice limited to a supervised, structured environment where the applicant's activities shall be supervised by another physician assistant.

(2) Total or partial restrictions on issuing a drug order for controlled substances.

(3) Continuing medical or psychiatric treatment.

(4) Ongoing participation in a specified rehabilitation program.

(5) Enrollment and successful completion of a clinical training program.

(6) Abstention from the use of alcohol or drugs.

(7) Restrictions against engaging in certain types of medical services.

(8) Compliance with all provisions of this chapter.

(b) The board and the Medical Board of California may modify or terminate the terms and conditions imposed on the probationary license upon receipt of a petition from the licensee.

(c) Enforcement and monitoring of the probationary conditions shall be under the jurisdiction of the board and the Medical Board of California. These proceedings shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 45. Section 3520 of the Business and Professions Code is amended to read:

3520. Within 10 days after the beginning of each calendar month the Medical Board of California shall report to the Controller the amount and source of all collections made under this chapter and at the same time pay all those sums into the State Treasury, where they shall be credited to the Physician Assistant Fund, which fund is hereby created. All money in the fund shall be used to carry out the purpose of this chapter.

SEC. 46. Section 3521 of the Business and Professions Code is amended to read:

3521. The fees to be paid for approval to supervise physician assistants are to be set by the board as follows:

(a) An application fee not to exceed fifty dollars ($50) shall be charged to each physician and surgeon applicant.

(b) An approval fee not to exceed two hundred fifty dollars ($250) shall be charged to each physician and surgeon upon approval of an application to supervise physician assistants.

(c) A biennial renewal fee not to exceed three hundred dollars ($300) shall be paid for the renewal of an approval.

(d) The delinquency fee is twenty-five dollars ($25).

(e) The duplicate approval fee is ten dollars ($10).

(f) The fee for a letter of endorsement, letter of good standing, or letter of verification of approval shall be ten dollars ($10).

SEC. 47. Section 3521.1 of the Business and Professions Code is amended to read:

3521.1. The fees to be paid by physician assistants are to be set by the board as follows:

(a) An application fee not to exceed twenty-five dollars ($25) shall be charged to each physician assistant applicant.

(b) An initial license fee not to exceed two hundred fifty dollars ($250) shall be charged to each physician assistant to whom a license is issued.

(c) A biennial license renewal fee not to exceed three hundred dollars ($300).

(d) The delinquency fee is twenty-five dollars ($25).

(e) The duplicate license fee is ten dollars ($10).

(f) The fee for a letter of endorsement, letter of good standing, or letter of verification of licensure shall be ten dollars ($10).

SEC. 48. Section 3521.2 of the Business and Professions Code is amended to read:

3521.2. The fees to be paid by physician assistant training programs are to be set by the board as follows:

(a) An application fee not to exceed five hundred dollars ($500) shall be charged to each applicant seeking program approval by the board.

(b) An approval fee not to exceed one hundred dollars ($100) shall be charged to each program upon its approval by the board.

SEC. 49. Section 3521.3 is added to the Business and Professions Code, to read:

~~3521.3. Every licensed physician assistant is exempt from the payment of the renewal fee and requirement for continuing medical education if the licensee has applied to the board for a retired license. The holder of a retired license may not engage in the practice of a physician assistant.~~

3521.3. (a) The board may establish, by regulation, a system for the placement of a license on a retired status, upon application, for a physician assistant who is not actively engaged in practice as a physician assistant or any activity that requires them to be licensed by the board.

(b) No licensee with a license on a retired status shall engage in any activity for which a license is required.

(c) The board shall deny an applicant's application for a retired status license if the license is canceled or if the license is suspended, revoked, or otherwise punitively restricted by the board or subject to disciplinary action under this chapter.

(d) Beginning one year from the effective date of the regulations adopted pursuant to subdivision (a), if an applicant's license is delinquent, the board shall deny an applicant's application for a retired status license.

(e) The board shall establish minimum qualifications for a retired status license.

(f) The board may exempt the holder of a retired status license from the renewal requirements described in Section 3524.5.

(g) The board shall establish minimum qualifications for the restoration of a license in a retired status to an active status. These minimum qualifications shall include, but are not limited to, continuing education and payment of a fee as provided in subdivision (c) of Section 3521.1.

~~SEC. 50. Section 3521.4 is added to the Business and Professions Code, to read:~~

~~3521.4. (a) Every licensed physician assistant is exempt from the payment of the renewal fee specified in Section 3521.1 while engaged in full-time training or active service in the Army, Navy, Air Force, or Marines, or in the United States Public Health Service.~~

~~(b) Every person exempted from the payment of the renewal fee by this section shall not engage in any private practice and shall become liable for payment of such fee for the current renewal period upon his or her discharge from full-time active service and shall have a period of 60 days after becoming liable within which to pay the renewal fee before the delinquency fee is required. Any person who is discharged from active service within 60 days of the end of a renewal period is exempt from the payment of the renewal fee for that period.~~

~~(c) The time spent in full-time active service or training shall not be included in the computation of the five-year period for renewal and reinstatement of licensure provided in Sections 3524.~~

~~(d) Nothing in this section shall exempt a person, exempt from renewal fees under this section, from meeting the continuing education requirements as provided in Section 3524.5.~~

~~SEC. 51.~~

SEC. 50. Section 3521.5 of the Business and Professions Code is amended to read:

3521.5. The board shall report to the appropriate policy and fiscal committees of each house of the Legislature whenever the Medical Board of California approves a fee increase pursuant to Sections 3521 and 3521.1. The board shall specify the reasons for each increase in the report. Reports prepared pursuant to this section shall identify the percentage of funds derived from an increase in fees pursuant to Senate Bill 1077 of the 1991–92 Regular Session (Chapter 917, Statutes of 1991) that will be used for investigational and enforcement activities by the Medical Board of California and board.

~~SEC. 52.~~

SEC. 51. Section 3522 of the Business and Professions Code is amended to read:

3522. An approval to supervise physician assistants shall expire at 12 midnight on the last day of the birth month of the physician and surgeon during the second year of a two-year term if not renewed.

The Medical Board of California shall establish a cyclical renewal program, including, but not limited to, the establishment of a system of staggered expiration dates for approvals and a pro rata formula for the payment of renewal fees by physician and surgeon supervisors.

To renew an unexpired approval, the approved supervising physician and surgeon, on or before the date of expiration, shall apply for renewal on a form prescribed by the Medical Board of California and pay the prescribed renewal fee.

~~SEC. 53.~~

SEC. 52. Section 3523 of the Business and Professions Code is amended to read:

3523. All physician assistant licenses shall expire at 12 midnight of the last day of the birth month of the licensee during the second year of a two-year term if not renewed.

The board shall establish by regulation procedures for the administration of a birthdate renewal program, including, but not limited to, the establishment of a system of staggered license expiration dates and a pro rata formula for the payment of renewal fees by physician assistants affected by the implementation of the program.

To renew an unexpired license, the licensee shall, on or before the date of expiration of the license, apply for renewal on a form provided by the board, accompanied by the prescribed renewal fee.

~~SEC. 54.~~

SEC. 53. Section 3524 of the Business and Professions Code is amended to read:

3524. A license or approval that has expired may be renewed at any time within five years after its expiration by filing an application for renewal on a form prescribed by the board or Medical Board of California, as the case may be, and payment of all accrued and unpaid renewal fees. If the license or approval is not renewed within 30 days after its expiration, the licensed physician assistant and approved supervising physician, as a condition precedent to renewal, shall also pay the prescribed delinquency fee, if any. Renewal under this section shall be effective on the date on which the application is filed, on the date on which all renewal fees are paid, or on the date on which the delinquency fee, if any, is paid, whichever occurs last. If so renewed, the license shall continue in effect through the expiration date provided in Section 3522 or 3523 which next occurs after the effective date of the renewal, when it shall expire, if it is not again renewed.

~~SEC. 55.~~

SEC. 54. Section 3524.5 of the Business and Professions Code is amended to read:

3524.5. The board may require a licensee to complete continuing education as a condition of license renewal under Section 3523 or 3524. The board shall not require more than 50 hours of continuing education every two years. The board shall, as it deems appropriate, accept certification by the National

Commission on Certification of Physician Assistants (NCCPA), or another qualified certifying body, as determined by the board, as evidence of compliance with continuing education requirements.

~~SEC. 56.~~

SEC. 55. Section 3526 of the Business and Professions Code is amended to read:

3526. A person who fails to renew his or her license or approval within five years after its expiration may not renew it, and it may not be reissued, reinstated, or restored thereafter, but that person may apply for and obtain a new license or approval if he or she:

(a) Has not committed any acts or crimes constituting grounds for denial of licensure under Division 1.5 (commencing with Section 475).

(b) Takes and passes the examination, if any, which would be required of him or her if application for licensure was being made for the first time, or otherwise establishes to the satisfaction of the board that, with due regard for the public interest, he or she is qualified to practice as a physician assistant.

(c) Pays all of the fees that would be required as if application for licensure was being made for the first time.

~~SEC. 57.~~

SEC. 56. Section 3527 of the Business and Professions Code is amended to read:

3527. (a) The board may order the denial of an application for, or the issuance subject to terms and conditions of, or the suspension or revocation of, or the imposition of probationary conditions upon a physician assistant license after a hearing as required in Section 3528 for unprofessional conduct that includes, but is not limited to, a violation of this chapter, a violation of the Medical Practice Act, or a violation of the regulations adopted by the board or the Medical Board of California.

(b) The board may order the denial of an application for, or the suspension or revocation of, or the imposition of probationary conditions upon, an approved program after a hearing as required in Section 3528 for a violation of this chapter or the regulations adopted pursuant thereto.

(c) The Medical Board of California may order the denial of an application for, or the issuance subject to terms and conditions of, or the suspension or revocation of, or the imposition of probationary conditions upon, an approval to supervise a physician

assistant, after a hearing as required in Section 3528, for unprofessional conduct, which includes, but is not limited to, a violation of this chapter, a violation of the Medical Practice Act, or a violation of the regulations adopted by the board or the Medical Board of California.

(d) Notwithstanding subdivision (c), the Division of Medical Quality of the Medical Board of California, in conjunction with an action it has commenced against a physician and surgeon, may, in its own discretion and without the concurrence of the Medical Board of California, order the suspension or revocation of, or the imposition of probationary conditions upon, an approval to supervise a physician assistant, after a hearing as required in Section 3528, for unprofessional conduct, which includes, but is not limited to, a violation of this chapter, a violation of the Medical Practice Act, or a violation of the regulations adopted by the board or the Medical Board of California.

(e) The board may order the denial of an application for, or the suspension or revocation of, or the imposition of probationary conditions upon, a physician assistant license, after a hearing as required in Section 3528 for unprofessional conduct that includes, except for good cause, the knowing failure of a licensee 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 ~~California~~ Medical Board *of California*, the Board of Podiatric Medicine, the Board of Dental Examiners, the Board of Registered Nursing, and the Board of Vocational Nursing and Psychiatric Technicians, 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.

(f) The board may order the licensee to pay the costs of monitoring the probationary conditions imposed on the license.

(g) The expiration, cancelation, forfeiture, or suspension of a physician assistant license by operation of law or by order or decision of the board or a court of law, the placement of a license on a retired status, or the voluntary surrender of a license by a licensee shall not deprive the board of jurisdiction to commence or proceed with any investigation of, or action or disciplinary proceeding against, the licensee or to render a decision suspending or revoking the license.

~~SEC. 58.~~

SEC. 57. Section 3529 of the Business and Professions Code is amended to read:

3529. The board may hear any matters filed pursuant to subdivisions (a) and (b) of Section 3527, or may assign the matter to a hearing officer. The Medical Board of California may hear any matters filed pursuant to subdivision (c) of Section 3527, or may assign the matter to a hearing officer. If a matter is heard by the board or the Medical Board of California, the hearing officer who presided at the hearing shall be present during the board's or the Medical Board of California's consideration of the case, and, if requested, assist and advise the board or the Medical Board of California.

~~SEC. 59.~~

SEC. 58. Section 3530 of the Business and Professions Code is amended to read:

3530. (a) A person whose license or approval has been revoked or suspended, or who has been placed on probation, may petition the board for reinstatement or modification of penalty, including modification or termination of probation, after a period of not less than the following minimum periods has elapsed from the effective date of the decision ordering that disciplinary action:

(1) At least three years for reinstatement of a license or approval revoked for unprofessional conduct, except that th~~e committee~~ *board* may, for good cause shown, specify in a revocation order that a petition for reinstatement may be filed after two years.

(2) At least two years for early termination of probation of three years or more.

(3) At least one year for modification of a condition, or reinstatement of a license or approval revoked for mental or physical illness, or termination of probation of less than three years.

(b) The petition shall state any facts as may be required by the Medical Board of California. The petition shall be accompanied by at least two verified recommendations from physicians licensed either by the Medical Board of California or the Osteopathic Medical Board who have personal knowledge of the activities of the petitioner since the disciplinary penalty was imposed.

(c) The petition may be heard by the board. The board may assign the petition to an administrative law judge designated in Section 11371 of the Government Code. After a hearing on the petition, the administrative law judge shall provide a proposed decision to the board that shall be acted upon in accordance with the Administrative Procedure Act.

(d) The board or the administrative law judge hearing the petition, may consider all activities of the petitioner since the disciplinary action was taken, the offense for which the petitioner was disciplined, the petitioner's activities during the time the license was in good standing, and the petitioner's rehabilitative efforts, general reputation for truth, and professional ability. The hearing may be continued, as the ~~committee~~ *board* or administrative law judge finds necessary.

(e) The board or administrative law judge, when hearing a petition for reinstating a license or approval or modifying a penalty, may recommend the imposition of any terms and conditions deemed necessary.

(f) No petition shall be considered while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole. No petition shall be considered while there is an accusation or petition to revoke probation pending against the person. The board may deny, without a hearing or argument, any petition filed pursuant to this section within a period of two years from the effective date of the prior decision following a hearing under this section.

(g) Nothing in this section shall be deemed to alter Sections 822 and 823.

~~SEC. 60.~~

SEC. 59. Section 3531 of the Business and Professions Code is amended to read:

3531. A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge of a felony or of any offense which is substantially related to the qualifications, functions, or duties of the business or profession to which the license was issued is deemed to be a conviction within the meaning of this chapter. The board may order the license suspended or revoked, or shall decline to issue a license when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code allowing such person to withdraw his *or her* plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

~~SEC. 61.~~

SEC. 60. Section 3533 of the Business and Professions Code is amended to read:

3533. Whenever any person has engaged in any act or practice which constitutes an offense against this chapter, the superior court of any county, on application of the Medical Board of California, may issue an injunction or other appropriate order restraining such conduct. Proceedings under this section shall be governed by Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure. The Medical Board of California or the board may commence action in the superior court under the provisions of this section.

~~SEC. 62.~~

SEC. 61. Section 3534 of the Business and Professions Code is amended to read:

3534. ~~(a)~~ It is the intent of the Legislature that the board shall seek ways and means to identify and rehabilitate physician assistants whose competency is impaired due to abuse of dangerous drugs or alcohol so that they may be treated and returned to the practice of medicine in a manner which will not endanger the public health and safety.

~~SEC. 63.~~

SEC. 62. Section 3534.1 of the Business and Professions Code is amended to read:

3534.1. The board shall establish and administer a diversion program for the rehabilitation of physician assistants whose competency is impaired due to the abuse of drugs or alcohol. The board may contract with any other state agency or a private organization to perform its duties under this article. The board may establish one or more diversion evaluation committees to assist it in carrying out its duties under this article. As used in this article, "committee" means a diversion evaluation committee. A committee created under this article operates under the direction of the diversion program manager, as designated by the executive officer of the board. The program manager has the primary responsibility to review and evaluate recommendations of the committee.

~~SEC. 64.~~

SEC. 63. Section 3534.2 of the Business and Professions Code is amended to read:

3534.2. (a) Any committee established by the board shall have at least three members. In making appointments to a committee the board shall consider the appointments of persons who are either recovering of substance abuse and have been free from abuse for at least three years immediately prior to their appointment or who are knowledgeable in the treatment and recovery of substance abuse. The board also shall consider the appointment of a physician and surgeon who is board certified in psychiatry.

(b) Appointments to a committee shall be by the affirmative vote of a majority of members appointed to the board. Each appointment shall be at the pleasure of the board for a term not to exceed four years. In its discretion, the board may stagger the terms of the initial members so appointed.

(c) A majority of the members of a committee shall constitute a quorum for the transaction of business. Any action requires an affirmative vote of a majority of those members present at a meeting constituting at least a quorum. Each committee shall elect from its membership a chairperson and a vice chairperson. Notwithstanding Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code, relating to public meetings, a committee may convene in closed session to consider matters relating to any physician

assistant applying for or participating in a diversion program, and a meeting which will be convened entirely in closed session need not comply with Section 11125 of the Government Code. A committee shall only convene in closed session to the extent it is necessary to protect the privacy of an applicant or participant. Each member of a committee shall receive a per diem and shall be reimbursed for expenses as provided in Section 103.

~~SEC. 65.~~

SEC. 64. Section 3534.3 of the Business and Professions Code is amended to read:

3534.3. Each committee has the following duties and responsibilities:

(a) To evaluate physician assistants who request participation in the program and to make recommendations to the program manager. In making recommendations, a committee shall consider any recommendations from professional consultants on the admission of applicants to the diversion program.

(b) To review and designate treatment facilities to which physician assistants in the diversion program may be referred, and to make recommendations to the program manager.

(c) The receipt and review of information concerning physician assistants participating in the program.

(d) To call meetings as necessary to consider the requests of physician assistants to participate in the diversion program, to consider reports regarding participants in the program, and to consider any other matters referred to it by the board.

(e) To consider whether each participant in the diversion program may with safety continue or resume the practice of medicine.

(f) To set forth in writing the terms and conditions of the diversion agreement that is approved by the program manager for each physician assistant participating in the program, including treatment, supervision, and monitoring requirements.

(g) To hold a general meeting at least twice a year, which shall be open and public, to evaluate the diversion program's progress, to prepare reports to be submitted to the board, and to suggest proposals for changes in the diversion program.

(h) For the purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code, any member of a committee shall be considered a public employee. No board or

committee member, contractor, or agent thereof, shall be liable for any civil damage because of acts or omissions which may occur while acting in good faith in a program established pursuant to this article.

~~SEC. 66.~~

SEC. 65. Section 3534.4 of the Business and Professions Code is amended to read:

3534.4. Criteria for acceptance into the diversion program shall include all of the following: (a) the applicant shall be licensed as a physician assistant by the board and shall be a resident of California; (b) the applicant shall be found to abuse dangerous drugs or alcoholic beverages in a manner which may affect his or her ability to practice medicine safely or competently; (c) the applicant shall have voluntarily requested admission to the program or shall be accepted into the program in accordance with terms and conditions resulting from a disciplinary action; (d) the applicant shall agree to undertake any medical or psychiatric examination ordered to evaluate the applicant for participation in the program; (e) the applicant shall cooperate with the program by providing medical information, disclosure authorizations, and releases of liability as may be necessary for participation in the program; and (f) the applicant shall agree in writing to cooperate with all elements of the treatment program designed for him or her.

An applicant may be denied participation in the program if the board, the program manager, or a committee determines that the applicant will not substantially benefit from participation in the program or that the applicant's participation in the program creates too great a risk to the public health, safety, or welfare.

~~SEC. 67.~~

SEC. 66. Section 3534.5 of the Business and Professions Code is amended to read:

3534.5. A participant may be terminated from the program for any of the following reasons: (a) the participant has successfully completed the treatment program; (b) the participant has failed to comply with the treatment program designated for him or her; (c) the participant fails to meet any of the criteria set forth in subdivision (d); or (d) it is determined that the participant has not substantially benefited from participation in the program or that his or her continued participation in the program creates too great a risk to the public health, safety, or welfare. Whenever an

applicant is denied participation in the program or a participant is terminated from the program for any reason other than the successful completion of the program, and it is determined that the continued practice of medicine by that individual creates too great a risk to the public health and safety, that fact shall be reported to the executive officer of the board and all documents and information pertaining to and supporting that conclusion shall be provided to the executive officer. The matter may be referred for investigation and disciplinary action by the board. Each physician assistant who requests participation in a diversion program shall agree to cooperate with the recovery program designed for him or her. Any failure to comply with that program may result in termination of participation in the program.

The board shall inform each participant in the program of the procedures followed in the program, of the rights and responsibilities of a physician assistant in the program, and the possible results of noncompliance with the program.

~~SEC. 68.~~

SEC. 67. Section 3534.6 of the Business and Professions Code is amended to read:

3534.6. In addition to the criteria and causes set forth in Section 3534.4, the board may set forth in its regulations additional criteria for admission to the program or causes for termination from the program.

~~SEC. 69.~~

SEC. 68. Section 3534.7 of the Business and Professions Code is amended to read:

3534.7. All board and committee records and records of proceedings and participation of a physician assistant in a program shall be confidential and are not subject to discovery or subpoena.

~~SEC. 70.~~

SEC. 69. Section 3534.9 of the Business and Professions Code is amended to read:

3534.9. If the board contracts with any other entity to carry out this section, the executive officer of the board or the program manager shall review the activities and performance of the contractor on a biennial basis. As part of this review, the board shall review files of participants in the program. However, the names of participants who entered the program voluntarily shall

remain confidential, except when the review reveals misdiagnosis, case mismanagement, or noncompliance by the participant.

~~SEC. 71.~~

SEC. 70. Section 3534.10 of the Business and Professions Code is amended to read:

3534.10. Participation in a diversion program shall not be a defense to any disciplinary action which may be taken by the board. This section does not preclude the board from commencing disciplinary action against a physician assistant who is terminated unsuccessfully from the program under this section. That disciplinary action may not include as evidence any confidential information.

~~SEC. 72.~~

SEC. 71. Section 3535 of the Business and Professions Code is amended to read:

3535. (a) Notwithstanding any other provision of law, physicians and surgeons licensed by the Osteopathic Medical Board of California may use or employ physician assistants provided (1) each physician assistant so used or employed is a graduate of an approved program and is licensed by the board, and (2) the scope of practice of the physician assistant is the same as that which is approved by the Division of Licensing of the Medical Board of California for physicians and surgeons supervising physician assistants in the same or similar specialty.

(b) Any person who violates subdivision (a) shall be guilty of a misdemeanor punishable by imprisonment in a county jail not exceeding six months, or by a fine not exceeding one thousand dollars ($1,000), or by both that imprisonment and fine.

(c) This section shall become operative on July 1, 2001.

~~SEC. 73.~~

SEC. 72. Section 3537.10 of the Business and Professions Code is amended to read:

3537.10. (a) Subject to the other provisions of this article, the Office of Statewide Health Planning and Development, hereafter in this article referred to as the office, shall coordinate the establishment of an international medical graduate physician assistant training program, to be conducted at an appropriate educational institution or institutions. The goal of the program shall be to place as many international medical graduate physician assistants in medically underserved areas as possible in order to

provide greater access to care for the growing population of medically indigent and underserved. The method for accomplishing this goal shall be to train foreign medical graduates to become licensed as physician assistants at no cost to the participants in return for a commitment from the participants to serve full-time in underserved areas for a four-year period.

(b) By February 1, 1994, or one month after federal funds to implement this article become available, whichever occurs later, the office shall establish a training program advisory task force. The task force shall be comprised of representatives from all of the following groups:

(1) Physician assistant program directors.

(2) Foreign medical graduates.

(3) The California Academy of Physician Assistants.

(4) Nonprofit community health center directors.

(5) Physicians.

(6) The board, at the board's option.

The office may, instead, serve solely as a consultant to the task force.

(c) The task force shall do all of the following:

(1) Develop a recommended curriculum for the training program that shall be from 12 to 15 months in duration and shall, at a minimum, meet curriculum standards consistent with the board's regulations. The program shall be subject to the board's approval. By April 1, 1994, or three months after federal funds to implement this article become available, whichever occurs later, the curriculum shall be presented by the office to the Committee on Allied Health Education and Accreditation of the American Medical Association, or its successor organization, for approval.

(2) Develop recommended admission criteria for participation in the pilot and ongoing program.

(3) Assist in development of linkages with academic institutions for the purpose of monitoring and evaluating the pilot program.

~~SEC. 74.~~

SEC. 73. Section 3537.20 of the Business and Professions Code is amended to read:

3537.20. Any person who has satisfactorily completed the program established by this article shall be eligible for licensure by the board as a "physician assistant" if the person has complied with all of the following requirements:

(a) Has successfully completed the written examination required under Section 3517.

(b) Has successfully completed the Test of English as a Foreign Language (TOEFL).

~~SEC. 75.~~

SEC. 74. Section 3537.30 of the Business and Professions Code is amended to read:

3537.30. (a) The Legislature recognizes that the goal of this program would be compromised if participants do not observe their commitments under this program to provide the required service in a medically underserved area. The goal of this program would not be met if all that it accomplished was merely to license physician assistants that served populations that are not medically underserved.

(b) Since damages would be difficult or impossible to ascertain in the event of default by the participant, this section shall set forth the extent of liquidated damages that shall be recoverable by the program in the case of default.

(c) In the case of default by a participant who has successfully completed the program and has obtained licensure under this article, the program shall collect the following damages from the participant:

(1) The total cost expended by the program for the training of the applicant, and interest thereon from the date of default.

(2) The total amount needed for the program to seek cover as set forth in subdivision (b) of Section 3537.35.

(3) The costs of enforcement, including, but not limited to, the costs of collecting the liquidated damages, the costs of litigation, and attorney's fees.

(d) The Attorney General may represent the office, or the board, or both in any litigation necessitated by this article, or, if the Attorney General declines, the office, or the board, or both may hire other counsel for this purpose.

(e) Funds collected pursuant to subdivision (c) shall be allocated as follows:

(1) Costs of training recovered pursuant to paragraph (1) of subdivision (c) shall be allocated to the office to be used upon appropriation for the continuing training program pursuant to this article.

(2) Costs of seeking cover recovered pursuant to paragraph (2) of subdivision (c) shall be deposited in the Physician Assistant Training Fund established pursuant to Section 3537.40 for the purposes of providing grants pursuant to subdivision (c) of Section 3537.35.

(3) Costs of enforcement recovered pursuant to paragraph (3) of subdivision (c) shall be allocated between the office, and the Attorney General, or other counsel, according to actual costs.

~~SEC. 76.~~

SEC. 75. Section 3537.50 of the Business and Professions Code is amended to read:

3537.50. No General Fund revenues shall be expended to carry out this article. The implementation of the pilot program and, if applicable, the permanent program established by this article shall be contingent upon the availability of federal funds, which do not divert or detract from funds currently utilized to underwrite existing physician assistant training programs or to fund existing functions of the board. The new funding shall be sufficient to cover the full additional cost to the educational institution or institutions that establish the program or programs, the cost of tuition and attendance for the students in the program or programs, and any additional costs, including enforcement costs, that the office or the board incurs as a result of implementing this article. Nothing in this article shall be construed as imposing any obligations upon the office, the board, or any physician assistant training program in the absence of adequate funding as described in this section. Nothing in this article shall be construed either as precluding applicants for the program established by this article from seeking state or federal scholarship funds, or state and federal loan repayment funds available to physician assistant students, or as requiring that any applicants be granted preference in the award of those funds. Nothing in this article shall be construed as impairing the autonomy of any institution that offers a physician assistant training program.

~~SEC. 77.~~

SEC. 76. Section 3540 of the Business and Professions Code is amended to read:

3540. A physician assistants corporation is a corporation which is authorized to render professional services, as defined in Section 13401 of the Corporations Code, so long as that corporation and

its shareholders, officers, directors, and employees rendering professional services who are certified physician assistants are in compliance with the Moscone-Knox Professional Corporation Act, the provisions of 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 physician assistants corporation, the governmental agency referred to in the Moscone-Knox Professional Corporation Act (commencing with Section 13400) of Division 3 of Title 1 of the Corporations Code~~)~~ is the board.

~~SEC. 78.~~

SEC. 77. Section 3546 of the Business and Professions Code is amended to read:

3546. The Medical Board of California may adopt and enforce regulations to carry out the purposes and objectives of this article, including regulations requiring (a) that the bylaws of a physician assistant corporation shall include a provision whereby the capital stock of the corporation owned by a disqualified person (as defined in Section 13401 of the Corporations Code), or a deceased person, shall be sold to the corporation or to the remaining shareholders of the corporation within the time as the regulations may provide, and (b) that a physician assistant corporation shall provide adequate security by insurance or otherwise for claims against it by its patients arising out of the rendering of professional services.

~~SEC. 79.~~

SEC. 78. 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

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1237
Author: Price
Bill Date: July 5, 2012, amended
Subject: Omnibus – Sunset Dates
Sponsor: Author

STATUS OF BILL:

This bill is in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill is the vehicle by which omnibus legislation has been carried in relation to sunset dates. This analysis will only include the relevant sections of the bill in the Business and Professions Code (BPC) that impact the Medical Board of California (Board). The omnibus language would extend the sunset date of the vertical enforcement and prosecution model, from January 1, 2013 to January 1, 2014.

ANALYSIS:

This bill extends the sunset date of the vertical enforcement and prosecution model from January 1, 2013, to January 1, 2014. The new date will coincide with the date the Board's sunset date, and vertical enforcement will be an issue that will be identified in the Board's sunset report.

Board staff is just making the Board aware of this bill, no position is needed.

FISCAL: None to the Board.

SUPPORT: California Retailers Association
California Society of Health-System Pharmacists
Court Reporters Board of California
California State Board of Pharmacy
Healthcare Distribution Management Association

OPPOSITION: None on file

POSITION: Recommendation: No Position

AMENDED IN ASSEMBLY JULY 5, 2012

AMENDED IN ASSEMBLY JUNE 15, 2012

AMENDED IN SENATE APRIL 30, 2012

AMENDED IN SENATE APRIL 16, 2012

SENATE BILL No. 1237

Introduced by Senator Price

February 23, 2012

An act to amend Sections 2006, 2450.3, 2602, 2607.5, 4001, 4003, 8000, 8005, 8027, 8030.2, ~~and~~ 8030.5, *9812.5, 9830.5, 9832.5, 9847.5, 9849, 9851, 9853, 9860, and 9863* of the Business and Professions Code, and to amend ~~Section~~ *Sections 12529, 12529.5, and* 12529.6 of the Government Code, relating to professions and vocations, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 1237, as amended, Price. Professions and vocations: regulatory boards.

(1) Existing law, until January 1, 2013, declares that using a vertical enforcement and prosecution model for the Medical Board of California's investigations is in the best interests of the people of California. Under existing law, a vertical enforcement and prosecution model is described as the joint assignment *of* a complaint to a board investigator and to a deputy attorney general responsible for prosecuting the case if the investigation results in the filing of an accusation. Existing law requires the board to, among other things, establish and implement a plan to locate specified staff in the same offices in order to carry out the intent of the vertical enforcement and prosecution model.

This bill would extend the operation of these provisions to January 1, 2014, and would also make a conforming change in that regard.

(2) Existing law, the Naturopathic Doctors Act, provides for the licensure and regulation of naturopathic doctors by the Naturopathic Medicine Committee within the Osteopathic Medical Board of California. Existing law repeals these provisions on January 1, 2014. Under existing law, boards scheduled for repeal are required to be evaluated by the Joint Sunset Review Committee.

This bill would make a conforming change with regard to the operation of these provisions until January 1, 2014, and the bill would also specify that this board would be subject to review by the appropriate policy committees of the Legislature.

(3) Existing law, the Physical Therapy Practice Act, provides for the licensure and regulation of physical therapists by the Physical Therapy Board of California. Existing law authorizes the board to appoint an executive officer. Existing law makes these provisions inoperative on July 1, 2013, and repealed on January 1, 2014. Under existing law, boards scheduled for repeal are required to be evaluated by the Joint Sunset Review Committee.

This bill would delete the inoperative date and would instead repeal these provisions on January 1, 2014. The bill would also specify that this board would be subject to review by the appropriate policy committees of the Legislature.

(4) Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacies, pharmacists, pharmacy technicians, wholesalers of dangerous drugs or devices, and others by the California State Board of Pharmacy. Existing law authorizes the board to appoint an executive officer. Under existing law, the board and its authority to appoint an executive officer will be repealed on January 1, 2013. Under existing law, boards scheduled for repeal are required to be evaluated by the Joint Sunset Review Committee.

This bill would extend the operation of the California State Board of Pharmacy and its authority to appoint an executive officer until January 1, 2017, and would specify that the board is subject to review by the appropriate policy committees of the Legislature.

(5) Existing law provides for the licensure and regulation of court reporters by the Court Reporters Board of California within the Department of Consumer Affairs. Existing law authorizes this board to appoint an executive officer and committees as necessary. Existing law repeals these provisions on January 1, 2013.

This bill would extend the operation of these provisions until January 1, 2017, and would specify that the board is subject to review by the appropriate policy committees of the Legislature.

Existing law requires, until January 1, 2013, certain fees and revenues collected by the board to be deposited into the Transcript Reimbursement Fund, to be available to provide reimbursement for the cost of providing shorthand reporting services to low-income litigants in civil cases. Existing law authorizes, until January 1, 2013, low-income persons appearing pro se to apply for funds from the Transcript Reimbursement Fund, subject to specified requirements and limitations. Existing law requires the board, until January 1, 2013, to publicize the availability of the fund to prospective applicants. Existing law requires the unencumbered funds remaining in the Transcript Reimbursement Fund as of January 1, 2013, to be transferred to the Court Reporters' Fund.

This bill would extend the operation of these provisions until January 1, 2017, and would make a technical change to these provisions. By extending the operation of the Transcript Reimbursement Fund, which is a continuously appropriated fund, the bill would make an appropriation.

(6) Existing law, the Electronic and Appliance Repair Dealer Registration Law, provides for the registration and regulation of electronic and appliance service dealers and service contractors by the Bureau of Electronic and Appliance Repair, Home Furnishings, and Thermal Insulation within the Department of Consumer Affairs and makes a failure to comply with its provisions a crime. Existing law, until January 1, 2013, requires a service contractor to pay specified fees to the bureau, including a registration fee and a registration renewal fee. Existing law, until January 1, 2013, requires the Director of Consumer Affairs to gather evidence of violations of the Electronic and Appliance Repair Dealer Registration Law, and any of its regulations, by a service contractor or by any employee, partner, officer, or member of any service contractor. Existing law, until January 1, 2013, requires a service contractor to maintain specified records to be open for inspection by the director and other law enforcement officials. Existing law, until January 1, 2013, also provides for the revocation of the registration of a service contractor by the director and for the superior court to issue a restraining order or injunction against a service contractor who violates these provisions.

This bill would extend the operation of these provisions to January 1, 2015. By extending the operation of certain of these provisions, the

violation of which is a crime, this bill would impose a state-mandated local program.

(7) Existing law, until January 1, 2013, establishes the Health Quality Enforcement Section within the Department of Justice for the purpose of investigating and prosecuting proceedings against licensees and applicants within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Psychology, or any committee under the jurisdiction of the Medical Board of California. Existing law, until January 1, 2013, requires all complaints against licensees of these boards to be made available to the Health Quality Enforcement Section.

This bill would extend the operation of these provisions until January 1, 2014.

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

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

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

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

1 SECTION 1. Section 2006 of the Business and Professions
2 Code is amended to read:
3 2006. (a) Any reference in this chapter to an investigation by
4 the board shall be deemed to refer to a joint investigation conducted
5 by employees of the Department of Justice and the board under
6 the vertical enforcement and prosecution model, as specified in
7 Section 12529.6 of the Government Code.
8 (b) This section shall remain in effect only until January 1, 2014,
9 and as of that date is repealed, unless a later enacted statute, that
10 is enacted before January 1, 2014, deletes or extends that date.
11 SEC. 2. Section 2450.3 of the Business and Professions Code
12 is amended to read:
13 2450.3. There is within the jurisdiction of the Osteopathic
14 Medical Board of California a Naturopathic Medicine Committee
15 authorized under the Naturopathic Doctors Act (Chapter 8.2
16 (commencing with Section 3610)). This section shall become

SEC. 25. Section 9863 of the Business and Professions Code, as amended by Section 62 of Chapter 354 of the Statutes of 2007, is amended to read:

9863. If, upon summary investigation, it appears probable to the director that a violation of this chapter, or the regulations thereunder, has occurred, the director, in his or her discretion, may suggest measures that in the director's judgment would compensate the complainant for the damages he or she has suffered as a result of the alleged violation. If the service dealer accepts the director's suggestions and performs accordingly, the director shall give that fact due consideration in any subsequent disciplinary proceeding. If the service dealer declines to abide by the suggestions of the director, the director may investigate further and may institute disciplinary proceedings in accordance with the provisions of this chapter.

This section shall become operative on January 1, ~~2013~~ *2015*.

SEC. 26. Section 12529 of the Government Code, as amended by Section 8 of Chapter 505 of the Statutes of 2009, is amended to read:

12529. (a) There is in the Department of Justice the Health Quality Enforcement Section. The primary responsibility of the section is to investigate and prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Psychology, or any committee under the jurisdiction of the Medical Board of California.

(b) The Attorney General shall appoint a Senior Assistant Attorney General of the Health Quality Enforcement Section. The Senior Assistant Attorney General of the Health Quality Enforcement Section shall be an attorney in good standing licensed to practice in the State of California, experienced in prosecutorial or administrative disciplinary proceedings and competent in the management and supervision of attorneys performing those functions.

(c) The Attorney General shall ensure that the Health Quality Enforcement Section is staffed with a sufficient number of experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions against the licensees of the board.

(d) Funding for the Health Quality Enforcement Section shall be budgeted in consultation with the Attorney General from the special funds financing the operations of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Psychology, and the committees under the jurisdiction of the Medical Board of California, with the intent that the expenses be proportionally shared as to services rendered.

(e) This section shall remain in effect only until January 1, ~~2013~~ *2014*, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, ~~2013~~ *2014*, deletes or extends that date.

SEC. 27. Section 12529 of the Government Code, as amended by Section 9 of Chapter 505 of the Statutes of 2009, is amended to read:

12529. (a) There is in the Department of Justice the Health Quality Enforcement Section. The primary responsibility of the section is to prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Psychology, or any committee under the jurisdiction of the Medical Board of California, and to provide ongoing review of the investigative activities conducted in support of those prosecutions, as provided in subdivision (b) of Section 12529.5.

(b) The Attorney General shall appoint a Senior Assistant Attorney General of the Health Quality Enforcement Section. The Senior Assistant Attorney General of the Health Quality Enforcement Section shall be an attorney in good standing licensed to practice in the State of California, experienced in prosecutorial or administrative disciplinary proceedings and competent in the management and supervision of attorneys performing those functions.

(c) The Attorney General shall ensure that the Health Quality Enforcement Section is staffed with a sufficient number of experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions against the licensees of the board.

(d) Funding for the Health Quality Enforcement Section shall be budgeted in consultation with the Attorney General from the special funds financing the operations of the Medical Board of California, the California Board of Podiatric Medicine, the Board

of Psychology, and the committees under the jurisdiction of the Medical Board of California, with the intent that the expenses be proportionally shared as to services rendered.

(e) This section shall become operative January 1, ~~2013~~ *2014*.

SEC. 28. Section 12529.5 of the Government Code, as amended by Section 10 of Chapter 505 of the Statutes of 2009, is amended to read:

12529.5. (a) All complaints or relevant information concerning licensees that are within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, or the Board of Psychology shall be made available to the Health Quality Enforcement Section.

(b) The Senior Assistant Attorney General of the Health Quality Enforcement Section shall assign attorneys to work on location at the intake unit of the boards described in subdivision (d) of Section 12529 to assist in evaluating and screening complaints and to assist in developing uniform standards and procedures for processing complaints.

(c) The Senior Assistant Attorney General or his or her deputy attorneys general shall assist the boards or committees in designing and providing initial and in-service training programs for staff of the boards or committees, including, but not limited to, information collection and investigation.

(d) The determination to bring a disciplinary proceeding against a licensee of the boards shall be made by the executive officer of the boards or committees as appropriate in consultation with the senior assistant.

(e) This section shall remain in effect only until January 1, ~~2013~~ *2014*, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, ~~2013~~ *2014*, deletes or extends that date.

SEC. 29. Section 12529.5 of the Government Code, as amended by Section 11 of Chapter 505 of the Statutes of 2009, is amended to read:

12529.5. (a) All complaints or relevant information concerning licensees that are within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, or the Board of Psychology shall be made available to the Health Quality Enforcement Section.

(b) The Senior Assistant Attorney General of the Health Quality Enforcement Section shall assign attorneys to assist the boards in intake and investigations and to direct discipline-related prosecutions. Attorneys shall be assigned to work closely with each major intake and investigatory unit of the boards, to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations.

A deputy attorney general of the Health Quality Enforcement Section shall frequently be available on location at each of the working offices at the major investigation centers of the boards, to provide consultation and related services and engage in case review with the boards' investigative, medical advisory, and intake staff. The Senior Assistant Attorney General and deputy attorneys general working at his or her direction shall consult as appropriate with the investigators of the boards, medical advisors, and executive staff in the investigation and prosecution of disciplinary cases.

(c) The Senior Assistant Attorney General or his or her deputy attorneys general shall assist the boards or committees in designing and providing initial and in-service training programs for staff of the boards or committees, including, but not limited to, information collection and investigation.

(d) The determination to bring a disciplinary proceeding against a licensee of the boards shall be made by the executive officer of the boards or committees as appropriate in consultation with the senior assistant.

(e) This section shall become operative January 1, ~~2013~~ *2014.*

~~SEC. 12.~~

SEC. 30. Section 12529.6 of the Government Code is amended to read:

12529.6. (a) The Legislature finds and declares that the Medical Board of California, by ensuring the quality and safety of medical care, performs one of the most critical functions of state government. Because of the critical importance of the board's public health and safety function, the complexity of cases involving alleged misconduct by physicians and surgeons, and the evidentiary burden in the board's disciplinary cases, the Legislature finds and declares that using a vertical enforcement and prosecution model

for those investigations is in the best interests of the people of California.

(b) Notwithstanding any other provision of law, as of January 1, 2006, each complaint that is referred to a district office of the board for investigation shall be simultaneously and jointly assigned to an investigator and to the deputy attorney general in the Health Quality Enforcement Section responsible for prosecuting the case if the investigation results in the filing of an accusation. The joint assignment of the investigator and the deputy attorney general shall exist for the duration of the disciplinary matter. During the assignment, the investigator so assigned shall, under the direction but not the supervision of the deputy attorney general, be responsible for obtaining the evidence required to permit the Attorney General to advise the board on legal matters such as whether the board should file a formal accusation, dismiss the complaint for a lack of evidence required to meet the applicable burden of proof, or take other appropriate legal action.

(c) The Medical Board of California, the Department of Consumer Affairs, and the Office of the Attorney General shall, if necessary, enter into an interagency agreement to implement this section.

(d) This section does not affect the requirements of Section 12529.5 as applied to the Medical Board of California where complaints that have not been assigned to a field office for investigation are concerned.

(e) It is the intent of the Legislature to enhance the vertical enforcement and prosecution model as set forth in subdivision (a). The Medical Board of California shall do all of the following:

(1) Increase its computer capabilities and compatibilities with the Health Quality Enforcement Section in order to share case information.

(2) Establish and implement a plan to locate its enforcement staff and the staff of the Health Quality Enforcement Section in the same offices, as appropriate, in order to carry out the intent of the vertical enforcement and prosecution model.

(3) Establish and implement a plan to assist in team building between its enforcement staff and the staff of the Health Quality Enforcement Section in order to ensure a common and consistent knowledge base.

1 (f) This section shall remain in effect only until January 1, 2014,
2 and as of that date is repealed, unless a later enacted statute, that
3 is enacted before January 1, 2014, deletes or extends that date.
4 *SEC. 31. No reimbursement is required by this act pursuant*
5 *to Section 6 of Article XIII B of the California Constitution because*
6 *the only costs that may be incurred by a local agency or school*
7 *district will be incurred because this act creates a new crime or*
8 *infraction, eliminates a crime or infraction, or changes the penalty*
9 *for a crime or infraction, within the meaning of Section 17556 of*
10 *the Government Code, or changes the definition of a crime within*
11 *the meaning of Section 6 of Article XIII B of the California*
12 *Constitution.*

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1274
Author: Wolk
Bill Date: April 26, 2012, amended
Subject: Hospitals: Employment
Sponsor: Shriners Hospital for Children
Position: Support

STATUS OF BILL:

This bill is in the Assembly Appropriations Comittee.

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.

This bill was recently amended to make technical changes; these changes do not impact the Board's analysis or recommended position.

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.

The April 26th amendments make technical changes only; these changes do not impact the Board's analysis or recommended position.

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. The Board has taken a support position on this bill.

FISCAL: None

SUPPORT: Shriners Hospital for Children (Sponsor)
Medical Board of California

OPPOSITION: None on file

AMENDED IN SENATE APRIL 26, 2012

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, 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~~ *licensee'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:

SECTION 1. Section 2401 of the Business and Professions 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~~ *board* or the Osteopathic Medical Board of California, may charge for professional services rendered to teaching patients by licensees who hold academic appointments on the faculty of the university, if the charges are approved by the physician and surgeon in whose name the charges are made.

(b) Notwithstanding Section 2400, a clinic operated under subdivision (p) of Section 1206 of the Health and Safety Code may employ licensees and charge for professional services rendered by those licensees. However, the clinic shall not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 or any other provision of law.

(c) Notwithstanding Section 2400, a narcotic treatment program operated under Section 11876 of the Health and Safety Code and regulated by the State Department of Alcohol and Drug Programs, may employ licensees and charge for professional services rendered by those licensees. However, the narcotic treatment program shall not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 or any other provision of law.

(d) 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 *professional* 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~~ *licensees* 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~~ *care coverage*.

(4) The medical staff concur by an affirmative vote that the ~~physician and surgeon's~~ *licensee'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~~ *a* physician and surgeon's professional judgment in a manner prohibited by Section 2400 or any other provision of law.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1416
Author: Rubio and Hernandez
Bill Date: May 29, 2012, amended
Subject: Medical Residency Training Program Grants
Sponsor: Author
Position: Support

STATUS OF BILL:

This bill is in the Assembly Appropriations 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.

This bill would require OSHPD, in consultation with the California Healthcare Workforce Policy Committee, to develop criteria for distribution of available moneys in the fund. This bill would require OSHPD to give priority to programs that meet particular specifications.

This bill was amended to require OSHPD to develop criteria only upon receipt of donations sufficient to cover the costs of developing the criteria and to specify that general fund monies cannot be used to implement this bill.

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 would require OSHPD, in consultation with the California Healthcare Workforce Policy Committee, to develop criteria for distribution of available moneys in the fund. This bill would require OSHPD to give priority to programs that meet the following specifications: are located in a medically underserved area; have a proven record of placing graduates in those medically underserved areas; place an emphasis on training primary care providers; and place an emphasis on training physician specialties that are most needed in the program's community. This bill would make other technical changes.

The May 29th amendments require OSHPD to develop criteria only upon receipt of donations sufficient to cover the costs of developing the criteria and specify that general fund monies cannot be used to implement this bill.

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. The Board took a support position on this bill and the recent amendments do not impact the Board's support position or the reasons for taking that position.

FISCAL: None

SUPPORT: American Federation of State, County and Municipal Employees
California Academy of Child and Adolescent Psychiatry
California Academy of Family Physicians
California Medical Association
Medical Board of California

OPPOSITION: California Right to Life Committee, Inc.

AMENDED IN SENATE MAY 29, 2012

AMENDED IN SENATE APRIL 30, 2012

AMENDED IN SENATE APRIL 16, 2012

SENATE BILL No. 1416

Introduced by 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 health care.

LEGISLATIVE COUNSEL'S DIGEST

SB 1416, as amended, Rubio. 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 *to consist of private moneys donated to the commission for deposit into the fund and any interest that accrues on those moneys,* and would require that moneys in the fund be used, upon appropriation by the Legislature, to fund grants to graduate medical residency training programs, as specified. The bill would require the Office of Statewide Health Planning and Development, in consultation with the California Healthcare Workforce Policy Commission, to develop criteria ~~by December 31, 2013~~, *upon receipt of private donations of sufficient moneys to develop the criteria,* for distribution of available funds. *The bill would state that no General Fund moneys shall be used to implement the provisions of the bill.*

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 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 solely for the purpose of funding grants to
11 graduate medical education residency programs in California.
12 (c) Notwithstanding Section 16305.7 of the Government Code,
13 all interest earned on the moneys that have been deposited into the
14 fund shall be retained in the fund and used for purposes consistent
15 with the fund.
16 (d) The fund shall consist of all of the following:
17 (1) All private moneys donated by private individuals or entities
18 to the commission for deposit into the fund.

~~(2) Any amounts appropriated to the fund by the Legislature.~~

~~(3)~~

(2) Any interest that accrues on amounts in the fund.

(e) No General Fund moneys shall be used to implement this article.

~~(e)~~

(f) (1) The Office of Statewide Health Planning and Development, in consultation with the California Healthcare Workforce Policy Committee, shall develop criteria ~~on or before December 31, 2013,~~ for distribution of available moneys in the fund.

(2) The office shall develop criteria only upon receipt of donations sufficient to cover the costs of developing the criteria.

~~(f)~~

(g) In developing the criteria, the office shall give priority to programs that meet the following specifications:

(1) Are located in medically underserved areas, as defined in subdivision (a) of Section 128552.

(2) Have a proven record of placing graduates in those medically underserved areas.

(3) Place an emphasis on training primary care providers.

(4) Place an emphasis on training physician specialties that are most needed in the community in which the program is located.

~~(g)~~

(h) Moneys appropriated from the fund may also be used to fund existing graduate medical education residency slots as well as new graduate medical education residency slots.

~~(h)~~

(i) Whenever applicable, the office shall utilize moneys appropriated from the fund to provide a match for available federal funds for graduate medical education.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1483
Author: Steinberg
Bill Date: July 2, 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 Assembly Appropriations 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 place the Committee in the Department of Consumer Affairs (DCA), and would require 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. This bill would increase the physician and surgeon license renewal fee by $39.50 to fund the costs of the PHP and the Committee.

ANALYSIS:

This bill would define "physician and surgeon" as a holder of a valid physician's 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; however, applicants would be required to report this information on their licensing application, as this information is already required to be reported on the Board's licensing application. The sponsors have been informed of this.

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.

It is not necessarily clear what other health condition could be monitored and treated with private and clinical monitoring programs. However, this would be under the purview of DCA.

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 who are not on probation with the Board.

It is not clear how the PHP will certify programs, but it is assumed that the Committee/DCA would have to promulgate regulations to establish this process.

This bill would create the Physician Health, Awareness, and Monitoring Quality Oversight Committee in DCA, which 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 is required to be formed no later than April 1, 2013 and 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 physicians 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 public member would be appointed by the Speaker of the Assembly, and one public 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. The rules are required to be consistent with the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees as adopted by the Substance Abuse Coordination Committee of DCA.

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 for immediately reporting physicians who fail to meet program requirements. 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.

Although this bill requires the program to report to the Board participants who fail to meet the requirements of this program, it does not require the reporting to the Board of those whose treatment does not substantially alleviate the impairment, those who withdraw or terminate prior to completion, or those who after an assessment are unable to practice medicine safely. This lack of reporting to the Board appears to be an oversight in how the bill was drafted and should be corrected for consumer protection purposes.

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.

This bill would require a physician to enter into an individual agreement with the PHP and agree to pay expenses related to treatment, monitoring, laboratory tests, and other activities specified in the written agreement as a condition of participation. The written 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.
- A stipulation that expenses related to treatment, monitoring, laboratory tests, and other activities specified in the written agreement will be paid by the participant.
- 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.

This bill would increase the biennial license renewal fee for all physicians and surgeons by $39.50, to fund the costs of the PHP and the Committee.

The previous major issues of concern with this bill – that it was located in the Medical Practice Act, that it did not identify a state agency to have oversight of the Committee and the PHP, and that it did not identify a funding source, have been addressed.

The Board does have a concern with implementing the fee increase on January 1, 2013. The Board sends renewal notices to physicians 90 days in advance of the renewal expiration date. For licensees with a renewal expiration date of January 1, 2013, the renewal letters go out on October 1, 2012. With the transition to a new computer system set for October 15, 2012, the Board's current computer system is frozen and no new changes can currently be made. The new system will not be able to accept revisions until mid to late November, then the programming time to accomplish this update and revise all renewal forms, the web site, cashiering, etc. will take approximately 3-4 months. Board staff would not have time to update the computer system, revise the renewal forms and get out the renewal letters by October 1, 2012. Board staff instead would either have to delay the renewal of those applicants, or have to send an additional letter to those applicants requesting an additional $39.50 in renewal fees. This additional workload would result in fiscal impact to the Board.

The Board would be able to implement this bill in a more efficient manner if the increased fee had a delayed implementation date of July 1, 2013. This would give the Board until April 1, 2013 to update the computer system and revise forms, etc., and would allow Board staff the necessary time to do this within its normal workload, and would not result in a fiscal impact to the Board. As this is the last remaining concern, Board staff is suggesting a Neutral if Amended position on this bill, with the amendment being to delay implementation of the increased fee to July 1, 2013.

FISCAL: As currently written, this bill would result in additional workload to Board staff at a cost of $20,000 to update its computer system and revise forms in an extremely short period of time.

SUPPORT: California Medical Association (Co-Sponsor)
California Hospital Association (Co-Sponsor)
California Psychiatric Association (Co-Sponsor)
California Society of Addiction Medicine (Co-sponsor)
California Academy of Family Physicians
California Society of Anesthesiologists
Kaiser Permanente

OPPOSITION: None on file

POSITION: Recommendation: Neutral if Amended

AMENDED IN ASSEMBLY JULY 2, 2012

AMENDED IN SENATE MAY 29, 2012

AMENDED IN SENATE APRIL 30, 2012

AMENDED IN SENATE APRIL 17, 2012

SENATE BILL No. 1483

Introduced by Senator Steinberg

February 24, 2012

An act to add Article 12.7 (commencing with Section 830) to Chapter 1 of Division 2 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 1483, as amended, Steinberg. Physicians and surgeons.

Existing law provides for the ~~licensing~~ *licensure* and regulation of physicians and surgeons by the Medical Board of California (board) within the Department of Consumer Affairs (department). Under existing law, the biennial license renewal fee for physicians and surgeons is required to be fixed by the board and may not exceed $790.

This bill would create the Physician Health Program, administered by the Physician Health, Recovery, and Monitoring Oversight Committee within the department, with 14 members to be appointed as specified. The purpose of the program would be, among other things, 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, and to make treatment available to all physicians and surgeons subject to a written agreement with the program that includes agreement by the physician and surgeon to pay for expenses

associated with the treatment. The bill would also 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 to select a contractor to implement the program, with the committee serving as the evaluation body for submitted proposals. The bill would require the program to report the name of a participant to the board and the committee when it learns of the participant's failure to meet the requirements of the program. The bill would require the committee to report to the department certain statistics received from the program, would require the department to report to the Legislature on the outcomes of the program, and would require regular audits of the program.

This bill would increase the biennial license renewal fee by $39.50 for purposes of these provisions, except as specified. The bill would direct the board to transfer this revenue on a monthly basis to the Physician Health, Awareness, and Monitoring Quality Trust Fund, which the bill would create, and would specify that the use of these funds is subject to appropriation by the Legislature.

The bill would enact other related provisions and make other conforming changes.

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

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

1 SECTION 1. 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 who 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 the
9 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

issues that could interfere with safe practice, to promote awareness that private early intervention options are available, to provide resources and referrals to ensure physicians and surgeons are better able to choose high-quality private interventions that meet their specific needs, and to provide a separate mechanism for monitoring treatment.

SEC. 2. Article 12.7 (commencing with Section 830) is added to Chapter 1 of Division 2 of the Business and Professions Code, to read:

Article 12.7. Physician Health, Awareness, and Monitoring Quality

830. This article shall be known and may be cited as the Physician Health, Awareness, and Monitoring Quality Act of 2012.

830.2. For purposes of this article, the following terms shall 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 830.6.

(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 830.10.

(f) "Physician Health Program" or "program" means the program defined in Section 830.4 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.

830.4. The Physician Health Program shall do all of the following:

(a) Subject to the requirements of Section 830.10, be available to all physicians and surgeons, as defined in subdivision (g) of Section 830.2.

(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 who are not on probation with the board.

830.6. (a) (1) There is hereby established within the Department of Consumer Affairs 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 April 1, 2013.

(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 physicians 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 *a* 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), the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) 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 the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees as adopted by the Substance Abuse Coordination Committee of the Department of Consumer Affairs pursuant to 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 the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees as adopted by the Substance Abuse Coordination Committee of the Department of Consumer Affairs pursuant to Section 315 and the guidelines of the Federation of State Physician Health Programs, Inc., and community standards of practice, the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees as adopted by the Substance Abuse Coordination Committee of the Department of Consumer Affairs pursuant to Section 315 shall prevail.

830.8. (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~~ *program vendor* 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)~~

(d) The program vendor shall monitor the monitoring entities that participating physicians and surgeons have retained for monitoring a participant's treatment and shall provide ongoing services to physicians and surgeons that resume practice.

~~(f)~~

(e) The program vendor shall have a system for immediately reporting physicians and surgeons who fail to meet the requirements of the program as provided in subdivision (e) of Section 830.10. 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)~~

(f) 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 (e) of Section 830.10. 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.

~~(h)~~

(g) In addition to the requirements of Section 830.16, 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)~~

(h) Copies of the audits referenced in paragraph (2) of subdivision ~~(g)~~ *(f)* 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.

830.10. (a) A physician and surgeon shall, as a condition of participation in the Physician Health Program, enter into an individual agreement with the program and agree to pay expenses related to treatment, monitoring, laboratory tests, and other activities specified in the participant's written agreement with the program.

(b) The written agreement between the physician and surgeon and the program shall be consistent with the standards adopted by the committee pursuant to subdivision (e) of Section 830.6, and 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.

(7) A stipulation that expenses related to treatment, monitoring, laboratory tests, and other activities specified in the participant's written agreement with the program will be paid by the participant.

(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)~~ *(e)* of Section 830.8, 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 board and the committee when it learns of the participant's failure to meet the requirements of the program, including failure to cease practice when required, failure to submit to evaluation, treatment, or biological testing when required, or a violation of the rules adopted by the committee pursuant to subdivision (e) of Section 830.6. 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) Notwithstanding subdivision ~~(f)~~ *(e)* of Section 830.8, the report shall provide sufficient information to permit the board to assess whether discipline or other action is required to protect the public.

(f) Except as otherwise provided in subdivisions (b), (c), ~~(c), and (f)~~ *(d), and (e)* of Section 830.8, subdivision (e) of this section,

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.

830.12. (a) The biennial license renewal fee established in subdivision (d) of Section 2435 shall increase by thirty-nine dollars and fifty cents ($39.50) for purposes of this article, except those purposes specified in Section 830.10. The board shall, on a monthly basis, transfer the revenue generated from this increase to the trust fund described in subdivision (b).

(b) There is hereby established in the State Treasury the Physician Health, Awareness, and Monitoring Quality Trust Fund into which all revenue generated pursuant to subdivision (a) shall be deposited. These funds shall be used, upon appropriation by the Legislature, exclusively for the purposes of this article, except those purposes specified in Section 830.10.

(c) Nothing in this section shall be construed to prohibit additional funding from private sources from being used to support operations of the program or to support the establishment of the committee and the program.

830.14. (a) The committee shall report to the department statistics received from the program pursuant to Section 830.8, and the department shall, thereafter, report to the appropriate policy committees of the Legislature on or before October 1, 2014, and annually thereafter, the outcomes of the program, including, but not limited to, the number of individuals served, the number of

1 participants currently in the program, the number of participants
2 referred by the board as a condition of probation, the number of
3 individuals who have successfully completed their agreement
4 period, the number of participants terminated from the program,
5 and the number of individuals reported to the board for
6 noncompliance pursuant to subdivision (e) of Section 830.10.
7 However, in making those reports, the committee and the
8 department shall not disclose any personally identifiable
9 information relating to any physician and surgeon participating in
10 the program pursuant to an agreement entered into pursuant to
11 Section 830.10.
12 (b) This section shall become inoperative on October 1, 2018,
13 pursuant to Section 10231.5 of the Government Code.
14 830.16. (a) The committee shall biennially contract to perform
15 an audit of the Physician Health Program and its vendors. This
16 section is not intended to reduce the number of audits the
17 committee may otherwise conduct. The initial audit shall
18 commence two years after the award of an initial five-year contract.
19 Under no circumstances shall General Fund revenue be used for
20 this purpose.
21 (b) Any person or entity conducting the audit required by this
22 section shall maintain the confidentiality of all records reviewed
23 and information obtained in the course of conducting the audit and
24 shall not disclose any information identifying any program
25 participant.
26 (c) The biennial audit shall be completed by ____ and shall
27 ascertain if the program is operating in conformance with the rules
28 and regulations established by the committee.

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MBC TRACKER II BILLS
7/10/2012

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 137	Portantino	Health Care Coverage: Mammographies	Sen. Health	01/23/12
AB 369	Huffman	Health Care Coverage: Prescriptions Drugs	Sen. Approps	07/03/12
AB 377	Solorio	Pharmacy	Sen. Approps	04/14/11
AB 439	Skinner	Health Care Information	Senate	06/15/12
AB 510	Lowenthal, B.	Radiation Control: Health Facilities and Clinics: Records	Enrolled	07/02/12
AB 714	Atkins	Health Care Coverage: California Health Benefit Exchange	Sen. Approps	06/30/11
AB 916	Perez, M.	Health: Underserved Communities	Sen. Approps	07/05/12
AB 1217	Fuentes	Surrogacy Agreements	Sen. Approps	06/11/12
AB 1280	Hill	Ephedrine: Retail Sale	Sen. Approps	02/09/12
AB 1309	Miller	UC Riverside Medical School	Senate	07/02/12
AB 1409	Perez, M.	Regulations: Small Business	Senate	06/19/12
AB 1453	Monning	Essential Health Benefits	Sen. Approps	04/17/12
AB 1461	Monning	Individual Health Care Coverage	Sen. Approps	04/09/12
AB 1580	Bonilla	Health Care: Eligibility: Enrollment	Sen. 3rd Reading	
AB 1588	Atkins	Reservist Licensees: Fees and Continuing Education	Sen. Approps	06/25/12
AB 1636	Monning	Health and Wellness Programs	Sen. Approps	06/25/12
AB 1687	Fong	Worker's Compensation	Sen. Approps	06/18/12
AB 1731	Block	Newborn Screening Program: Critical Congenital Heart Disease	Sen. Approps	07/06/12
AB 1733	Logue	Telehealth	Sen. Approps	06/20/12
AB 1783	Perea	Public Contracts: Small Business Preferences	Enrolled	04/10/12
AB 1800	Ma	Health Care Coverage	Sen. Approps	06/26/12
AB 1904	Block	Military Spouses: Expedited Licensure	Sen. Approps	06/12/12
AB 2009	Galgiani	Communicable Disease: Influenza Vaccinations	Sen. Consent	06/01/12
AB 2041	Swanson	Regulations: Adoption: Disability Access	Sen. Approps	06/12/12
AB 2109	Pan	Communicable Disease: Immunization Exemption	Sen. Approps	06/20/12
AB 2214	Monning	Health Workforce Development	Sen. Approps	07/03/12

MBC TRACKER II BILLS
7/10/2012

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 2221	Block	Public Records	Sen. 3rd Reading	03/28/12
AB 2266	Mitchell	Medi-Cal: Enhanced Health Homes	Sen. Approps	06/25/12
AB 2285	Eng	Peace Officer Testing: Cheating	Sen. 3rd Reading	05/23/12
AB 2343	Torres	Criminal History Information	Sen. 3rd Reading	03/28/12
AB 2348	Mitchell	Registered Nurses: Dispensation of Drugs	Senate	06/27/12
AB 2356	Skinner	Tissue Donation	Senate	05/30/12
SB 103	Liu	State Government: Meetings	Asm. Approps	07/12/11
SB 173	Simitian	Healing Arts: Mammograms	Asm. Approps	08/15/11
SB 393	Hernandez	Medical Homes	Assembly	06/15/12
SB 411	Price	Home Care Services Act of 2011	Inactive File	08/30/11
SB 628	Yee	Acupuncture: Regulation	Asm. Approps	05/31/12
SB 703	Hernandez	Basic Health Program	Asm. Approps	
SB 764	Steinberg	Developmental Services: Telehealth Systems Program	Asm. Approps	07/03/12
SB 951	Hernandez	Health Care Coverage: Essential Health Benefits	Asm. Approps	04/16/12
SB 961	Hernandez	Individual Health Care Coverage	Asm. Approps	04/09/12
SB 975	Wright	Professions & Vocations: Regulatory Authority	Asm. 3rd Reading	06/27/12
SB 1050	Alquist	Autism: Telehealth Task Force	Asm. Approps	06/15/12
SB 1099	Wright	Regulations	Asm. Approps	05/17/12
SB 1134	Yee	Persons of Unsound Mind: Psychotherapist Duty to Protect	Enrolled	05/08/12
SB 1172	Lieu	Sexual Orientation Change Efforts	Asm. 3rd Reading	07/05/12
SB 1185	Price	Centralized Intelligence Partnership Act	Asm. Approps	05/29/12
SB 1199	Dutton	Radiologic Technologists	Asm. Approps	06/25/12
SB 1301	Hernandez	Prescription Drugs: 90-Day Supply	Asm. Approps	06/21/12
SB 1329	Simitian	Prescription Drugs: Collection & Distribution Program	Asm. 3rd Reading	06/26/12
SB 1407	Leno	Medical Information: Disclosure	Asm. Approps	06/20/12
SB 1410	Hernandez	Independent Medical Review	Asm. Approps	05/25/12

MBC TRACKER II BILLS
7/10/2012

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 1446	Negrete McLeod	Naturopathic Doctors	Asm. Approps	06/28/12
SB 1524	Hernandez	Nursing	Asm. Approps	06/28/12
SB 1538	Simitian	Health Care: Mammograms	Asm. Approps	06/19/12
SCR 72	Price	National Consumer Protection Week	Senate	03/06/12

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 by Board	Date to DCA (and other control agencies) for Review *	Date to OAL for Review **	Date to Sec. of State***
Sponsored Free Health Care Events	Pending review at OAL	1/28/11	3/11/11	5/6/11	5/4/12	To DCA 10/26/11; To SCSA 11/14; To DOF 11/16/11; To DCA 7/2/12; To SCSA 7/6/12	2/10/12 Disapproved 3/13/12 Resubmitted 7/10/12	
Misdemeanor Convictions	Staff finalizing file	2/03/12	3/09/12	5/04/12	5/04/12			
Non-substantive changes from all units (Section 100 changes)	Next review of MBC regulations – Fall 2012							

Prepared by Chris Valine
Updated July 10, 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

AGENDA ITEM 13B

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	July 20, 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:
Attached is the progress on the Board's Strategic Plan as of July 3, 2012, including 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	7/20/12 – To be provided to the Licensing Committee at the July 2012 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	7/20/12 - Presentation to be made at the July 2012 Licensing Committee 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	7/20/12 – Discussion after the above-mentioned presentation at the July 2012 Licensing Committee meeting.

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	7/20/12 - The FSMB gave a presentation at the May 2012 Board meeting regarding MOL and discussion will ensue at future Board meetings. There are other States beginning pilot programs for MOL. The Board will await the findings from these programs.
• 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	7/20/12 - The FSMB gave a presentation at the May 2012 Board meeting regarding physician re-entry and discussion will ensue at future Board meetings. Staff is beginning to look into this issue to determine what steps need to be taken in California.
• 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	7/20/12 - The FSMB gave a presentation at the May 2012 Board meeting regarding MOL and discussion will ensue at future Board meetings. There are other States beginning pilot programs for MOL. The Board will await the findings from these programs.
• 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	7/20/12 – Presentation to be made at the July 2012 Licensing Committee 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	7/20/12 - The Licensing Program will provide the plan to the Licensing Committee at the July 2012 meeting.
• Research all international medical schools to create a comprehensive database.	Summer 2012 - Summer 2014, ongoing	Licensing	A	7/20/12 – The Licensing Program has begun the research to develop this database now that the staff for this program has been hired and trained.
• 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 this review and update had been delayed until Summer 2012 – Fall 2012. 7/20/12 - Now that the staff has been hired for this program, they are beginning the process of reviewing the application, surveys, and evaluations.

*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. 7/20/12 – Due to the inability to move forward with hiring a legal counsel retired annuitant, a revised timeline will need to be developed and presented in Fall 2012.
• 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. 7/20/12 – Due to the inability to move forward with hiring a legal counsel retired annuitant, a revised timeline will need to be developed and presented in Fall 2012.
• 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. 7/20/12 – The Board continues to work with the Attorney General's office on reconciling the data provided.
• 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. 7/20/12 – Staff continues to research the information from other states and will provide a report on the data in the future.

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	7/20/12 – Presentation to be made at the July 2012 Enforcement Committee meeting.
• Review and evaluate the complaints and their relation to physician disciplinary action.	Winter – Summer 2012	Enforcement	A	7/20/12 – 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	7/20/12 – Presentation to be made at the July 2012 Enforcement Committee meeting.
• 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	7/20/12 – Discussion will ensue after above presentations.

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 and May 2012 Enforcement Committee meetings a presentation on the components of the new Expert Reviewer Training Program was provided.
• Examine the training and evaluation measures, as well as policies to identify problem areas and those that should be amended.	Spring 2012	Enforcement	A	7/20/12 - Board staff provided the new training to the Northern California Expert Reviewers on May 19, 2012. 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	7/20/12 – An evaluation will be performed after the roll out of this new program to identify where changes, if any, need to be made. Already identified that more feedback needs to be provided to the experts after their review, testimony, and examinations. Enforcement staff is working on the implementation of this feedback process.
• 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. 7/20/12 – The Board and OAH performed training for the ALJs on June 22, 2012. An update will be provided at the July 2012 Enforcement Committee meeting.
• Conduct OAH training semiannually.	Spring 2012-Ongoing	Enforcement	B	7/20/12 – On June 22, 2012 the training was held and staff will continue this in the future, although it has been suggested that a full day of training may not be the best format on a semi-annual basis. Quarterly lunch presentations or half day sessions may work better for ALJ schedules.
• Examine disciplinary decisions to determine if they meet the Board's mission to protect the public.	Winter 2012-Spring 2012	Enforcement	B	7/20/12 – Due to staffing vacancies this item has deferred; however, it will begin during Spring 2013.
• Identify any inconsistent outcomes in disciplinary cases and present the findings to the Board.	Spring 2012	Enforcement	B	7/20/12 – Due to staffing vacancies this item has deferred; however, it will begin during Spring 2013.
• 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. 7/20/12 – Implementation has begun and will continue throughout the year.
• 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. 7/20/12 – SB 100 must be fully implemented before the need for additional staff can be fully realized.
• 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	7/20/12 – A presentation was made to the Licensing Committee in February 2012. Additionally, a presentation will be made 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 2.9: Examine Board responsibilities that could be eliminated or moved to a more appropriate board, bureau, or program. (Midwives, Registered Dispensing Opticians, Spectacle Lens Dispensers, Research Psychoanalysts, approval of non-ABMS specialty boards, etc.)

Activity	Date	Staff	Priority	Status
• Educate the membership about the Board's authority over allied health professions. Staff should make a presentation at a Board meeting.	Summer 2012	Executive	B	7/20/12 – A presentation will be made at the July 2012 Licensing Committee meeting on the other allied health professions within the Board's authority.
• Identify those areas where the Board may not have sufficient expertise or resources to adequately provide consumer protection.	Fall 2012 through Spring 2013	Executive	B	
• Depending upon areas identified by the membership, seek legislation to move or eliminate responsibilities of the Board that appear to be inappropriate. (To be completed to coincide with Sunset Review.)	Summer 2013	Executive	B	

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 – In January 2012, the new Public Information Officer (PIO) began looking at the Board's Web site layout and identified improvements that are needed. The Board also has developed a Web Design Committee that meets to review the Web Site for improvements. 7/20/12 - The PIO has developed a plan to implement the Objectives of Goal 3.1. This information will be provided to the Education & Wellness Committee at its July 2012 Meeting.
• 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		7/20/12 – Feature articles and sections are a part of the Newsletter, keeping licensees informed via News 2 Use, Tech Corner, and World Pulse. New sections are being developed for future issues.
• Work with state, county and federal agencies to inform licensees.	Fall 2012	Public Affairs	B	7/20/12 - The PIO has developed a plan to implement the Objectives of Goal 3. This information will be provided to the Education & Wellness Committee at its July 2012 Meeting.
• 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	7/20/12 – Updated *Guide to the Laws Governing the Practice of Medicine* is being drafted with a tentative release date in September 2012.

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	7/20/12 – After the Education & Wellness Committee in July 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	7/20/12 – Specific outreach will be identified in the PIO's plan provided to the Education & Wellness Committee at the July 2012 meeting.

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 – In January 2012, the new PIO began looking at the Board's Web site layout and identified improvements that are needed. The Board also has developed a Web Design Committee that meets to review the Web Site for improvements. 7/20/12 - The PIO has developed a plan to implement the Objectives of Goal 3.2. This information will be provided to the Education & Wellness Committee at its July 2012 Meeting.
• 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	7/20/12 – Phone discussions have occurred with KOVR 13, News10, Fox40, and KCRA3.
• Update the content of brochures to reflect the current practice environment.	Various 2012-13	Public Affairs	C	7/20/12 – Brochures are being updated on a priority basis; working on the older ones or those requiring immediate updating first.
• Work with other state agencies to provide Board materials to consumers	Various 2012-13	Public Affairs	C	7/20/12 – Relationships have been established with the California Medical Association, Los Angeles County Medical Association, Employment Development Department, Managed Risk Medical Insurance Board, and others will be identified.
• 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	7/20/12 – The PIO has begun communicating with the DCA's Public Affairs Office and will establish a procedure on joint actions.

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.

• Explore the use of social media in outreach to the public.	Summer 2012	Public Affairs	C	7/20/12 – This process has begun and the Board staff is exploring social media as a conduit to the public. This information will be provided to the Education & Wellness Committee at its July 2012 Meeting.
• 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 that 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. Relationships with the San Francisco and Los Angeles District Attorney's Offices have been established.
• When the budget allows, provide press kits about the Board to all media outlets.	Winter 2013	Public Affairs	C	7/20/12 – Press kits were distributed at the May Board Meeting and will be provided at the July Board Meeting.
• Participate in professional/public outreach programs (see Objective 3.2)	Various 2012-15	Public Affairs	C	7/20/12 – The PIO participated a class at Sacramento State University discussing medical ethics.

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	7/20/12 – This item will be addressed in the plan developed by the PIO and discussed with the Education & Wellness Committee at the July 2012 meeting.
• 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	7/20/12 – Each Newsletter contains information that encourages feedback. Additionally, the Fall Newsletter will have a feature where the reader can "click" to provide a comment directly to the Board.
• Examine ways of promoting the Newsletter to encourage more readers.	Winter 2012	Public Affairs	C	7/20/12 – This item will be addressed in the plan developed by the PIO and discussed with the Education & Wellness Committee. 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	7/20/12 – Articles from the Employment Development Department, Board of Pharmacy, and Managed Risk Medical Insurance Board are included in the Summer Newsletter.
• 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.

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

• Encourage professional associations and societies to include a link to the Newsletter.	Various 2011-13	Public Affairs	C	7/20/12 – This item will be addressed in the plan developed by the PIO and discussed with the Education & Wellness Committee at its July 2012 meeting.

Objective 3.9: Conduct outreach to ethnic and other language publications and groups.

Activity	Date	Staff	Priority	Status
• Identify the ethnic and cultural groups to be targeted.	Summer 2012	Public Affairs	C	7/20/12 – This item will be addressed in the plan developed by the PIO and discussed with the Education & Wellness Committee at its July 2012 meeting.
• Identify the media outlets for various ethnic groups and other-than-English publications, including community newspapers, radio, television stations, and web groups.	Summer 2012	Public Affairs	C	7/20/12 – This item will be addressed in the plan developed by the PIO and discussed with the Education & Wellness Committee at its July 2012 meeting.
• Identify those in staff or on the Board who may be able to communicate with the targeted groups, either through language fluency, or cultural sensitivity.	Summer 2012	Public Affairs	C	7/20/12 – This item will be addressed in the plan developed by the PIO and discussed with the Education & Wellness Committee at its July 2012 meeting.
• Establish a plan to coincide with the outreach to English language and general audience.	Summer 2012	Public Affairs	C	7/20/12 – This item will be addressed in the plan developed by the PIO and discussed with the Education & Wellness Committee at its July 2012 meeting.

<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 is 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	7/20/12 – A new report will be provided to the Board at the July 2012 Board meeting and ongoing.
• 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	7/20/12 – This activity is intended to relate to the VEP. Staff is preparing reports that look at the spending for the prosecution of cases by the Attorney General's Office and the Office of Administrative Hearings. This information will be provided as part of the sunset report.
• 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	7/20/12 – Staff is awaiting information from the Attorney General's Office on spending due to VEP and will compare to the reports prepared above. Additionally, staff will look into the spending at the Office of Administrative Hearings.
• Establish a procedure to regularly evaluate the value of spending to outside areas.	Spring-Fall 2012	Administra-tion/Budget	B	7/20/12 – Staff has begun reviewing the billing to determine the value of VEP and also determining if the spending is commensurate to the activities of the Board (e.g. when more stipulations are occurring the spending at the Office of Administrative Hearings is decreasing). Staff will continue tracking the spending data and verifying that when reductions occur the Board sees the decreases in the billing provided by the outside agencies.
• 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	7/20/12 – A new report will be provided to the Board at the July 2012 Board meeting and ongoing. Any findings will be reported to the Board during the quarterly meetings.

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. 7/20/12 – As time allows, a visit to the Sacramento office and headquarters may occur during 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	7/20/12 – The Board will continue to send out the complaint survey form and will include information from it in the sunset review.
• Establish a survey for newly licensed physicians about the application/licensing process	Spring 2012 Ongoing	Research Program Specialist	B	7/20/12 – 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	7/20/12 – The Research Program Specialist has begun to establish a survey for Web users and is establishing a survey monkey tool to use for the survey.
• 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	

MEDICAL BOARD STAFF REPORT

ATTENTION: Members, Medical Board of California
SUBJECT: National Practitioner Data Bank (NPDB) Information
STAFF CONTACT: Letitia Robinson, Research Specialist

RECOMMENDED ACTION

Staff requests the Board review the additional information provided and direct staff to implement the recommendations specified below as an alternative to querying the NPDB.

As reported at the May 2012 Board meeting (see attached agenda item memo), the Board has initiated and will continue, on an annual basis, to request from the NPDB reports filed from peer review bodies for California physicians. Board staff will review these reports to determine if the Board has received all of the reports and to pursue investigations if it has not received reports.

Staff recommends outreach activities to ensure mandated reporters are informed of their responsibility to report certain events to the Board. As suggested at the May 2012 Board meeting, an article regarding Peer review reporting has been placed in the Board's summer Newsletter, and more could be done via meetings with reporters.

BACKGROUND

At the February 3, 2012 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.

Kimberly Kirchmeyer presented data on the feasibility of querying the NPDB for physician renewal candidates at the Board's May 4, 2012 meeting. The Board requested additional information including NPDB statistical data for review at the July 2012 Board meeting. The information below is in response to this request.

ANALYSIS

Peer Review Reporting

An annual review is performed in order for the Board to conduct a periodic reconciliation of peer review reports made to NPDB versus reports made to the Board. The Board has, for the last two years and proposes to do on an annual basis, requested from the NPDB reports filed from peer review bodies for California physicians. Board staff will review these reports to determine if the Board has received all of the reports and pursue investigations if it has not received the reports.

Board staff has reviewed the 2010 and 2011 peer review actions for California physicians reported to the NPDB. In 2010, the Board received all peer review reports that were received by the NPDB. In 2011, there was one peer review report that was submitted to the NPDB but was not reported to the Board. Board staff has requested this report from the NPDB and will investigate the action taken against the licensee. Board staff will also investigate why the report was not made to the Board.

The 2010 and 2011 reports from NPDB did not include any physician peer review actions from other states where the physician was also licensed to practice medicine. The Board agrees that

these actions are important to know about in order to protect California consumers. However, if the state for which the report was made did not take disciplinary action, it may not be worth the resources it would take for the Board to investigate. It is difficult to prosecute a case in another state, and if the other state did not take action, it would be much more difficult to attain the clear and convincing evidence standard.

For the Board to investigate such an action, it may require Board investigators to travel to other states. This is especially difficult with the requirement that all out-of-state travel be approved by the Governor's Office. An out-of-state investigation may also require the Board to obtain out-of-state approval from the Governor's Office and incur costs to bring witnesses to California. This is provided that the witness agrees to testify because the Board cannot compel a witness to come to California to testify. The Board's subpoenas are not enforceable outside of California and obtaining witnesses and medical records may be problematic as the Board could not issue a subpoena. California consumers may be better served with having resources expended on physicians who are currently practicing in California.

The chart below shows the NPDB and MBC Peer Review reporting requirements. The biggest difference in the reporting requirements is the NPDB requires reporting actions that adversely affect privileges in excess of 30 days. The Board requires reporting of suspension in excess of 14 days and restrictions imposed for a cumulative total of 30 days or more for any 12-month period.

NPDB and MBC Peer Review Reporting Requirements

NPDB	***MBC***
Professional review action, based on reasons related to professional competence or conduct, adversely affecting clinical privileges for a period <u>longer than 30 days</u> including revocation, denial, non-renewal, and suspension. Voluntary surrender or restriction of clinical privileges while under, or to avoid, investigation.	Peer Review actions, based on medical disciplinary cause or reason, when clinical privileges are denied or rejected; terminated or revoked; and when restrictions are imposed for a <u>cumulative total of 30 days or more</u> for any 12-month period. [B&P805(b)] Licensee resigns or take a leave of absence while under investigation; Licensee withdraws application or renewal of privileges while under investigation [B&P805(c)] Suspension in effect in excess of 14 days – [B&P805(e)]

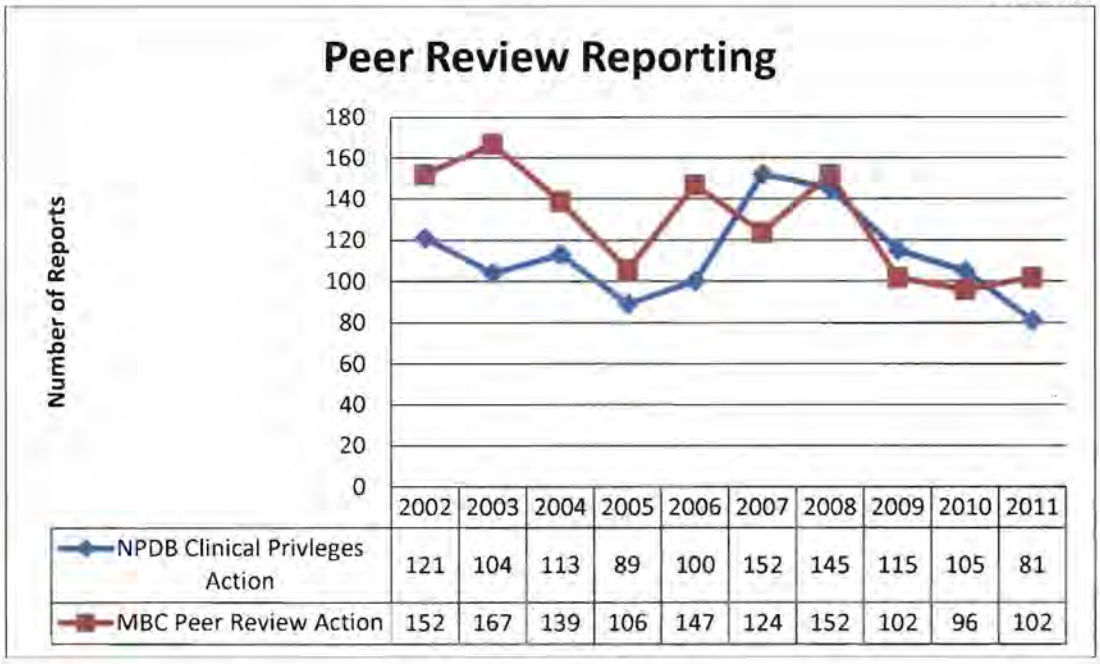
The chart below shows the NPDB and MBC sanctions for failing to report Peer Review actions. The NPDB informed the Board that no sanctions have been levied against any entity in the last ten years. The Board has levied civil penalties for six cases of failure to report Peer Review actions within the past ten years. The penalties in these cases ranged from $5,000 to $50,000 as some of these penalties were assessed prior to the increase in the amount of fines. SB 16 Figueroa (Statutes 2001, Chapter 614) increased the amount of the fine for a willful failure to report Peer Review actions from $10,000 to $100,000 and increased the amount of the fine for any failure to report from $5,000 to $50,000.

NPDB and MBC Sanctions for Failing to Report Peer Review Actions

NPDB	***Sanctions Issued in Years 2002-2011***	***MBC***	***Sanctions Issued in Years 2002-2011***
The entity will be published in the *Federal Register* and will lose immunity under the provisions of Title IV with respect to professional review activities for a period of 3 years.	None	A willful failure to report: person designated to report may be fined up to $100,000. [B&P 805(k)] Any failure to report: person designated to report may be fined up to $50,000. [B&P 805(l)]	Six

The following graph shows NPDB and MBC peer review reporting for the past 10 calendar years. The Board shows a higher number of reports than the NPDB in 7 of the 10 reporting years. Further, the NPDB peer review reports include reports of change in action of the reporting entity and restoration or reinstatement by the reporting entity as separate reports. The NPDB methodology of reporting is different than MBC reporting because MBC only counts the initial peer review report. The Board's data does not include any supplemental reports it receives nor does it include any restoration/reinstatement in the data reporting.

For example in 2011, the NPDB reported receipt of 81 cases of Peer Review action against physicians in California. Of the 81 reports, seven were reports of restoration/reinstatement and nine were supplemental reports to an earlier 2011 report. These 16 reports would not be reflected in the Boards 2011 data because the Board only counts the report on its initial reporting. Therefore, only 65 of the 81 reports from the NPDB would be included in the MBC reports. However, in 2011 the Board reported 102 peer review reports. This is 37 more *initial* reports than what was reported to the NPDB.



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
NPDB Clinical Privleges Action	121	104	113	89	100	152	145	115	105	81
MBC Peer Review Action	152	167	139	106	147	124	152	102	96	102

Medical Malpractice Reporting

Assembly Bill 1070 Hill (Statutes 2009, Chapter 505) included amendments to Business and Professions Code § 801.01 – Report of Settlement or Arbitration Award. Previously, the law stated the failure of the licensee or his or her counsel to report the settlement or arbitration award was a public offense punishable by a fine from $50 to $500 and knowing and intentional failure to comply was punishable by a fine from $5,000 to $50,000. AB 1070 authorizes penalties for all reporters and states failure to substantially comply with the reporting requirements in B&P Code § 801.01 is a public offense punishable by a fine from $500 to $5,000. AB 1070 also added language to B&P Code § 801.01 (b)(3) to further clarify that the University of California System, as a self-insured agency, is required to report settlements and arbitration awards.

The charts below show the difference in NPDB and MBC Medical Malpractice reporting. The NPDB requires any and all payment claims in any amount be reported. The Board requires malpractice settlements over $30,000, and judgments or arbitration awards of any amount be reported.

Difference in NPDB and MBC Medical Malpractice Reporting

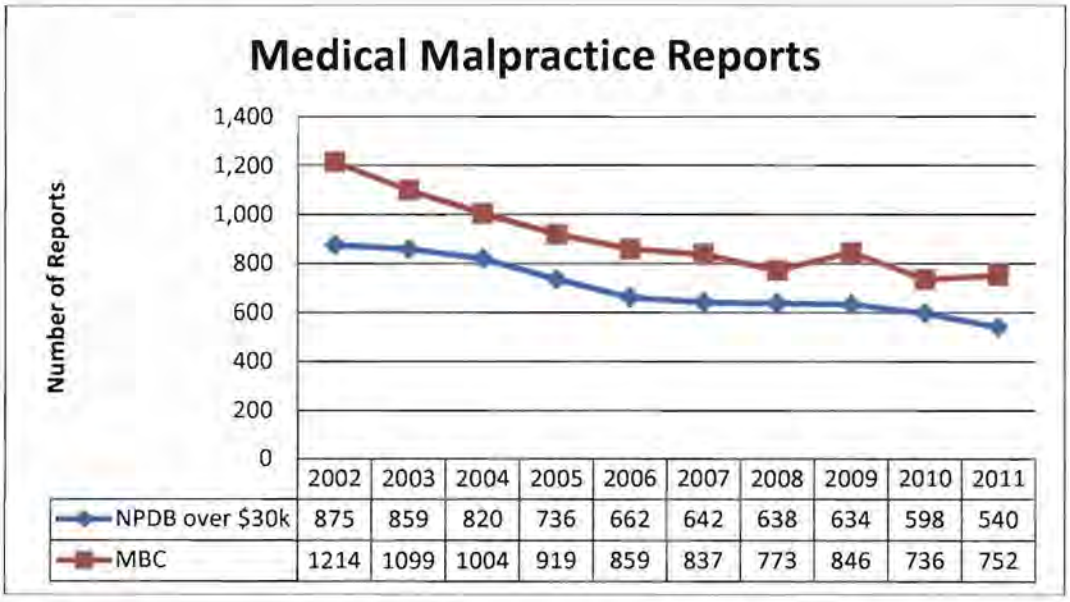
NPDB	***MBC***
Payment resulting from written claim or judgment.	Malpractice settlements over $30,000; and judgments or arbitration awards of any amount. [B&P 801.01 (a)(1)(2)]

The charts below shows the sanctions imposed for failing to report medical malpractice payments to the NPDB and MBC. According to the NPDB, there has not been a penalty assessed in the last ten years for failure to report medical malpractice payments. The Board has also not levied any sanctions against any entity for failure to report medical malpractice payments.

Sanctions for Failing to Report Medical Malpractice Payments to the NPDB and MBC

NPDB	***Sanctions Issued 2001-2011***	***MBC***	***Sanctions Issued 2001-2011***
A civil money penalty up to $11,000 for each payment involved.	None	Failure to substantially comply with the State's reporting requirement is a public offense punishable by a fine ranging from $500 to $5,000. [B&P 801.01(f)]	None

The graph below shows NPDB and MBC medical malpractice payment reporting for the past 10 calendar years. The Board shows a higher number of reports than the NPDB in all 10 reporting years. The graph shows the decline of malpractice payment reports to the Board is similar to the decline of these reports to the NPDB. The Board requires malpractice settlements over $30,000 and judgments/arbitration awards of any amount be reported to the Board. The graph below only shows the reports from the NPDB that are over $30,000 to compare those of the same type of reports to the MBC.



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
NPDB over $30k	875	859	820	736	662	642	638	634	598	540
MBC	1214	1099	1004	919	859	837	773	846	736	752

Actions Reportable to the Healthcare Integrity and Protection Data Bank (HIPDB) and MBC

In addition to actions reported by the NPDB, HIPDB also receives reports. Below is a chart that shows the actions that are reported to HIPDB and MBC.

Reporting Organization	Reportable Action*	Are Reports Required?	
		To HIPDB	To MBC
Federal, State, and Local Prosecutors, Law Enforcement and Investigative Agencies	Criminal convictions, civil judgments (excluding those resulting from medical malpractice), injunctions, and *nolo contendere*/no contest pleas related to delivery of a health care item or service	Yes, must report	Yes, licensee must report: felony indictments; conviction of felony or misdemeanor. Fine up to $5,000 for not reporting (B&P 802.1). District Attorney must report filing of felony charges; Clerk of the Court must report criminal convictions (B&P 803.5)
Federal and State Licensing or Certification Agencies	Final adverse actions related to the delivery of a health care item or service	Yes, must report	No report required
Federal and State Government Agencies	Exclusions from participating in Federal or State health care programs	Yes, must report	No report required (however, MBC obtains information from these entities)
Federal and State Government Agencies and Health Plans	Other adjudicated actions or decisions related to the delivery of a health care item or service	Yes, must report	No report required

* Subject of Report - Health Care Practitioners, Providers, and Suppliers

Update on NPDB Merger

Currently, when querying the NPBD there are two reports requested and there is a fee for each of the reports. These reports are the NPBD and the HIPDB. The data bank anticipates the NPBD and the HIPDB reports will be merged into the NPDB report by the end of 2012. The data bank could not confirm the fee for a query after the merger but stated it is probable that the current NPDB query fee would be increased.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	July 20, 2012
ATTENTION:	Medical Board of California
SUBJECT:	American Health and Safety Institute – Petition for Regulatory Amendment of California Code of Regulations Section 1379.50
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing

REQUESTED ACTION:

Direct staff on how to proceed with the American Health and Safety Institute's petition for regulatory amendment of California Code of Regulations (CCR), Title 16, Chapter 4.3, section 1327.50(a)(3), section 1327.50(b)(4), and section 1327.50(c)(1).

BACKGROUND:

This memo provides the Medical Board of California (Board) members with information regarding the petition for regulatory amendment submitted by the American Health and Safety Institute (AHSI). AHSI has petitioned the Board to amend its recently adopted polysomnography regulations to allow a Basic Life Support (BLS) certification issued by AHSI to satisfy the registration requirements of the registered polysomnographic technologists, technicians, and trainees.

Currently, the regulations require that a BLS certificate issued by the American Heart Association is necessary to satisfy the registration requirements in subdivisions (a)(1), (b)(4), and (c)(1) of section 1379.50 of the CCR for polysomnographic technologists, technicians, and trainees. When the regulation was first promulgated, other organizations conducting certification in BLS were not readily known. As stated above, this proposed change would mean that a BLS certificate issued by ASHI would satisfy the Board's registration criteria.

A review by the Board indicates that the certification criteria used by AHSI are sufficiently robust and there would no appreciable loss of consumer protection with this change.

OPTIONS:

Pursuant to section 11340.7 of the Government Code, the Board may grant or deny the request in whole or in part or may grant other relief. If the petition is granted, the Board would commence the rulemaking process. Please note that the proposed change would not take effect until the rulemaking process is completed.

If the Board decides to proceed with AHSI's petition to amend section1327.50 subdivisions (a)(1), (b)(4), and (c)(1), the proposed language would look like this:

> 1379.50(a)(1) "Possess at the time of application a current certificate in Basic Life Support issued by the American Heart Association <u>or the American Health and Safety Institute."</u>

1379.50(b)(4) "Possess at the time of application a current certificate in Basic Life Support issued by the American Heart Association or the American Health and Safety Institute."

1379.50(c)(1) "Polysomnographic Technologist. An applicant for registration as a polysomnographic technologist shall meet the requirements set forth in Sections 3575 and 3576 of the Code and shall possess at the time of application a current certificate in Basic Life Support issued by the American Heart Association or the American Health and Safety Institute."

STAFF RECOMMENDATION:
Grant the petition and set the matter for public hearing. As the matter relates to the amendment of existing regulations, specifying that a current certificate in BLS, issued by the AHSI or the American Heart Association, satisfies the registration requirements of the registered polysomnographic technologists, technicians, and trainees.

MEDICAL BOARD OF CALIFORNIA
Executive Office

May 22, 2012

Ralph M. Shenefelt
Health & Safety Institute
1450 Westec Drive
Eugene, OR 97402

Dear Mr. Shenefelt:

The Medical Board of California (Board) is in receipt of your petition to amend 16 CCR §1379.50, subsections (a)(3), (b)(4), & (c)(1) to allow a current certificate in Basic Life Support ("BLS") issued by the American Health and Safety Institute (ASHI) to satisfy the registration requirements of polysomnographic technologists, technicians, and trainees.

In accordance with the provisions of section 11340.7 of the Government Code, your petition has been placed on the agenda for deliberation at the Board's upcoming meeting on July 20, 2012.

Please contact me if you have any questions.

Sincerely,

Christine Valine

Christine Valine
Regulations Coordinator

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2389 Fax: (916) 263-2387 www.mbc.ca.gov

Health & Safety Institute

/IA CERTIFIED MAIL AND EMAIL

May 4th, 2012

Linda Whitney
Executive Director
Medical Board of California
2005 Evergreen Street,
Suite 1200
Sacramento, CA 95815

RE: Petition to Amend Chapter 4.3. Polysomnography

Dear Ms. Whitney:

The purpose of this letter is to request that, pursuant to Government Code Sections 11340.6 and 11340.7, the California Medical Board ("Board") amend 16 CCR § 1379.50, (a) (3), (b) (4), & (c) (1) to allow a current certificate in Basic Life Support ("BLS") issued by the American Health and Safety Institute (ASHI) to satisfy the registration requirements of polysomnographic technologists, technicians, or trainees.

Regulations

1. § 1379.50 (a) (3) Possess at the time of application a current certificate in Basic Life Support issued by the American Heart Association; (b) (4) Possess at the time of application a current certificate in Basic Life Support issued by the American Heart Association; (4) (c) (1) ...and shall possess at the time of application a current certificate in Basic Life Support issued by the American Heart Association.

Reason

1. *The regulations restrain competition and violate principles of fairness by excluding qualified entities other than the American Heart Association®, Inc. ("AHA"), including ASHI.*
    a. The ASHI BLS program is recognized by the American Academy of Sleep Medicine, a specialty Board approved by the Medical Board of California (**EXHIBIT A**)
    b. Like the AHA, HSI is a nationally accredited organization of the Continuing Education Coordinating Board for Emergency Medical Services (CECBEMS) ((**EXHIBIT B**)). CECBEMS is the national accrediting body for Emergency Medical Services (EMS) continuing education courses and course providers. CECBEMS accreditation requires an evidence-based peer-review process for continuing education programs comparable to all healthcare accreditors. The ASHI BLS program is CECBEMS approved.

c. The ASHI BLS program has been found equivalent to the AHA and has been accepted as meeting the training, continuing education, and licensing requirements of EMTs and paramedics in California since 1999 (**EXHIBIT C**).

2. *The regulations have an adverse economic impact on small business*
   a. There are currently 541 ASHI Training Centers in the State of California, many of which are small or micro businesses employing or independently contracting with nearly 1400 ASHI authorized Instructors.
   b. Granting an exclusive market for BLS training to the AHA is an impediment to these training businesses and discourages the expansion of existing or new ASHI Training Centers in California.
3. *The regulations have an adverse impact on registrants who present valid ASHI BLS certification*
   a. By direct penalties including denial, suspension, or revocation of registration, or by indirect penalties such as the time and cost of superfluous AHA BLS training and certification; and
   b. By unjustly denying a choice in BLS training program price, selection, and service.

Board Authority to Take Requested Action

1. Sections 2018 and 3575, Business and Professions Code.

Additional Facts

1. The AHA is not a recognized accrediting organization (**EXHIBIT D**).
2. The AHA is not a recognized regulatory standards developing organization (**EXHIBIT E**).
3. The AHA has previously established that it does not review or sanction the CPR training programs or materials of other organizations. It directs such approval to appropriate regulatory authorities (**EXHIBIT F**).
4. As a profit-making, non-tax paying entity, and the dominant competitor in the resuscitation training business, the AHA, its approved training centers, and affiliated instructors have a vested economic interest in BLS training, particularly where required for occupational licensing.
5. Though corporate structures differ (HSI is a tax-paying corporation), the profit-making business units of HSI and the AHA are similar (**EXHIBIT G**).
   a. Each organization develops and markets commercially available, proprietary training programs, products, and services to Training Centers, either directly or via distributors.
   b. The business structures of Training Centers include; sole proprietorships, partnerships, corporations, LLCs, and non-profits.
   c. Instructors affiliated with Training Centers are authorized to certify course participants. Certification of health care providers requires successful completion of a written exam and performance and evaluation of hands-on skills to verify provider skill competency.
6. The Health and Safety Institute (HSI) is a large privately held emergency care and response training organization, joining together the training programs of the American Safety and Health Institute (ASHI), MEDIC First Aid, 24-7 EMS, 24-7 Fire, First Safety Institute, GotoAID, and EMP Canada.
7. An ASHI representative participated in the *International Committee on Resuscitation 2005 and 2010 International Conference on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science with Treatment Recommendations*, hosted by the AHA.
8. An ASHI representative was a volunteer member of the AHA and American Red Cross 2005 *National* and 2010 *International First Aid Science Advisory Board* and were contributors to the 2005 and 2010 *Consensus on First Aid Science and Treatment Recommendations* (**EXHIBIT H**).
9. ASHI resuscitation training programs conform to the ILCOR 2010 Consensus on Science and the 2010 American Heart Association (AHA) Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science.

10. HSI is a member of the American National Standards Institute (ANSI) and ASTM International (ASTM) – both globally recognized leaders in the development and delivery of international voluntary consensus standards.
11. HSI is a member of the Council on Licensure, Enforcement and Regulation (CLEAR), the premiere international resource for professional regulation stakeholders.
12. On whole, ASHI training programs are currently endorsed, accepted, approved, or meet the requirements of more than 1400 state and provincial regulatory agencies, occupational licensing boards, national associations, commissions, and councils.

Conclusions

The facts presented demonstrate the ASHI BLS training programs are equivalent to the commercial training products offered by the AHA in California. Consequently, we request that the Board amend its regulations to allow a current certificate in BLS issued by ASHI to satisfy the registration requirements of polysomnographic technologists, technicians, or trainees.

We value, believe in, and promote successful completion of a legitimate BLS course as an important component in protecting patient safety and health. We value, believe in, and promote free and fair competition that does not adversely affect health and safety. We look forward to helping the Board protect the health and safety of the citizens of California.

Respectfully,

Digitally signed by Ralph Shenefelt
DN: cn=Ralph Shenefelt, o=HSI, ou, email=rshenefelt@hsi.com, c=US
Date: 2012.05.04 14:24:42 -04'00'

Ralph M. Shenefelt
Vice President, Strategic Compliance
Health and Safety Institute

Cc:
Gregory R. Ciottone, MD, FACEP, Medical Director, Health and Safety Institute
Bill Clendenen, MBA, Chief Executive Officer, Health and Safety Institute
Jeff Jackson, MBA, Chief Financial Officer, SVP Product Development, Health and Safety Institute
Jeff Lindsey, PhD, Chief Learning Officer, Health and Safety Institute
Joe Rose, JD, Rose Law

Enclosures: Exhibits A-H

OFFICERS

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/ Aronsky, DO

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Nathaniel Watson, MD, MS

Merrill Wise, MD

Jerome A. Barrett
Executive Director

AUG 11 2011

American Academy of Sleep Medicine

August 9, 2011

Ralph M. Shenefelt
Vice President, Strategic Compliance
Health & Safety Institute
1450 Westec Drive
Eugene, OR 97402

Dear Mr. Shenefelt:

As the leader in setting standards and promoting excellence in sleep medicine health care, education and research, the American Academy of Sleep Medicine (AASM) represents more than 9,000 clinicians, scientists, dentists, nurses and allied health-care professionals, as well as more than 2,200 AASM-accredited sleep disorders centers.

At its recent meeting, the AASM Board of D[illegible] ed in detail the proposal from the Health & Safety Institute [illegible] that the AASM provide waiver or variance, or amend Standard [illegible] AASM Standards for Accreditation of Sleep Disorders C[illegible] permi[illegible] use of the HSI cardiopulmonary resuscitation ([illegible]ns.

After a thorough review of [illegible] upporting documentation, the Board of Directors approved t[illegible] the language of Standard B-11. The specific references t[illegible] Association (AHA) and American Red Cross (ARC) certi[illegible] will be removed from the requirement for valid certificatio[illegible]

This char[illegible] gitimacy of HSI's claim that its CPR programs are sound [illegible] quivalent to those offered by the AHA and ARC. The revi[illegible] medical directors of AASM-accredited sleep disorders centers to [illegible] n in selecting a local CPR certification program that is most ap[illegible] eir staff.

If you [illegible] any questions about this decision, please contact AASM Executive Director Jerry Barrett at 630-737-9700 or jbarrett@aasmnet.org.

On behalf of the Board of Directors, I thank the HSI for contacting the AASM with this request and for promoting excellence in emergency care and response training.

Sincerely,

Nancy A Collop

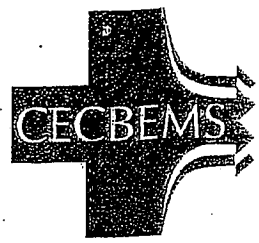
Nancy Collop, MD
President

cc: Jerome A. Barrett - AASM Executive Director
Sam Fleishman, MD – Chair, Accreditation Review Process Task Force
Demaree Dufour-Noneman – Director of Policy & Professional Standards

2510 North Frontage Road, Darien, IL 60561-1511
Phone: (630) 737-9700, Fax: (630) 737-9790
www.aasmnet.org

Exhibit A

NOV 1 5 2010



12200 Ford Road
Suite 478
Dallas, Texas 75234
Phone 972.247.4442
Fax 214.432.0545
cecbems@cecbems.org

American College of Emergency Physicians

American College of Osteopathic Emergency Physicians

National Association of Emergency Medical Technicians

National Association of EMS Educators

National Association of EMS Physicians

National Association of State EMS Officials

National Registry of Emergency Medical Technicians

November 10, 2010

Nicole Printup
Health & Safety Institute/24-7EMS
1450 Westec Drive
Eugene, OR 97402

Email: nprintup@hsi.com

Dear Nicole;

CECBEMS is pleased to inform you that the Health & Safety Institute has been awarded approval as a CECBEMS accredited organization through February 2014. The provider number is **P247E1100**. Use this number to identify your organization on course completion reports, on course completion certificates and other correspondence with CECBEMS headquarters.

- **For assigning numbers to the activities accredited by the Health & Safety Institute, use the following format:**
- **Year the activity received its initial accreditation or its last comprehensive review (2 digits)**
- **Alpha abbreviation for organization (247E)**
- **Course format (F1, indicates a live, one-time event activity; F2, a live, multiple event activity; F3, a distributed learning activity)**
- **A four digit number for your internal tracking purposes**

For example, the number for an activity initially approved or receiving a comprehensive review in 2010 and that is a distributed learning (activity-code F3), would be **10-247E-F3-0001**. You must review and update each course *at least* every three years. When that review is complete, the course must be re-entered into the CECBEMS database with the new activity number which would begin with the first two digits reflecting the most recent year in which the course was reviewed. When you log into the *Providers Only* area, you will find a downloadable *Provider Manual Supplement* in the Course Management Tools box at the bottom of the screen. This Supplement gives complete instructions for entering courses in the CECBEMS Accreditation Management System.

Please check at www.cecbems.org for the most recent *Standards and Requirements for Organizational Accreditation* and http://cecbems.org/faqAnswers.aspx?RecID=56 for a downloadable version of the Accreditation Management System manual. Let me know if you have questions about these documents. You should also download the CECBEMS Distributed Learning Policy Statement, CECBEMS Item Writing Policy, and the CEH Hour Assignment Guidance, at http://cecbems.org/applications/Default.aspx .

We are proud to have the Health & Safety Institute as a CECBEMS-accredited organization. We welcome your comments and suggestions for making our processes work better and for making EMS continuing education a positive force in improving patient care and in developing EMS as a profession.

Sincerely,

Elizabeth Sibley/BR
Executive Director

Continuing Education Coordinating Board for Emergency Medical Services

Exhibit B

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY GRAY DAVIS, *Governor*

EMERGENCY MEDICAL SERVICES AUTHORITY
10 9TH STREET
CRAMENTO, CA 95814-7043
16) 322-4336 FAX: (916) 324-2875

August 19, 1999

Gregg A. Rich and Tim Eiman
The American Safety & Health Institute
8324 Corporate Way
New Port Richey, FL 34653

Dear Mr. Rich and Mr. Eiman:

Thank you for submitting your child care training program for re-approval by the Emergency Medical Services Authority as required by Title 22, Division 9 [illegible] 1.1 of the California Code of Regulations.

After a comprehensive review of the material, we find that it continues to meet the requirements set forth in law and regulation and approved by the Commission on Emergency Medical Services.

Enclosed with this approval letter is a Certificate of Approval which includes the date on which your training program approval will expire.

We will advise, by copy of this letter, the EMSA approved programs list, the Department of Social Services, Community Care Licensing Division and the Child Care Health Project of the approval of this program.

Thank you for submitting your course for re-approval and for offering this much needed training to California's [illegible] care providers.

Sincerely,

Richard E. Watson
Interim Director

cc: Lynn Anderson
Department of Social Services
Community Care Licensing Division

Marsha Sherman
Child Care Health Project

Enclosure
DRS:LC:ss

Exhibit C

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY

GRAY DAVIS, *Governor*

EMERGENCY MEDICAL SERVICES AUTHORITY
1930 9TH STREET
SACRAMENTO, CA 95814-7043
(916) 322-4336 FAX: (916) 324-2675

October 19, 2001

Timothy Eiman
Program Director
American Safety & Health Institute
8324 Corporate Way, Suite A
New Port Richey, FL 34653

Dear Mr. Eiman:

Thank you for your letter advising the Californ[illegible]S Auth[illegible] of the rollout of the American Safety and Health Institute/Mosby A[illegible]gram. In California, we do accept equivalency courses for ACLS , PA[illegible] In addition, courses approved by the Continuing Education Coordinati[illegible]ergency Medical Services, courses approved by other state EMS [illegible]rses approved by the National Registry of Emergency Medical T[illegible]urses accepted in California for continuing education for preho[illegible]

Again, thank you for the i[illegible]our program.

Sincerely,

Nancy Steiner

Nancy J. Steiner
Paramedic Program Manager

cc: Local EMS Agency Administrators
Paramedic Training Program Directors

c:\word\training program\ASHI – ACLS Pgm.

Exhibit C

EMS
San Joaquin
Emergency Medical Services Agency
A Division of Health Care Services

July 10, 2000

Mr. Timothy Eiman
Program Director
American Safety and Health Institute
8324 Corporate Way, Suite A
New Port Richey, FL 34653

Dear Tim:

Thank you for your interest in providing EMS programs in San Joaquin County. We are pleased to notify you that your request for approval of the ASHI CPR Pro Program has been approved. We appreciate your interest in our [illegible] and look forward to working with your organization. If you have any questions [illegible] free to contact the Agency at the number listed below. Good luck with your [illegible]

Sincerely,

Michael Volkov
EMS Field Coordinator

cc: Dr. Richard N. Buys, MD, EMS Medical Director
Darrell Cramphorn, EMS Administrator

Exhibit C

P.O. Box 1020 • Stockton, California 95201 • 209-468-6818
sjemsa@co.san-joaquin.ca.us • www.co.san-joaquin.ca.us/ems/index.htm

County of San Diego

RODGER G. LUM, Ph.D.
AGENCY DIRECTOR

GAIL F. COOPER
PUBLIC HEALTH ADMINISTRATOR

NANCY L. BOWEN, M.D., M.P.H
PUBLIC HEALTH OFFICER (Acting)

HEALTH AND HUMAN SERVICES AGENCY

PUBLIC HEALTH SERVICES
1700 PACIFIC HIGHWAY, SAN DIEGO, CALIFORNIA 92101-2417
(619) 515-6583 . FAX (619) 515-6707

EMERGENCY MEDICAL SERVICES
6255 Mission Gorge Road
San Diego, CA 92120-3599
(619) 285-6429 Fax: (619) 285-6531

Children, Youth & Family Health Services
Disease Control/Epidemiology
Disease Prevention/Health Promotion
Emergency Medical Services
HIV/AIDS Services
Medical Quality Assurance
Public Health Laboratory
PH Nursing/Border Health
TB & STD Control
Vital Records

January 6, 2003

Eric Reale
Regulatory Affairs
American Safety & Health Institute
4148 Louis Avenue
Holiday, FL 34691

Dear Mr. Reale: Eric

Congratulations! After review o[illegible] rgency Responder and First Responder outlines, the County of San Diego Div[illegible] cy Medical Services has approved the use of American Safety & Health [illegible] programs for use in San Diego County.

As per Title 22 of the Cal[illegible] of Regulations, Division 9, Chapter 1.5, Article 4, 100027 (c), a copy of the final exam[illegible] is requested.

Thank you for your interest in San Diego County. I look forward to working with you and with the rest of the ASHI correspondents in the future.

Please feel free to contact me at any time for any questions or concerns, or any other issues dealing with San Diego County EMS. I can be reached by phone at (619) 285-6429 or via Email at steven.leapley@sdcounty.ca.gov .

STEVEN LEAPLEY
EMS Specialist

SL

Exhibit C

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES
EMERGENCY MEDICAL SERVICES AGENCY

5555 Ferguson Drive, Suite 220
Commerce, CA 90022
(323) 890-7500

Carol Gunter
ACTING DIRECTOR

William J. Koenig, M.D., FACEP
MEDICAL DIRECTOR

February 24, 2004

Mr. Eric Reale, Regulatory Affairs Representative
American Safety & Health Institute
4148 Louis Avenue
Holiday, Fl 34691

Dear Mr. Reale:

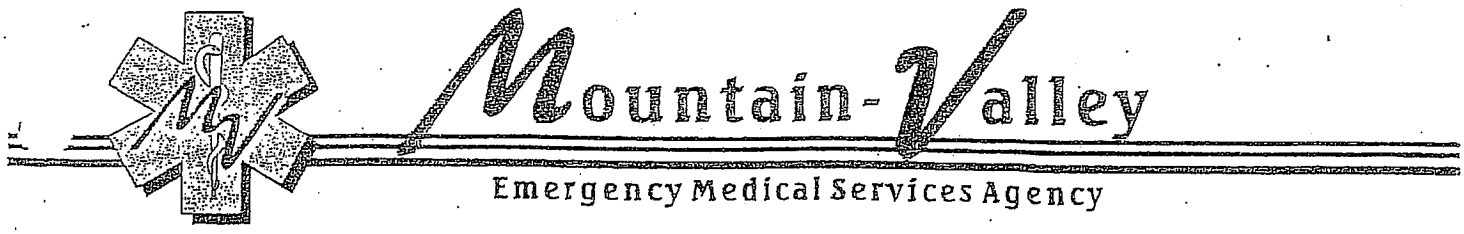
This letter is in response to your reque[illegible] [illegible]geles County EMS agency recognizes ASHI programs for healthcare training in f[illegible] [illegible]d workplace. Since California accepts equivalent courses for ACLS, PALS and BI[illegible] these cards as being equivalent to the American Heart Association and Red Cr[illegible]

Continuing education cre[illegible] [illegible]hese courses through Continuing Education Coordinating Board for Emergency [illegible]s (CECBEMS) will be applied to the mandatory continuing education hours required [illegible]certification.

Yours very truly,

William J. Koenig, MD., FACEP
EMS Medical Director

Exhibit C



February 13, 2004

Eric Reale
American Safety and Health Institute
Regulatory Affairs Representative
4148 Louis Avenue
Holiday, FL 34691

RE: Acceptance of Training

Dear Mr. Reale:

Please let this letter serve as verification th[illegible] Valley EMS Agency accepts the following in regard to CPR certification:

> A CPR program, which in[illegible] exam, that is taught to the curriculum standards of the Ameri[illegible]ation, American Red Cross or the National Safety Council at the [illegible]vider or equivalent level.

The Mountain-Valley [illegible] located in California and serves as the local EMS Agency for the counties of Alpine, Amado[illegible]eras, Mariposa, and Stanislaus.

Sincerely

Marilyn Smith

Marilyn Smith
Staffing and Training Coordinator

Exhibit C

NORTHERN CALIFORNIA EMS, INC.
43 Hilltop Drive, Redding, California 96003-2807
Phone (530) 229-3979 Fax (530) 229-3984

29 July 03

Ralph M. Shenefelt
Executive Director
American Safety & Health Institute
4148 Louis Avenue
Holiday, FL 34691 USA

Dear Mr. Shenefelt:

After reviewing the program information you sent, it's appa[illegible] that your CPR and ACLS courses follow the guidelines established b[illegible] American Heart Association. Accordingly, we will accept ASHI provider car[illegible] [illegible] poses of EMT certification and paramedic accreditation.

If any questions should arise, please fe[illegible] or Ron Grider, our Training Director.

Sincerely,

Chester Ward, MD

Chester Ward, MD
Medical Director

CW:rg:psl

Exhibit C

F:\F-Desk\Training\ASHI29july03.doc

PUBLIC HEALTH DEPARTMENT
Emergency Medical Services Agency
645 South Bascom Avenue, San Jose, California 95128
Tel (408) 885-4250
Fax (408) 885-4264

SANTA CLARA VALLEY HEALTH & HOSPITAL SYSTEM

August 14, 2000

Timothy Eiman
Program Director
American Safety and Health Institute
8324 Corporate Way, Suite A
New Port Richey, FL 34653

Dear Mr. Eiman:

Thank you for forwarding a copy of the course approval b[illegible] aquin EMS Agency. In that your CPR courses have been approved as meeting the CP[illegible] e uirements for prehospital personnel certification by another California local EM[illegible] agency, w[illegible] likewise accept that training as meeting our requirements. Our literature and [illegible] terials [illegible] ll be revised accordingly.

Should you have any questions or concern[illegible] esitate to call.

Sincerely,

Jim McPherson
Operations Manager

JM:jm

K:\Staff\Jim\american safety.cpr2.wpd

Exhibit C

The Public Health Department is a division of the Santa Clara Valley Health & Hospital System.
Dedicated to the Health of the Whole Community. Owned and operated by the County of Santa Clara.

PUBLIC HEALTH DEPARTMENT
Emergency Medical Services Agency
645 South Bascom Avenue, San Jose, California 95128
Tel (408) 885-4250
Fax (408) 885-4264

SANTA CLARA VALLEY HEALTH & HOSPITAL SYSTEM

August 9, 2005

Sgt. Steve Papenfafts
Training Officer
San Jose Police Department
1302 N. Fourth Street
San Jose, CA 95112

RE: ASHI CPR, First Aid and AED Training Program

Dear Steve:

I have reviewed the training materials from the A[illegible] Safety and Health Institute entitled *CPR-Pro, CPR and AED* and [illegible] and find that the curriculum meets or exceeds CCR Title [illegible] Chapter 1.5 First Aid Standards for Public Safety Personne[illegible] is, therefore, approved for your use in training your [illegible]

If you have any questions or if o[illegible] please give me a call anytime. I can be reached at 4[illegible]

Sincerely,

David Ghilarducci M.D.
Medical Director

Exhibit C

The Public Health Department is a division of the Santa Clara Valley Health & Hospital System
Dedicated to the Health of the Whole Community. Owned and operated by the County of Santa Clara

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES
EMERGENCY MEDICAL SERVICES AGENCY

5555 Ferguson Drive, Suite 220
Commerce, CA 90022
(323) 890-7500

Carol Gunter
ACTING DIRECTOR

William J. Koenig, M.D., FACEP
MEDICAL DIRECTOR

February 24, 2004

Mr. Eric Reale, Regulatory Affairs Representative
American Safety & Health Institute
4148 Louis Avenue
Holiday, Fl 34691

Dear Mr. Reale:

This letter is in response to your reque[illegible] Angeles County EMS agency recognizes ASHI programs for healthcare training in t[illegible] workplace. Since California accepts equivalent courses for ACLS, PALS and BI[illegible] these cards as being equivalent to the American Heart Association and Red Cr[illegible]

Continuing education cred[illegible] these courses through Continuing Education Coordinating Board for Emergency M[illegible] (CECBEMS) will be applied to the mandatory continuing education hours required [illegible] certification.

Yours very truly,

William J. Koenig, MD., FACEP
EMS Medical Director

Exhibit C

COUNTY OF ORANGE
HEALTH CARE AGENCY

HEALTH DISASTER MANAGEMENT
EMERGENCY MEDICAL SERVICES

DAVID L. RILEY
DIRECTOR

RONALD B. NORBY
DEPUTY AGENCY DIRECTOR
MEDICAL SERVICES

HOLLY A. VEALE
CHIEF, MEDICAL SERVICES OPERATIONS

TERRE DUENSING
DIVISION MANAGER
HEALTH DISASTER MANAGEMENT

TAMMI McCONNELL, MSN, RN
EMS PROGRAM MANAGER

405 W FIFTH STREET, SUITE 301
SANTA ANA, CALIFORNIA 92701

TELEPHONE: 714-834-3500
FAX: 714-834-3125

Excellence
Integrity
Service

October 26, 2011

Kristal Langner
Regulatory Approval Specialist
Health & Safety Institute
1450 Westec Drive
Eugene, OR 97402

Re: ***CPR Pro for the Professional Rescuer***

Dear Ms. Langner:

You had contacted our office last month seeking ou[illegible] approv[illegible] to offer the above named training in Orange County (California). You stat[illegible] of your instructors had expressed interest in using the American Safety & Heal[illegible] *CPR Pro for the Professional Rescuer* to train EMTs for their BLS certificat[illegible] ceeding, you wished to verify that this training would be acceptable in our co[illegible] ders.

CPR training is a prerequisite for i[illegible] for EMT or paramedic training. State regulations require that said [illegible] 'equivalent' to the AHA guidelines for cardiopulmonary resuscitation [illegible] cardiovascular care at the healthcare provider level. Training programs h[illegible] determine if non-AHA CPR training meets their admission requirements; [illegible] EMS does not dictate nor will our agency interfere with a training program's [illegible] subject.

The Continuing Edu[illegible] dinating Board for Emergency Medical Services (*aka* CECBEMS) recognizes y[illegible] stitution as a continuing education (CE) provider. As long as the above referenced course has CECBEMS approval, CE units offered for training classes can be applied towards EMT or paramedic licensure renewal in the State of California. Local EMS agency (LEMSA) approval is not required for CECBEMS approved classes or courses.

Thank you for your interest in providing initial and continuing educational and training opportunities in Orange County. If we can be of further assistance, please do not hesitate to contact us.

Sincerely,

Jane Elder RN

Jane Elder RN
Advanced Life Support Coordinator
jelder@ochca.com

JE:ksh #1375

EXHIBIT C

RIVERSIDE COUNTY

COMMUNITY HEALTH AGENCY • DEPARTMENT OF PUBLIC HEALTH
EMERGENCY MEDICAL SERVICES AGENCY

14 December 2010

Ralph M. Shenefelt
Vice President, Regulatory and QA
Health & Safety Institute
1450 Westec Drive
Eugene, OR 97402

Mr. Shenefelt:

After an extensive review (on my part) and much patience (on you[illegible]) I am pleased to inform you that the Riverside County EMS Agency will accept ASHI [illegible] life support (BLS/CPR) courses as meeting our requirements for certification/recertification for E[illegible] accreditation/reverification for paramedics (EMT-Ps).

I was most impressed at the speed with whi[illegible] to post updates regarding the new American Heart Association (AHA) 2010 [illegible] the depth and format of those preliminary presentations. There is no reason for [illegible] NOT to teaching the most up to date material in line with the AHA.

Sincerely,

Karen Petrilla, RN
EMS Specialist – Certification and Training

Exhibit C

Recognized Accrediting Organizations

(as of January 2012)

This chart lists regional, national faith-related, national career-related and programmatic accreditors that are or have been recognized by the Council for Higher Education Accreditation (CHEA) or the U.S. Department of Education (USDE) or both. Organizations identified by (•) are recognized; (–) indicates those not currently recognized. An asterisk (*) identifies accrediting organizations that were formerly recognized.

CHEA-recognized organizations must meet CHEA eligibility standards (www.chea.org/recognition/recognition.asp). Accreditors exercise independent judgment about whether to seek CHEA recognition. For USDE recognition, accreditation from the organization is used by an institution or program to establish eligibility to participate in federal student aid or other federal programs (www.ed.gov/about/offices/list/ope/index.html). Some accreditors cannot be considered for USDE recognition because they do not provide access to federal funds. Other accreditors have chosen not to pursue USDE recognition.

Because CHEA affiliation and USDE recognition depend on a range of factors, readers are strongly cautioned against making judgments about the quality of an accrediting organization and its institutions and programs based solely on CHEA or USDE status. Additional inquiry is essential. If you have questions about the CHEA or USDE recognition status of an accreditor, please contact the accrediting organization.

This chart is updated when the CHEA Board of Directors recognizes or withdraws recognition of an accrediting organization and when the United States Secretary of Education recognizes or withdraws recognition of an accrediting organization. Please visit the CHEA website at: www.chea.org

ACCREDITOR	CHEA Recognized Organization	USDE Recognized Organization
REGIONAL ACCREDITING ORGANIZATIONS		
Middle States Association of Colleges and Schools Middle States Commission on Higher Education	•	•
New England Association of Schools and Colleges Commission on Institutions of Higher Education	•	•
New England Association of Schools and Colleges Commission on Technical and Career Institutions	*	•
North Central Association of Colleges and Schools The Higher Learning Commission	•	•
Northwest Commission on Colleges and Universities	*	•
Southern Association of Colleges and Schools Commission on Colleges	•	•
Western Association of Schools and Colleges Accrediting Commission for Community and Junior Colleges	•	•
Western Association of Schools and Colleges Accrediting Commission for Senior Colleges and Universities	•	•
NATIONAL FAITH-RELATED ACCREDITING ORGANIZATIONS		
Association for Biblical Higher Education Commission on Accreditation	•	•
Association of Advanced Rabbinical and Talmudic Schools Accreditation Commission	•	•
Commission on Accrediting of the Association of Theological Schools in the United States and Canada	•	•
Transnational Association of Christian Colleges and Schools Accreditation Commission	•	•
NATIONAL CAREER-RELATED ACCREDITING ORGANIZATIONS		
Accrediting Bureau of Health Education Schools	—	•
Accrediting Commission of Career Schools and Colleges	—	•
Accrediting Council for Continuing Education and Training	—	•
Accrediting Council for Independent Colleges and Schools	•	•
Council on Occupational Education	—	•
Distance Education and Training Council Accrediting Commission	•	•
National Accrediting Commission of Career Arts and Sciences, Inc.	—	•

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Recognized Accrediting Organizations (continued)

ACCREDITOR	CHEA Recognized Organization	USDE Recognized Organization
PROGRAMMATIC ACCREDITING ORGANIZATIONS		
AACSB International–The Association to Advance Collegiate Schools of Business	•	*
ABET, Inc.	•	*
Accreditation Commission for Acupuncture and Oriental Medicine	—	•
Accreditation Council for Business Schools and Programs	•	*
Accreditation Council for Midwifery Education	—	•
Accreditation Council for Pharmacy Education	•	•
Accreditation Review Commission on Education for the Physician Assistant, Inc.	•	—
Accrediting Council on Education in Journalism and Mass Communications	•	*
American Academy for Liberal Education	—	*
American Association for Marriage and Family Therapy Commission on Accreditation for Marriage and Family Therapy Education	•	•
American Association of Family and Consumer Sciences Council for Accreditation	•	—
American Bar Association Council of the Section of Legal Education and Admissions to the Bar	—	•
American Board of Funeral Service Education Committee on Accreditation	•	•
American Council for Construction Education	•	*
American Culinary Federation's Education Foundation, Inc. Accrediting Commission	•	*
American Dental Association Commission on Dental Accreditation	—	•
American Dietetic Association Commission on Accreditation for Dietetics Education	*	•
American Library Association Committee on Accreditation	•	*
American Occupational Therapy Association Accreditation Council for Occupational Therapy Education	•	•
American Optometric Association Accreditation Council on Optometric Education	•	•
American Osteopathic Association Commission on Osteopathic College Accreditation	*	•
American Physical Therapy Association Commission on Accreditation in Physical Therapy Education	•	•
American Podiatric Medical Association Council on Podiatric Medical Education	•	•
American Psychological Association Commission on Accreditation	•	•
American Society for Microbiology American College of Microbiology	—	*
American Society of Landscape Architects Landscape Architectural Accreditation Board	•	*
American Speech-Language-Hearing Association Council on Academic Accreditation in Audiology and Speech-Language Pathology	•	•
American Veterinary Medical Association Council on Education	•	•
Association for Clinical Pastoral Education, Inc., Accreditation Commission	[illegible]	•
Association of Technology, Management, and Applied Engineering	•	*
Aviation Accreditation Board International	•	—
Commission on Accreditation of Allied Health Education Programs	•	*

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Recognized Accrediting Organizations (continued)

ACCREDITOR	CHEA Recognized Organization	USDE Recognized Organization
Commission on Accreditation of Healthcare Management Education	●	●
Commission on Collegiate Nursing Education	*	●
Commission on English Language Program Accreditation	—	●
Commission on Massage Therapy Accreditation	—	●
Commission on Opticianry Accreditation	●	*
Council for Accreditation of Counseling and Related Educational Programs	●	—
Council for Interior Design Accreditation	●	*
Council on Accreditation of Nurse Anesthesia Educational Programs	●	●
Council on Chiropractic Education Commission on Accreditation	●	●
Council on Education for Public Health	—	●
Council on Naturopathic Medical Education	—	●
Council on Rehabilitation Education Commission on Standards and Accreditation	●	*
Council on Social Work Education Office of Social Work Accreditation and Educational Excellence	●	*
International Assembly for Collegiate Business Education	●	—
International Fire Service Accreditation Congress Degree Assembly	●	—
Joint Review Committee on Education Programs in Radiologic Technology	●	●
Joint Review Committee on Educational Programs in Nuclear Medicine Technology	●	*
Liaison Committee on Medical Education	—	●
Midwifery Education Accreditation Council	—	●
Montessori Accreditation Council for Teacher Education	—	●
National Accrediting Agency for Clinical Laboratory Sciences	●	*
National Architectural Accrediting Board, Inc.	—	*
National Association of Nurse Practitioners in Women's Health Council on Accreditation	—	●
National Association of Schools of Art and Design Commission on Accreditation	*	●
National Association of Schools of Dance Commission on Accreditation	*	●
National Association of Schools of Music Commission on Accreditation and Commission on Community/Junior College Accreditation	*	●
National Association of Schools of Public Affairs and Administration Commission on Peer Review and Accreditation	●	—
National Association of Schools of Theatre Commission on Accreditation	*	●
National Council for Accreditation of Teacher Education	●	●
National Environmental Health Science and Protection Accreditation Council	—	*
National League for Nursing Accrediting Commission, Inc.	●	●
National Recreation and Park Association Council on Accreditation of Parks, Recreation, Tourism, and Related Professions	●	—
Planning Accreditation Board	●	—

Draft

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Recognized Accrediting Organizations (continued)

ACCREDITOR	CHEA Recognized Organization	USDE Recognized Organization
Society of American Foresters	•	*
Teacher Education Accreditation Council Accreditation Committee	•	•
United States Conference of Catholic Bishops Commission on Certification and Accreditation	—	*

Exhibit D

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Regulatory

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All Regulatory

R-SIBR Statistics

Fri Apr 27, 2012

Standards Incorporated by Reference (SIBR) Database

Regulatory SIBR (R-SIBR)

Search by Keyword: 'American Heart Association'

Total Record Count: 0 New Search Link Printer Friendly

There are no records that meet this search criteria.

Back Link

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Exhibit E

Chairman of the Board
Andrew B. Bunker, Esq

President
Raymond J. Gibbons, MD, FAHA

nan-Elect
L. Ellis

President-Elect
Daniel W. Jones, MD, FAHA

Immediate Past Chairman of the Board
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Immediate Past President
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John Moultrie
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Hon. John Edward Porter, Esq
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Chief Operating Officer Operations
McCullough

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Rose Marie Robertson, MD, FAHA

Executive Vice President Corporate Operations & CFO
Sunder D. Joshi

Executive Vice President Healthcare Markets
Meighan Girgus

Executive Vice President Communications
Robyn Lee Landry, APR

Executive Vice President Corporate Secretary & General Counsel
David Wm. Livingston, Esq.

Executive Vice President Advocacy
Mark A. Schoeberl

Executive Vice President Development
Suzie Upton

Executive Vice President Technology & Customer Strategies
Michael Wilson

American Heart Association. American Stroke Association.
Learn and Live.

National Center
7272 Greenville Avenue Dallas, Texas 75231-4596 Tel 214.373.6300
americanheart.org

June 22, 2007

Mr. Bill Clendenen
MEDIC FIRST AID International, Inc.
PO Box 21738
1450 Westec Dr.
Eugene, Oregon 97402

Dear Bill,

Sorry about the delay in responding to your May 15th, 2007 letter to me. It's great to hear that health clubs will require at least one staff member to complete a CPR and defibrillator course. Our policy, however, precludes us from reviewing outside material, as we do not have the resources nor are we in a position to sanction non-AHA material.

My recommendation is that you move forward with this letter to the appropriate regulatory body that states your training courses have been developed to comply with the American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care.

Please let me know if I can answer any further questions. Thank you.

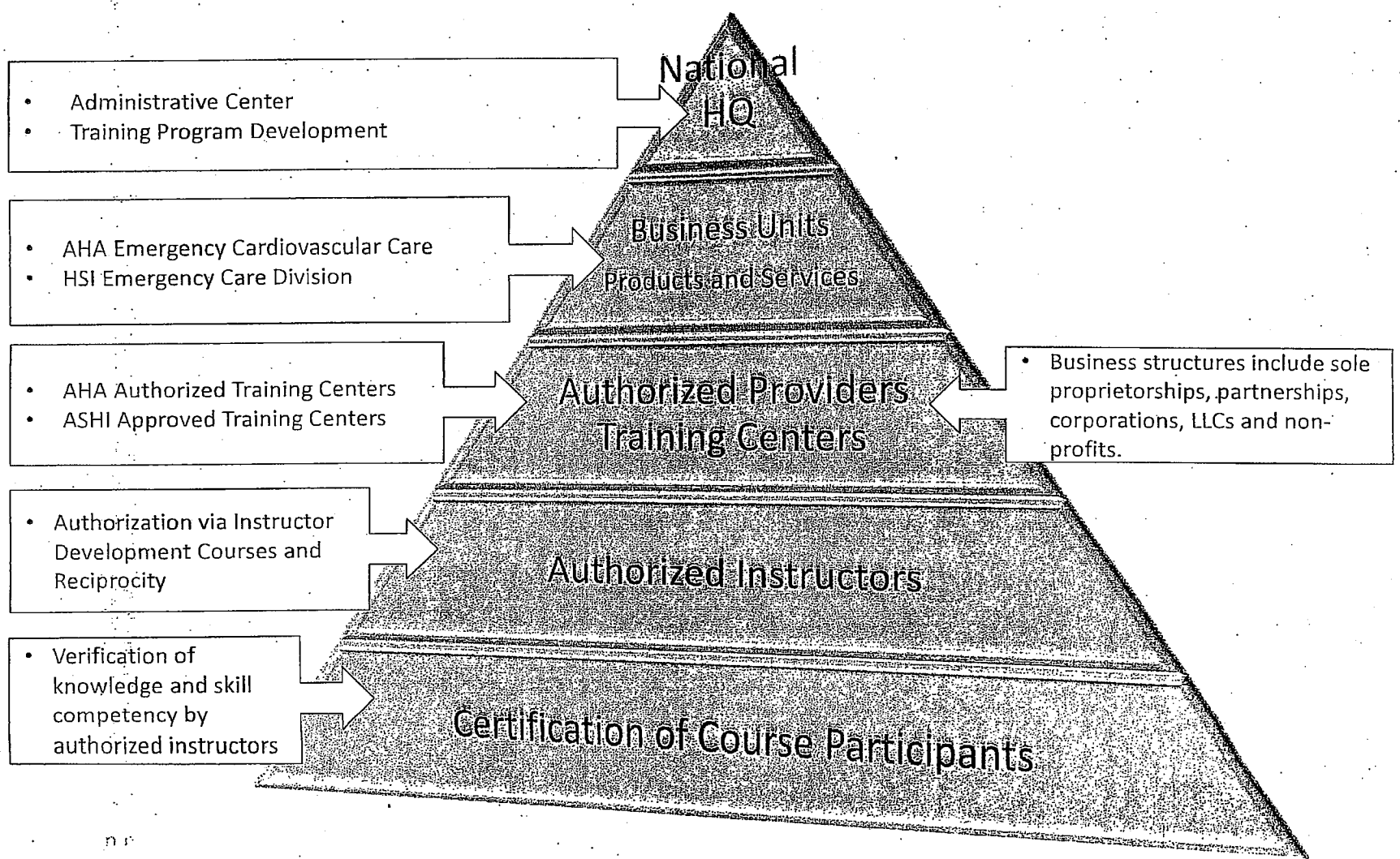
Sincerely,

Michael C. Bell
VP of ECC Operations

MCB/jb

Enclosure

Exhibit G



Organizational Structure

Organizations Represented on the National First Aid Science Advisory Board

- Academy of Orthopaedic Surgeons
- American Academy of Pediatrics
- American Association of Poison Control Centers
- American Burn Association
- American College of Emergency Physicians
- American College of Occupational and Environmental Medicine
- American College of Surgeons
- American Heart Association
- Army Medical Command
- The American Pediatric Surgical Association
- American Red Cross
- American Safety and Health Institute
- Australian Resuscitation Council
- Canadian Red Cross
- International Association of Fire Chiefs
- International Association of Fire Fighters
- Medic First Aid International
- Military Training Network
- National Association of EMS Educators
- National Association of EMS Physicians
- National Association of EMTs
- National Safety Council
- Occupational Safety and Health Administration
- Save a Life Foundation

variables prevent extrapolation of the results of any of the reviewed studies to first aid applications.

Treatment Recommendation
There is insufficient evidence to recommend for or against the use of oxygen by the first aid provider.

Assistance With Use of Inhalers[W146A]

Consensus on Science
Severe asthma and deaths from asthma are increasing,[1] so it is likely that first aid responders will be asked to help victims with respiratory distress caused by asthma. Patients with asthma often use prescribed bronchodilator inhalers, but the reviewers found no studies evaluating the efficacy of first aid providers assisting patients in the use of these inhalers for breathing difficulty. Nonrandomized studies documented the ability of adults to appropriately self-administer bronchodilator medications (LOE 4)[2–4] and the ability of parents to correctly administer metered-dose inhalers to their children (LOE 4).[5] An important difference in the first aid situation, however, is that the first aid provider may not know the victim, the victim's medical history, or what medications the victim takes. Thus the studies regarding parents constitute LOE 7 (extrapolated) information applied to first aid.

Treatment Recommendation
Because the frequency and mortality from severe asthma is increasing[1] and bronchodilator therapy is safe and can be effective during episodes of severe asthma, the first aid rescuer should assist with administration of bronchodilator therapy.

Epinephrine Autoinjector[W199,W252]

Consensus on Science
A severe allergic reaction (anaphylaxis) can cause life-threatening airway edema and obstruction, vasodilation, and cardiovascular collapse. Although administration of epinephrine is a cornerstone of emergency management of severe allergic reactions, the reviewers found no studies of the safety, efficacy, or feasibility of first aid providers assisting with administration of epinephrine autoinjectors. Many adults and children with a history of anaphylaxis carry a prescribed epinephrine autoinjector.

Evidence from one small retrospective study (LOE 7)[6] reported that parents who administer epinephrine to their children via an autoinjector can do so safely and effectively. Evidence from other studies (LOE 7)[7–9] highlighted the need for additional education and retraining of parents and healthcare providers in the use of epinephrine autoinjectors.

Treatment Recommendation
Given the widespread use of epinephrine autoinjectors and their documented efficacy in the rapid delivery of epinephrine,[10] first aid providers may be trained to assist in the use of an epinephrine autoinjector for a victim of anaphylaxis when the victim has a prescribed autoinjector and the victim is unable to use it.

Recovery Position[W146A,W146B,W155,W274]

Consensus on Science
Although the recovery position is widely used in healthcare settings, the reviewers found no studies evaluating the safety, effectiveness, or feasibility of this position in unresponsive, breathing victims in the out-of-hospital setting. All identified studies of specific recovery positions used healthy, responsive adult volunteers (LOE 3–5), so results are at best extrapolated (LOE 7) to unresponsive victims.

Any recovery position used for the patient with known or suspected spinal injury should maintain a patent airway, stabilize the spine, and minimize movement of the victim. Two human prospective cohort studies in healthy adult volunteers (extrapolated from LOE 3)[11,12] suggest that the modified HAINES position results in more neutral position of the cervical spine than the traditional lateral recovery position. HAINES is an acronym for **H**igh **A**rm **IN** **E**ndangered **S**pine: the rescuer extends the victim's arm above the head and rolls the victim to the side, onto that arm, and then bends the victim's knees. The subjects in these studies were responsive (with presumably normal muscle tone), however, and had no head, neck, or cervical spine injury. In addition, the study of the HAINES position did not include study of the movement of patients to that position.

The recovery position was also reviewed by the Basic Life Support Task Force. For additional information see Part 2: "Adult Basic Life Support" and the associated worksheets.[W146A,W146B,W155]

Treatment Recommendation
The use of the recovery position with the victim lying on his or her side with the dependent hand placed in front of the

Exhibit

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

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

July 8, 2011

Marcie Ellen Berman
Broad & Gusman, LLP
1127 11th Street, Suite 501
Sacramento, CA 95814

RE: Petition to Repeal Section 1349

Dear Ms. Berman:

The Medical Board of California (Board) is in receipt of your petition requesting that the Board repeal section 1349 of title 16 of the California Code of Regulations. This section relates to physician-podiatrist partnerships and fee sharing.

In accordance with the provisions of section 11340.7 of the Government Code, your petition has been placed on the agenda for deliberation at the Board's upcoming meeting on July 29, 2011.

Please contact me if you have any questions.

Sincerely,

DOREATHEA JOHNSON
Deputy Director, Legal Affairs

By KURT HEPPLER
Senior Staff Counsel

cc: Linda Whitney, Executive Director, Medical Board of California

Table. International First Aid Science Advisory Board Member Organizations

American Academy of Pediatrics
American Burn Association
American College of Emergency Physicians
American College of Occupational and Environmental Medicine
American College of Surgeons
American Heart Association
American Pediatric Surgical Association
American Red Cross
American Red Cross Advisory Council on First Aid, Aquatics, Safety and Preparedness (ACFASP)
American Safety & Health Institute (ASHI)
Austrian Red Cross
Canadian Red Cross
Divers Alert Network
European Reference Center on First Aid Education
Egyptian Red Crescent
French Red Cross
Grenada Red Cross
Hong Kong Red Cross
Hungarian Red Cross
International Federation of Red Cross and Red Crescent Societies
Medic First Aid International
National Association of EMS Educators
National Association of EMS Physicians
National Athletic Trainers' Association
National Safety Council
Norwegian Red Cross
Occupational Safety and Health Administration
Red Cross Society of China
Resuscitation Council of Asia
St. John Ambulance, UK

Previous reports[5–8] have noted the paucity of scientific evidence supporting many interventions in prehospital emergency care. In reviewing the medical literature, members of the International First Aid Science Advisory Board once again found a paucity of evidence to guide first aid interventions. Very little research is being conducted in first aid, and many of the following recommendations are extrapolated from the experience of healthcare professionals. It is important to recognize the limitations of the evidence that supports many of these guidelines so that research can be undertaken and future guidelines can be based on a larger body of scientific evidence.

Definition of First Aid

We define first aid as the assessments and interventions that can be performed by a bystander (or by the victim) with minimal or no medical equipment. A first aid provider is defined as someone with formal training in first aid, emergency care, or medicine who provides first aid. First aid assessments and interventions should be medically sound and based on scientific evidence or, in the absence of such evidence, on expert consensus. Administration of first aid must not delay activation of the emergency medical services (EMS) system or other medical assistance when required. We strongly believe that education in first aid should be universal: everyone can learn first aid and everyone should.

The scope of first aid is not purely scientific; it is influenced by both training and regulatory issues. The definition of scope is therefore variable, and should be defined according to circumstances, need, and regulatory requirements.

Calling for Help

A first aid provider must be able to recognize when help is needed and how to get it. First aid providers should learn how and when to access the EMS system, how to activate the on-site emergency response plan (ERP), and how to contact the Poison Control Center (see "Poison Emergencies" below).

Positioning the Victim

As a general rule a victim should not be moved, especially if you suspect, from the victim's position or the nature of the injury, that the victim may have a spinal injury (see "Spine Stabilization" below). There are times, however, when the victim should be moved:

- If the area is unsafe for the rescuer or the victim, move the victim to a safe location if it is safe to do so.
- If the victim is face down and is unresponsive, turn the victim face up.
- If the victim has difficulty breathing because of copious secretions or vomiting, or if you are alone and have to leave an unresponsive victim to get help, place the victim in a modified High Arm IN Endangered Spine (HAINES) recovery position:[9,10] Extend one of the victim's arms above the head and roll the body to the side so the victim's head rests on the extended arm. Bend both legs to stabilize the victim (Class IIb, LOE C).
- If a victim shows evidence of shock, have the victim lie supine. If there is no evidence of trauma or injury, raise the feet about 6 to 12 inches (about 30° to 45°) (Class IIb, LOE C). Do not raise the feet if the movement or the position causes the victim any pain.

The evidence for a benefit to raising the feet is extrapolated from leg raising studies on volume expansion; there are no studies on the effect of leg raising as a first aid maneuver for shock. The results of the volume expansion studies are contradictory with some showing an increase in cardiac output,[11–13] while others show no change in cardiac output or mean arterial pressure[14–18] with leg raising.

Oxygen

There is insufficient evidence to recommend routine use of supplementary oxygen by a first aid provider for victims complaining of chest discomfort[19,20] or shortness of breath[21]

Downloaded from circ.ahajournals.org by on November 17, 2010

Exhibit H

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	$ 14,324	$ 7,809
Prior Year Adjustment	$ (556)	$ -	$ -	$ -	$ -
Adjusted Beginning Balance	$ 27,347	$ 30,246	$ 18,855	$ 14,324	$ 7,809
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	$ 47	$ 8
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	$ 52,645	$ 52,994
Transfers:					
GENERAL FUND LOAN		$ (9,000) *			
TOTALS, REVENUES AND TRANSFERS	$ 49,912	$ 43,234	$ 52,107	$ 52,645	$ 52,994
TOTAL RESOURCES	$ 77,259	$ 73,480	$ 70,962	$ 66,968	$ 60,803
EXPENDITURES					
Disbursements:					
0840 State Controller (State Operations)	$ 80	$ 58	$ 53	$ -	$ -
8880 FSCU (State Operations)	$ 31	$ 168	$ 108		
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					
Anticipated BreEZe Cost				$ 1,300	$ 1,300
Anticipated Northern Operation Safe Medicine				$ 253	$ 203
Totals, Disbursements	$ 47,013	$ 54,625	$ 56,638	$ 59,160	$ 60,262
FUND BALANCE					
Reserve for economic uncertainties	$ 30,246	$ 18,855	$ 14,324	$ 7,809	$ 541
Months in Reserve	6.6	4.0	2.9	1.6	0.1

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.

7/2/2012

Medical Board of California
FY 11/12
Budget Expenditure Report
(As of May 31, 2012)
(91% 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	12,202,693	76.8	3,680,696
Board Members	31,500	48,100	152.7	(16,600)
Phy Fitness Incentive Pay	29,623	28,690	96.9	933
Temp Help	1,137,513	1,595,769	140.3	(458,256)
Overtime	12,143	39,205	322.9	(27,062)
Staff Benefits	7,515,777	5,459,160	72.6	2,056,617
Salary Savings	(892,664)			(892,664)
TOTALS, PERS SERVICES	23,717,281	19,373,617	81.7	4,343,664
OPERATING EXP & EQUIP				
General Expense	770,168	404,086	52.5	366,082
Fingerprint Reports	333,448	291,906	87.5	41,542
Minor Equipment	187,500	112,167	59.8	75,333
Printing	685,755	385,530	56.2	300,225
Communications	372,190	195,271	52.5	176,919
Postage	282,511	174,358	61.7	108,153
Insurance	41,053	13,345	32.5	27,708
Travel In-State	482,298	130,928	27.1	351,370
Travel Out-of-State	1,000	1,794	179.4	(794)
Training	78,895	29,015	36.8	49,880
Facilities Operation (Rent)	2,702,140	2,398,552	88.8	303,588
Consult/Prof Services	982,594	1,341,103	136.5	(358,509)
Examinations	0	1,629		(1,629)
Departmental Prorata	4,118,830	4,118,904	100.0	(74)
Interagency Services	5,142	0	0.0	5,142
Consolidated Data Center	646,809	438,841	67.8	207,968
Data Processing	129,492	514,052	397.0	(384,560)
Central Admin Svcs (Statewide Prorata)	2,140,440	2,140,440	100.0	0
Attorney General Services	13,347,280	12,105,088	90.7	1,242,192
Office of Administrative Hearings	1,595,080	964,201	60.4	630,879
Evidence/Witness	1,893,439	1,774,739	93.7	118,700
Court Reporter Services	155,000	270,071	174.2	(115,071)
Major Equipment	633,000	0	0.0	633,000
Other Items of Expense	81	53,854	66,486.4	(53,773)
Vehicle Operations	261,925	270,323	103.2	(8,398)
Court-ordered Payments	0	2,250		(2,250)
Board of Control Claim	0	1,350		(1,350)
TOTALS, OE&E	31,846,070	28,133,797	88.3	3,712,273
TOTALS, EXPENDITURES	55,563,351	47,507,414	85.5	8,055,937
Scheduled Reimbursements	(384,000)	(333,615)	86.9	(50,385)
Distributed Costs	(780,000)	(756,494)	97.0	(23,506)
NET TOTAL, EXPENDITURES	54,399,351	46,417,305	85.3	7,982,046
Unscheduled Reimbursements		(1,284,604)		
		45,132,701		

Budget Expenditure Report.xls
Date: June 29, 2012

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
BUDGET REPORT
JULY 1, 2011 - MAY 31, 2012

	FY 10/11 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	2,252,648	2,037,104	current
Staff Benefits	1,089,713	879,511	current
TOTAL PERSONAL SERVICES	3,342,361	2,916,616	
OPERATING EXPENSES & EQUIPMENT			
General Expense	80,434	18,832	1-2
Fingerprint Reports*	333,448	288,189	1-2
Printing	61,000	38,583	1-2
Communications	52,246	19,679	1-2
Postage	125,000	99,176	1-2
Travel In-State	25,000	5,003	1-2
Training	8,500	7,263	1-2
Facilities Operation	226,000	254,578	current
Consult/Professional Services	601,873	700,425	1-2
Departmental Services	402,825	402,831	current
Interagency Services	500	0	current
Data Processing	4,000	7,761	1-2
Statewide Pro Rata	209,335	209,335	current
Attorney General	190,000	140,627	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	1,367	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	2,419,911	2,193,818	
SCHEDULED REIMBURSEMENTS	(384,000)	(333,615)	
DISTRIBUTED COSTS	(42,257)	(31,692)	
TOTAL BUDGET/EXPENDITURES	**5,336,015**	**4,745,127**	

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

6/29/2012

MEDICAL BOARD OF CALIFORNIA
ENFORCEMENT PROGRAM
BUDGET REPORT
JULY 1, 2011 - MAY 31, 2012

	FY 11/12 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	10,550,011	8,606,807	current
Staff Benefits	4,778,306	3,307,843	current
TOTAL PERSONAL SERVICES	15,328,317	11,914,649	
OPERATING EXPENSE & EQUIPMENT			
General Expense/Fingerprint Reports	436,406	263,624	1-2
Printing	305,755	182,160	1-2
Communications	224,358	132,323	1-2
Postage	70,000	69,527	1-2
Insurance	38,770	11,589	current
Travel In-State	290,298	72,287	1-2
Travel Out-of-State	0	1,794	1-2
Training	34,000	14,313	1-2
Facililties Operations	2,071,140	1,775,691	current
Consultant/Professional Services	300,000	213,956	1-2
Departmental Services	3,070,588	3,070,645	current
Interagency Services	3,833	0	1-2
Data Processing	19,000	9,946	1-2
Statewide Pro Rata	1,595,698	1,595,698	current
Examination	0,000	1,267	
Attorney General 1/	13,157,280	11,964,461	current
OAH	1,595,080	964,201	1
Evidence/Witness Fees	1,820,939	1,728,472	1-2
Court Reporter Services	154,750	270,071	1-2
Major Equipment	511,000	0	1-2
Other Items of Expense (Law Enf. Materials/Lab, etc.)	81	52,065	1-2
Vehicle Operations	215,925	227,871	1-2
Minor Equipment	2,500	28,348	1-2
Court-Ordered Payments	0	3,070	current
TOTAL OPERATING EXPENSES & EQUIPMENT	25,917,401	22,653,379	
DISTRIBUTED COSTS	(735,630)	(723,216)	
TOTAL BUDGET/EXPENDITURES	**40,510,088**	**33,844,812**	
Unscheduled Reimbursements		(90,604)	
		33,754,208	

1/See next page for monthly billing detail

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	5,618.75	170.00	955,187.50
	Paralegal Services	111.00	120.00	13,320.00
	Auditor/Analyst	99.00	99.00	9,801.00
	Cost of Suit			2,084.00
				980,392.50
December	Attorney Services	5,270.75	170.00	896,027.50
	Paralegal Services	127.25	120.00	15,270.00
	Auditor/Analyst	62.75	99.00	6,212.25
	Cost of Suit			1,050.00
				918,559.75
			Total July-Dec =	**6,407,236.56**
			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	6,012.00	170.00	1,022,040.00
	Paralegal Services	238.75	120.00	28,650.00
	Auditor/Analyst	149.50	99.00	14,800.50
	Cost of Suit			0.00
				1,065,490.50
March	Attorney Services	6,735.00	170.00	1,144,950.00
	Paralegal Services	283.00	120.00	33,960.00
	Auditor/Analyst Services	156.00	99.00	15,444.00
	Cost of Suit			5,133.00
				1,199,487.00
April	Attorney Services	5,701.25	170.00	969,212.50
	Paralegal Services	220.25	120.00	26,430.00
	Auditor/Analyst Services	175.25	99.00	17,349.75
	Cost of Suit			88.00
				1,013,080.25
May	Attorney Services	6,420.75	170.00	1,091,527.50
	Paralegal Services	323.75	120.00	38,850.00
	Auditor/Analyst Services	147.00	99.00	14,553.00
	Cost of Suit			4,348.00
				1,149,278.50
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 =	**11,964,461.81**
FY 11/12 Budget =	**13,157,280.00**

Revised 06/29/2012

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	205	0		56,157
Criminal Cost Recovery	0	0	150	0	50	250	605	504	1,055	754	14,147		17,515
Probation Monitoring	42,542	41,848	44,639	105,369	96,368	109,993	343,253	222,925	83,025	97,287	59,217		1,246,465
Exam	1,639	777	2,481	627	1,692	2,552	977	1,106	6,495	1,831	6,024		26,200
Cite/Fine	200	4,350	800	10,650	3,250	6,400	8,650	7,002	3,450	7,825	3,075		55,652
MONTHLY TOTAL	44,681	47,325	48,370	116,745	101,409	123,127	394,074	231,587	104,307	107,903	82,462	0	1,401,989
FYTD TOTAL	44,681	92,005	140,375	257,120	358,530	481,657	875,730	1,107,317	1,211,624	1,319,527	1,401,989	1,401,989	

excel:enfreceiptsmonthlyprofile.xls.revised 7/2/2012

MEDICAL BOARD OF CALIFORNIA BUDGET OVERVIEW BY BOARD COMPONENT

	EXEC	ENFORCE	OPERATION SAFE MEDICINE	LICENSING	ADMIN SERVICES	INFO SYSTEMS	PROBATION MONITORING	BOARD TOTAL
FY 08/09								
$ Budgeted	2,158,000	36,659,000		4,599,000	2,048,000	3,370,000	1,914,000	50,748,000
$ Spent *	1,875,000	34,026,000		4,522,000	1,697,000	2,668,000	625,000	45,413,000 *
Positions Authorized	8.8	146.6		45.5	15.0	16.0	20.0	251.9
FY 09/10								
$ Budgeted	2,030,000	36,539,000	567,000	4,262,000	1,558,000	2,953,000	1,589,000	49,498,000
$ Spent *	2,920,000	34,130,000	494,000	4,772,000	1,547,000	2,728,000	500,000	47,091,000 *
Positions Authorized	8.8	146.6	6.0	45.5	15.0	16.0	25.0	262.9
FY 10/11								
$ Budgeted	1,944,000	37,720,000	577,000	5,045,000	1,688,000	3,118,000	1,735,000	51,827,000
$ Spent*	1,771,000	34,420,000	651,000	5,061,000	1,564,000	2,948,000	487,000	46,902,000 *
Positions Authorized	8.8	165.0	6.0	52.3	15.0	17.0	25.0	289.1
FY 11/12								
$ Budgeted	1,885,220	40,510,088		5,336,015	1,585,554	3,069,028	2,013,445	54,399,350
$ Spent thru 05/31*	1,775,576	33,754,208		4,745,127	1,543,636	2,810,667	503,487	45,132,701
Positions Authorized	8.8	164.1		53.3	15.0	17.0	25.0	283.2

* net expenditures (includes unscheduled reimbursements)

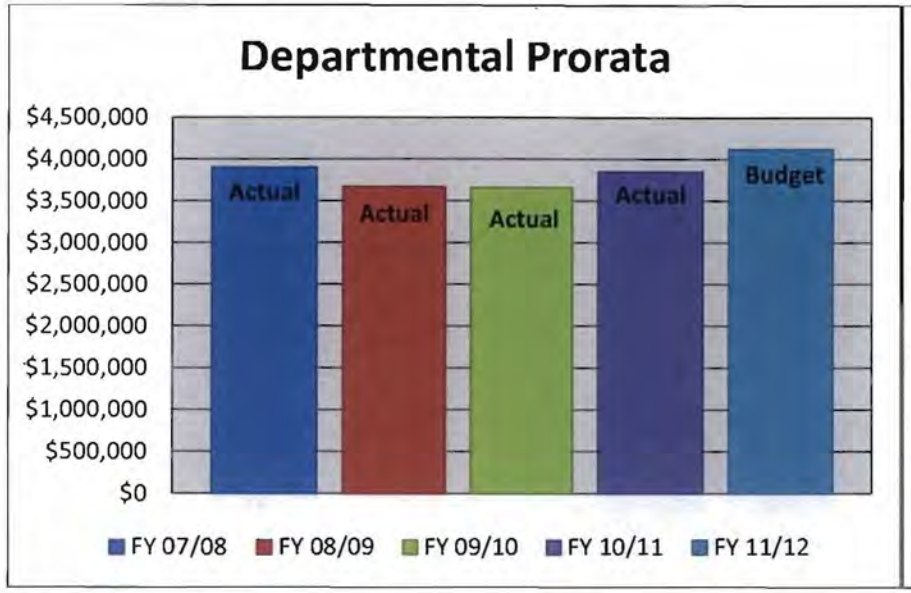
6/29/2012
Budget Overview by Program.xls

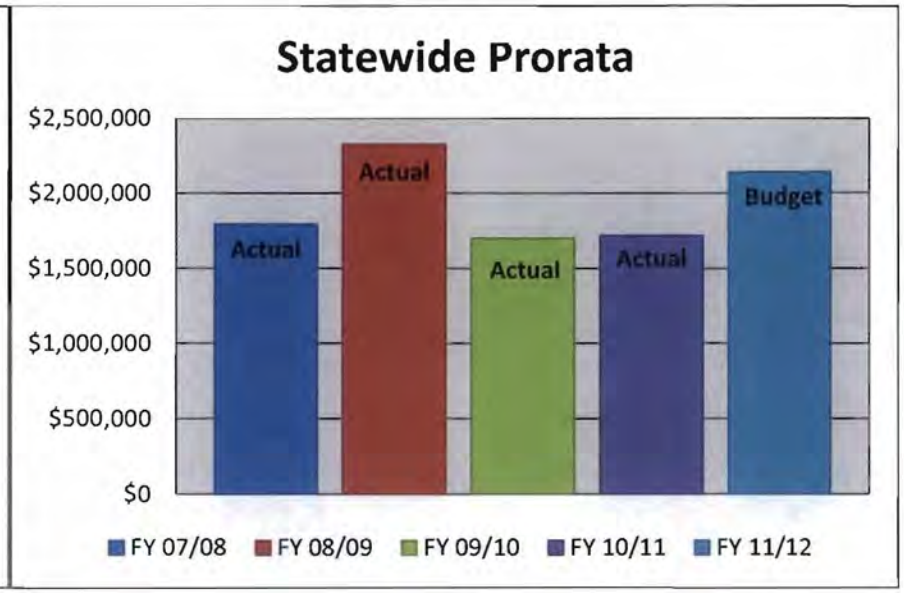
Board Members' Expenditures - Per Diem/Travel
July 1, 2011 - June 30, 2012

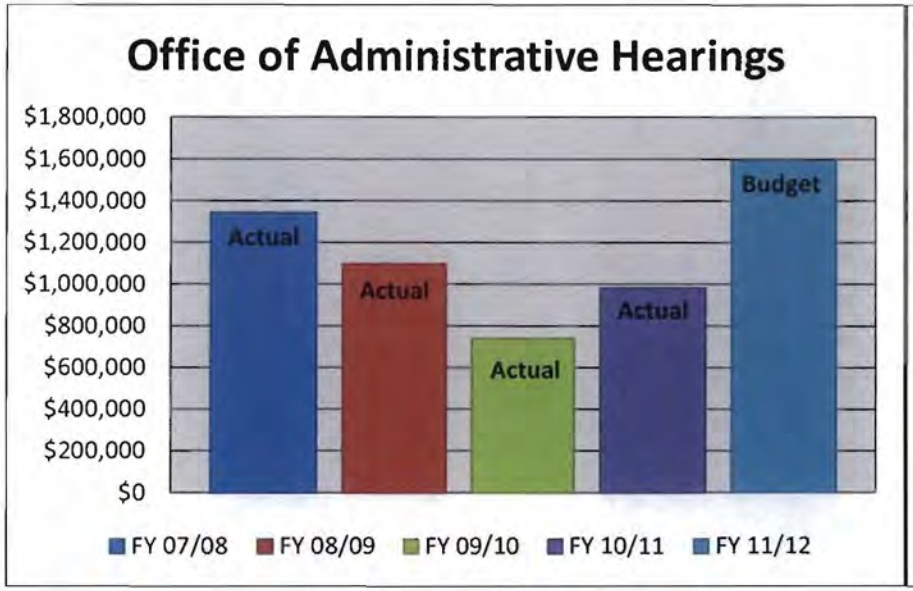
NAMES	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APRIL	MAY	JUNE	YTD
DR. BISHOP - Per diem							$ 400.00	$ 600.00	$ 300.00				$ 1,300.00
Travel							$ 489.63	$ 794.65		$ 81.47	$ 462.91		$ 1,828.66
	$ -	$ -	$ -	$ -	$ -	$ -	$ 889.63	$ 1,394.65	$ 300.00	$ 81.47	$ 462.91	$ -	**$ 3,128.66**
DR. CARREON - Per diem	$ 1,300.00	$ 1,100.00	$ 1,100.00	$ 1,300.00	$ 1,000.00	$ 1,000.00	$ 600.00	$ 1,100.00		$ 600.00	$ 400.00		$ 9,500.00
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	$ -	$ 600.00	$ 400.00	$ -	**$ 11,186.51**
MS. CHANG - Per diem	$ 400.00	$ 200.00	$ 100.00	$ 200.00	$ 200.00	$ 200.00	$ 500.00	$ 700.00	$ 400.00	$ 300.00	$ 800.00		$ 4,000.00
Travel	$ 452.94							$ 157.88			$1,068.95		$ 1,679.77
	$ 852.94	$ 200.00	$ 100.00	$ 200.00	$ 200.00	$ 200.00	$ 500.00	$ 857.88	$ 400.00	$ 300.00	$ 1,868.95	$ -	**$ 5,679.77**
DR. DIEGO - Per diem		$ 200.00	$ 1,000.00	$ 1,000.00	$ 1,400.00	$ 800.00	$ 800.00	$ 900.00	$ 1,200.00	$ 800.00			$ 8,100.00
Travel				$ 1,052.64		$ -	$ -	$ 505.39			$ 742.31		$ 2,300.34
	$ -	$ 200.00	$ 1,000.00	$ 2,052.64	$ 1,400.00	$ 800.00	$ 800.00	$ 1,405.39	$ 1,200.00	$ 800.00	$ 742.31	$ -	**$ 10,400.34**
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	$ 800.00	$ 600.00	$ -	$ 8,700.00
Travel	$ 71.04			$ 864.71	$ -		$ -	$ 505.84			$ 808.90		$ 2,250.49
	$ 1,071.04	$ 700.00	$ 600.00	$ 1,764.71	$ 800.00	$ 600.00	$ 1,000.00	$ 1,505.84	$ 700.00	$ 800.00	$ 1,408.90	$ -	**$ 10,950.49**
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			$ -			$ 100.00	$ 300.00		$ 800.00
Travel	$ -			$ 892.82			$ -			$ 61.06			$ 953.88
	$ -	$ -	$ -	$ 1,292.82	$ -	$ -	$ -	$ -	$ -	$ 161.06	$ -	$ -	**$ 1,753.88**
MS.SCHIPSKE - Per diem	$ 1,000.00	$ -	$ 300.00	$ 900.00	$ 100.00	$ 300.00	$ 600.00	$ 200.00	$ 500.00	$ 800.00	$1,300.00	$ -	$ 6,000.00
Travel	$ 618.06			$ 444.58			$ -		$ -				$ 1,062.64
	$ 1,618.06	$ -	$ 300.00	$ 1,344.58	$ 100.00	$ 300.00	$ 600.00	$ 200.00	$ 500.00	$ 800.00	$ 1,300.00	$ -	**$ 7,062.64**
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	$2,200.00	$ 500.00	$ -	$16,800.00
Travel	$ 709.66			$ 465.44	$ -	$ 620.02	$ 386.15	$ 742.00	$ 494.87	$ 424.87	$1,286.40		$ 5,129.41
	$ 2,509.66	$ 1,800.00	$ 1,500.00	$ 2,365.44	$ 1,100.00	$ 1,620.02	$ 2,286.15	$ 2,142.00	$ 2,194.87	$ 2,624.87	$ 1,786.40	$ -	**$ 21,929.41**

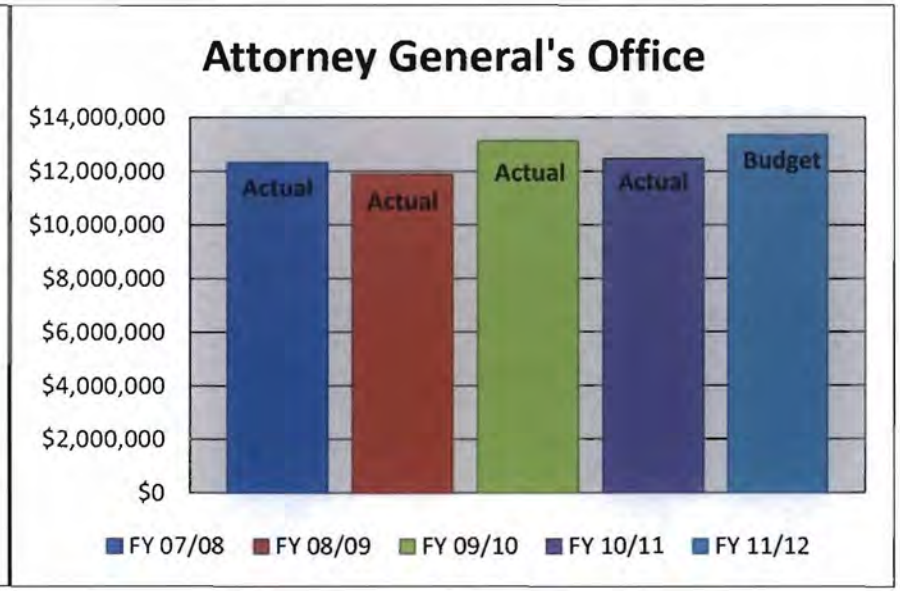
TOTAL PER DIEM	$56,600.00
TOTAL TRAVEL	$ 17,305.56
TOTAL	**$ 73,905.56**

Strategic Plan Objective 5.3
External Agencies' Spending





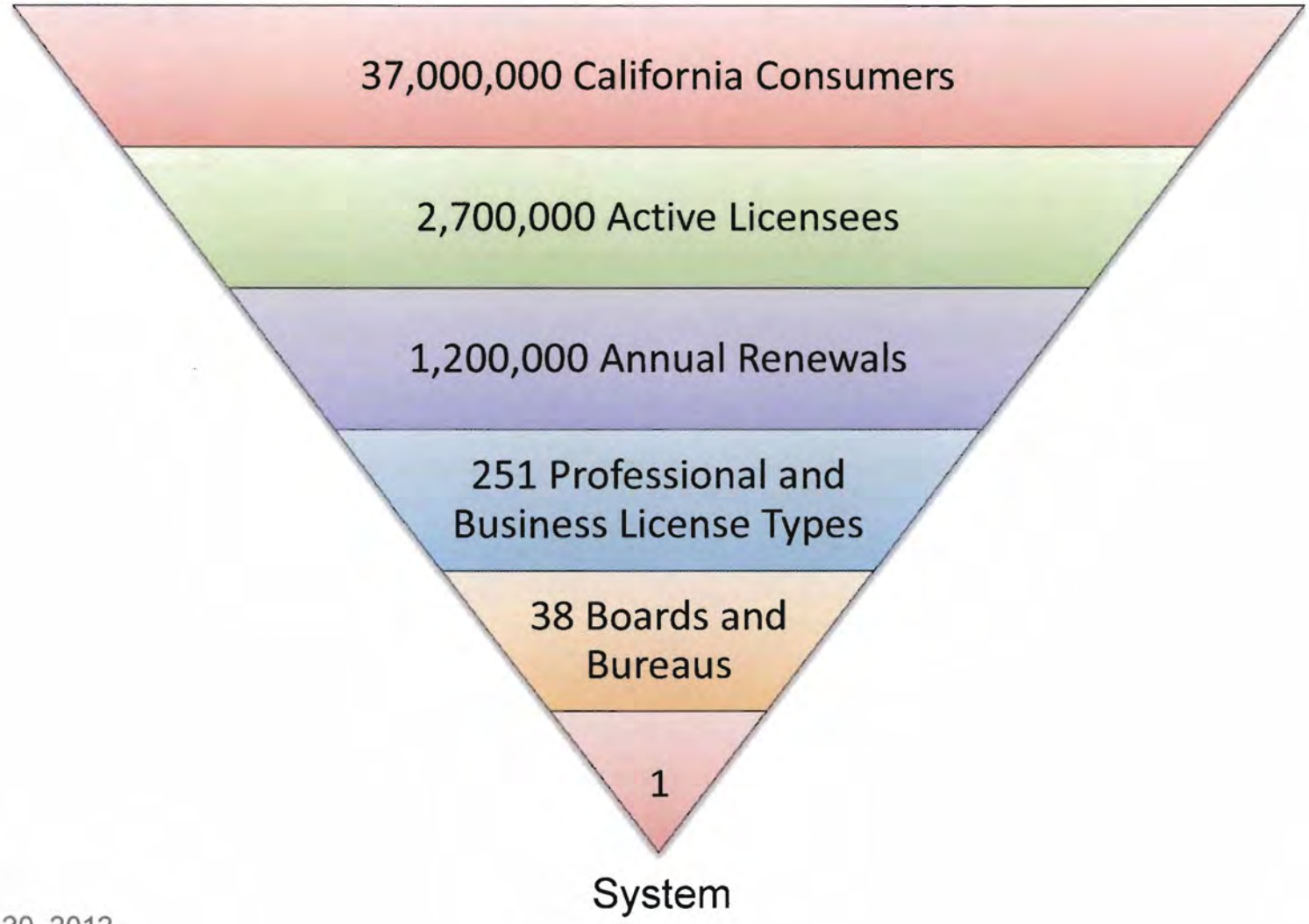




dca BREEZE

Project Presentation

Project Landscape



Background

- Integrated Licensing & Enforcement solution
- Completely replaces legacy licensing and enforcement systems (3 legacy & 90 workaround databases)
- Consolidates separate project efforts

Enforcement Improvements

- Automated complaint intake process
- Prioritization of enforcement cases
- Efficient allocation of enforcement resources
- System prompts staff to ensure timely case follow-up
- Improves case management to reduce lag time and case aging
- Allows complainants to submit a complaint and track its status online
- Notifies appropriate Boards when enforcement actions involve individuals with multiple licenses

Licensing Improvements

- Allows online application – ensuring applications are complete
- Offers third party payment
- Ensures completion of the Board survey online at time of renewal
- Allows applicants to track application status online
- Provides "other" online services for licensees
- Prompts staff to ensure timely follow-up

Significant Activities

Completed

- Contract executed - September 22, 2011
- First Legacy System data extract
- Requirements Refinement
- Hardware Procurement and Installation
- Initial Configuration Interviews
- Conference Room Pilots
- Standardization Efforts

Significant Activities

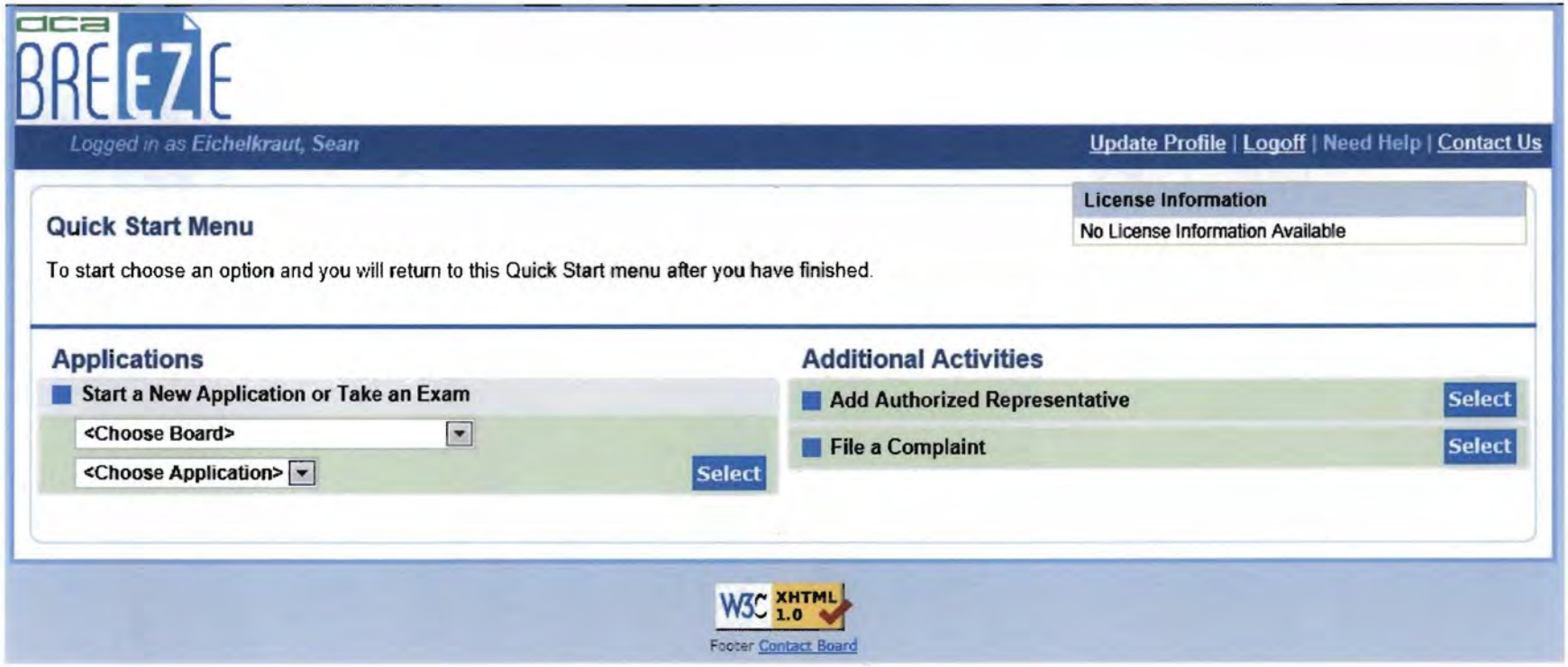
In Progress

- Vendor System Testing
- On-going Configuration Refinement
- User Acceptance Test preparation
- Data Conversion Validation & on-going clean-up

Milestone Status

Key Action (Activity)	SPR	Baseline	Current
Solution Vendor Start	**September 2011**	**October 2011**	**October 2011**
First Mock Data Conversion Run Milestone	NA	March 2012	May 2012
Detailed Design Complete	March 2012	May 2012	June 2012
Release 1 User Acceptance Test Complete	July 2012	August 2012	September 2012
Converted Data Accepted for Production Use	NA	July 2012	September 2012
Release 1 Go-Live	July 2012	September 2012	October 2012
Release 2 Go-Live	March 2013	TBD	April 2013
Release 3 Go-Live	September 2013	TBD	September 2013
Full System Acceptance	**October 2013**	**October 2013**	**October 2013**

User Home Page



Introduction Page

dca BREEZE

Logged in as Eichelkraut, Sean

Update Profile | Logoff | Need Help | Contact Us

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- Transaction Suitability Questions
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- Contact Details
- Physician Survey
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- Online L1A Examination Information
- L1A Examination Information
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- Online L1B Postgraduate Training
- PG Training Info
- Online L1C Postgraduate Training
- Online L1C Medical License Information
- Online L1C ABMS Certification
- Online L1D DEA Certification

PTAL Initial Application - Introduction

Press "Next" to continue.

Press "Cancel" to cancel this application and return to the main menu.

Please be advised, this application requires detailed information to be provided. To help with the completion of the application, please review the following documents to gather the necessary information:

- PTAL Application Information
- PTAL Checklist
- PTAL Application

A Postgraduate Training Authorization Letter (PTAL) authorizes an applicant to seek and commence Accreditation Council for Graduate Medical Education (ACGME) accredited training in California.

As an applicant, **you are personally responsible for all information disclosed**, including any responses that may have been completed on your behalf by others. An application may be denied based upon falsification or misrepresentation of any item or response on the application or any attachment. Any alterations to any application and/or supporting application forms may result in the denial of your application. The Medical Board considers violations of an ethical nature to be a serious breach of professional conduct.

For minimum requirements, information, instructions, and forms, please see the PTAL application packet located at http://www.mbc.ca.gov/applicant/application_international.pdf.

Next Cancel

Eligibility Questions

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- Online L1C Medical License Information
- Online L1C ABMS Certification
- Online L1D DEA Certification Part 1
- Online L1D DEA Certification

PTAL Initial Application - Eligibility Questions

Answer the questions and press "Next".

Press "Previous" to return to the previous section.

Press "Cancel" to cancel this application and return to the main menu.

Question	Answer
#1) Did you receive all of your medical school education and graduate from a medical school(s) recognized by the Medical Board of California?	○ Yes ◉ No
#3) Have you completed all components of USMLE Steps 1 and 2 with results of 75 or better?	○ Yes ◉ No
#2) Are you currently certified by ECFMG?	○ Yes ◉ No

Question #1
To be eligible for a Postgraduate Training Authorization Letter (PTAL), applicants must have received all of their medical school education and graduate from a medical school recognized by the Medical Board of California. The medical school's name must match the name on the Board's list of recognized medical schools exactly. Please refer to the Board's website to verify your medical school is recognized:
http://www.mbc.ca.gov/applicant/schools_recognized.html

Question #2
To meet the examination requirement for a PTAL, you must have completed all components of United States Medical Licensing Examination (USMLE) Steps 1 and 2 per Section 1328 of Title 16 California Code of Regulations. Results of 75 or better are required to satisfy the examination requirement.

Question #3
Certification by the Educational Council for Foreign Medical Graduates (ECFMG) is required. To obtain further information regarding ECFMG Certification, please refer to their website at www.ecfmg.org.

Previous | Next | Cancel

Eligibility Questions

dca BREEZE

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- Online L1D DEA Certification Part 2
- Online L1D DEA Certification

PTAL Initial Application - Eligibility Questions

Error

- This function is not suitable for your situation. Press "Cancel" and select a different function.

Answer the questions and press "Next".

Press "Previous" to return to the previous section.

Press "Cancel" to cancel this application and return to the main menu.

Question	Answer
#1) Did you receive all of your medical school education and graduate from a medical school(s) recognized by the Medical Board of California?	○ Yes ◉ No
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Previous | Next | Cancel

Physician Survey

BREEZE

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- Online L1B Postgraduate Training
- PG Training Info
- Online L1C Postgraduate

PTAL Initial Application - Activities in Medicine

Enter the data and press "Next" to continue.

Press "Previous" to return to the previous screen.

Press "Cancel" to cancel this application and return to the main menu.

Hours	None	1-9	10-19	20-29	30-39	40+
Patient Care	○	○	○	○	○	●
Telemedicine	●	○	○	○	○	○
Administration	●	○	○	○	○	○
Research	●	○	○	○	○	○
Teaching	●	○	○	○	○	○
Other	●	○	○	○	○	○

Practice Location (U.S. Only)

Patient Care	Zip	95831	County	SACRAMENTO
Telemedicine	Zip		County	

Secondary Practice Location (CA Only)

Patient Care	Zip		County	
Telemedicine	Zip		County	

Are you retired? ○ Yes ● No

Current Training Status ○ Residency ○ Fellow ● Not in Training

Previous Next Cancel

Physician Survey (cont.)

dca BREEZE

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- Online L1D DEA Certification Part 2

PTAL Initial Application - Areas of Practice

Select one primary (P) and all secondary (S) practice areas and press "Next" to continue.

Press "Previous" to return to the previous screen.

Press "Cancel" to cancel this application and return to the main menu.

P	S		P	S		P	S		P	S	
◉	☑	Aerospace Medicine	○	☐	Gastroenterology	○	☐	Nuclear Medicine	○	☐	Public Health and General Preventive Medicine
○	☐	Allergy and Immunology	○	☐	General Practice	○	☐	Obstetrics and Gynecology	○	☐	Pulmonary
○	☐	Anesthesiology	○	☐	General Surgery	○	☐	Occupational Medicine	○	☐	Radiation Oncology
○	☐	Cardiology	○	☐	Geriatric Medicine	○	☐	Oncology	○	☐	Radiologic Physics
○	☐	Colon and Rectal Surgery	○	☐	Hematology	○	☐	Ophthamology	○	☐	Radiology
○	☐	Complementary and Alternative Medicine	○	☐	Infectious Disease	○	☐	Orthopedic Surgery	○	☐	Rheumatology
○	☐	Cosmetic Surgery	○	☐	Internal Medicine	○	☐	Otolaryngology	○	☐	Sleep Medicine
○	☐	Critical Care	○	☐	Medical Genetics	○	☐	Pain Medicine	○	☐	Spine Surgery
○	☐	Dermatology	○	☐	Neonatal-Perinatal Medicine	○	☐	Pathology	○	☐	Sports Medicine
○	☐	Emergency Medicine	○	☐	Nephrology	○	☐	Pediatrics	○	☐	Surgical Oncology
○	☐	Endocrinology	○	☐	Neurodevelopmental Disabilities	○	☐	Physical Medicine and Rehabilitation	○	☐	Thoracic Surgery
○	☐	Epilepsy	○	☐	Neurological Surgery	○	☐	Plastic Surgery	○	☐	Urology
○	☐	Facial, Plastic and Reconstructive Surgery	○	☐	Neurology	○	☐	Psychiatry	○	☐	Vascular Surgery
○	☐	Family Medicine	○	☐	Neurology with Special Qualification in Child Neurology	○	☐	Psychosomatic Medicine	○	☐	Other ☐ Not Listed

Previous | Next | Cancel

4

Physician Survey (cont.)

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- Online L1C Medical License Information
- Online L1C ABMS Certification
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- Online L1D DEA Certification Part 2
- Online L1D DEA Certification

PTAL Initial Application - Foreign Language Proficiency and Web Site Profile

Enter the data and press "Next" to continue.

Press "Previous" to return to the previous screen.

Press "Cancel" to cancel this application and return to the main menu.

WEB SITE PROFILE

Do you want the following information included in your physician profile on the Medical Boards's Web site?

Cultural Background ○ Yes ◉ No Foreign Language Proficiency ○ Yes ◉ No Gender ○ Yes ◉ No

Email Address: Sean.Eichelkraut@mbc.ca.gov WILL NOT BE RELEASED TO THE PUBLIC

FOREIGN LANGUAGE PROFICIENCY

In addition to English, indicate additional languages in which you are proficient.

☐ African Languages	☐ Hebrew	☐ Panjabi (Punjabi)	☐ Turkish
☐ American Sign Language	☐ Hindi	☐ Persian (Farsi)	☐ Ukrainian
☐ Amharic	☐ Hmong	☐ Polish	☐ Urdu
☐ Arabic	☐ Hungarian	☐ Portuguese	☐ Vietnamese
☐ Armenian	☐ Ilocano	☐ Russian	☐ Xiang Chinese
☐ Cantonese	☐ Indonesian	☐ Samoan	☐ Yiddish
☐ Croatian	☐ Italian	☐ Scandinavian Languages	☐ Yoruba
☐ Fijian	☐ Japanese	☐ Serbian	☐ Other Chinese
☐ Formosan (Amis)	☐ Korean	☐ Spanish	☐ Other Non-English
☐ French	☐ Lao	☐ Swahili	☐ Other Sign Language
☐ French Creole	☐ Mandarin	☐ Tagalog	☐ Other (not listed)
☐ German	☐ Mien	☐ Telugu	☑ None
☐ Greek	☐ Mon-Khmer (Cambodian)	☐ Thai	☐ Decline to state
☐ Gujarati	☐ Navajo	☐ Tonga	

Previous Next Cancel

L1A Examination Information Questions

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PTAL Initial Application - L1A Examination Information - Information

Press "Previous" to return to the previous section.

Enter appropriate details and press "Next" to continue.

Press "Cancel" to cancel this application and return to the main menu.

Have you ever been found to have engaged in irregular behavior during an examination?	○ Yes	◉ No
Have you ever been subject to an investigation by an examination entity?	○ Yes	◉ No
Are you certified by the Educational Commission for Foreign Medical Graduates?	○ Yes	◉ No

If you indicated you are certified by the Educational Commission for Foreign Medical Graduates above, provide the date your certificate was issued below.

Certificate Issue Date: (mm/dd/yyyy)

Previous Next Cancel

View Application Status

dca BREEZE

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Quick Start Menu

To start choose an option and you will return to this Quick Start menu after you have finished.

License Information

No License Information Available

Applications

- Start a New Application or Take an Exam
  - <Choose Board>
  - <Choose Application> Select
- View Application Status
  - Medical Board of California - PTAL Initial Application Status: Open Details

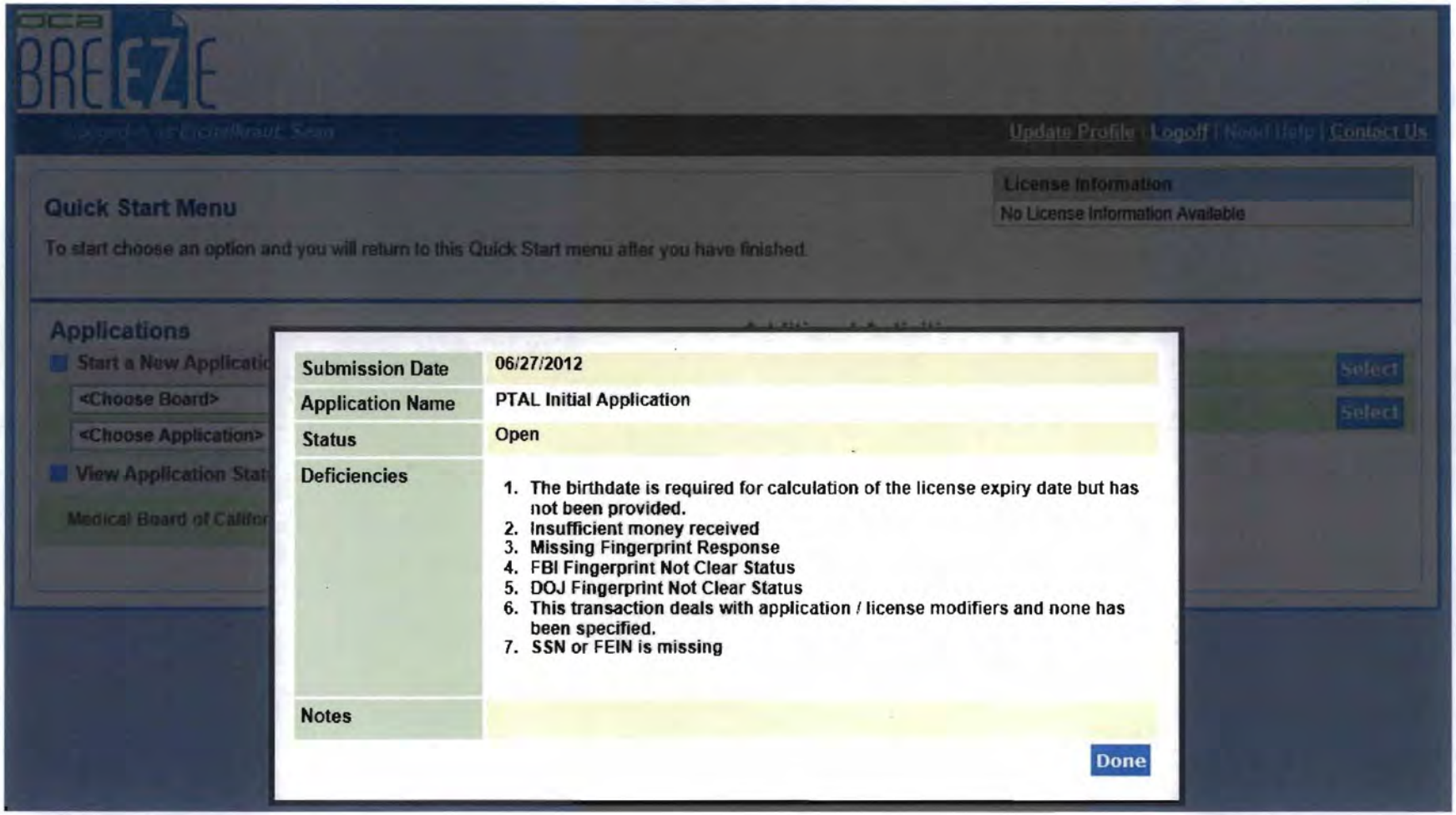
Additional Activities

- Add Authorized Representative Select
- File a Complaint Select

W3C XHTML 1.0

Footer Contact Board

View Application Status Details



Firefox | File a Complaint - Complaint Details

www2.versasys.com:9456/datamart/complaint.do

Share Browser WebEx

CA.GOV CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

Logon

File a Complaint - Complaint Details

Enter complaint information and press "Next" to continue.

Press "Cancel" to cancel this complaint and return to the main menu.

- Board: Medical Board
- License Type: Physician and Surgeon
- Incident Date: 11/01/2011 (mm/dd/yyyy)
- Complaint Description: Description of complaint goes here.

Next Cancel

W3C XHTML 1.0

Footer Contact Board

2:44 PM 08/11/2011

Firefox | File a Complaint - Respondent Details | (al12) License Home

Share Browser WebEx

.GOV CONSUMER AFFAIRS

Logon

File a Complaint - Respondent Details

The respondent is the individual or organization who you are filing a complaint against.

If known, enter the respondent's license number and press "Lookup" to quickly retrieve their name and contact details. You may add or change any of these details.

If the respondent is not licensed or the license number is not known, enter the respondent's name and contact details.

Press "Previous" to return to previous screen.

Press "Next" to continue.

Press "Cancel" to cancel this complaint and return to the main menu.

License Type: **Physician and Surgeon**

License Number: 10351204008 [Lookup]

- First Name: SCOTT
- Second Name:
- Last Name: ADES

Gender:

Street Number: 1121

- Street Name: 15th Street

Address Line 1:

Address Line 2:

- City: SACRAMENTO
- State: California

Zip code: 95814

Country: United States

County: SACRAMENTO

Phone Number: 201 410 4588

Phone Extension:

E-mail:

[Previous] [Next] [Cancel]

2:51 PM
08/11/2011

Firefox | File a Complaint - Confirmation | (al12) License Home

Share Browser WebEx

File a Complaint - Confirmation

Press "Previous" to return to the previous screen.

Press "Submit" to Submit the complaint.

Press "Cancel" to return to the Public Services Main Menu.

Complaint Detail

License Type	**Physician and Surgeon**
Incident Date:	**09/25/2011**
Expected Resolution:	
Documents:	
Submitted to Other Agencies:	
Agencies Info:	
Description:	**Description of complaint goes here**

Respondent Detail

License Type	**Physician and Surgeon**
License Number:	**10351204008**
Name:	**ADES, SCOTT**
Address:	**1121 SACRAMENTO, CA SACRAMENTO US 95814**
Phone:	**201 410 4588**

Complainant Detail

Anonymous.

Previous Submit Cancel

2:53 PM
08/11/2011

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License Information

No License Information Available

Quick Start Menu

To start choose an option and you will return to this Quick Start menu after you have finished.

What can we help you with today?

Authorized License

Applications

- **Start a New Application or Take an Exam**
  - **Board of Barbering and Cosmetology - Initial Application** — Select
  - **Board of Barbering and Cosmetology - Initial Application - Apprentice** — Select
  - **Board of Barbering and Cosmetology - Initial by Reciprocity** — Select
  - **Board of Barbering and Cosmetology - Pre-Application and Exam Request** — Select
- **View Status of your Applications (1)** — Select

Additional Activities

- **Make Payment** — Select
- **Add Authorized Representative** — Select
- **Enforcement Voting** — Select

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Logged in as ***Anderson, Anthony***

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Voting Summary Screen

Text 1

Case #	Respondent	Vote Date	Vote Result	Vote Notes	Actions	
20120001	HAGMAN, NICKLAS	02/02/2012	Accepted	Note Contents	Edit	Attach
20120003	THOMAS, KERRY	01/02/2012	Rejected	Notes Notes Notes	Edit	Attach
					Edit	Attach

Text 2

Return

CA.GOV CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

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Voting Screen

Text 1

Vote Result

Notes

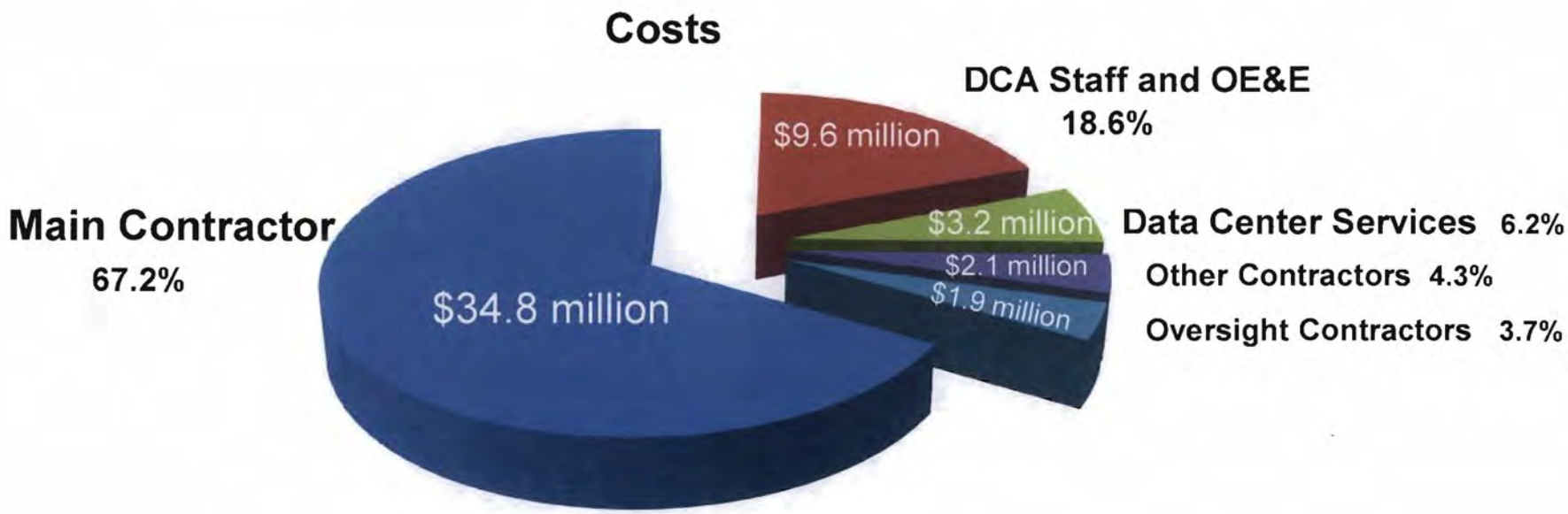
Text 2

Save Cancel

Costs

All project costs paid by DCA Special Funds

BreeZe Cost	Costs
Total One-Time	$ 51.6 million



Avoiding Risk

BreEZe Deployed → Then 5-year payment begins

Performance-based Payment Model

Collaborative Project

- Reports Workgroup – Review of Standard Reports
- Forms Workgroup – Correspondence Unit Analysis of Letters
- Data Conversion Workgroup
- Standardization
  - License Status Codes
  - Enforcement Codes

Board Involvement

- License Configuration interviews to review processes
- Enforcement Configuration Interviews
- Workflow and Security Interviews
- Online System Configuration Interviews
- Conference Room Pilots
- Data Verification
- Acceptance Testing

Organizational Change Management

- Provide a OCM Coach for the Board to discuss concerns/issues and to provide assistance where needed
- Town Halls were provided to Board staff to discuss BreEZe impacts
- Conduct OCM presentations for managers/supervisors, if requested
- Prepare BreEZe marketing materials – posters/brochures
- Work with the Board to develop outreach strategy to all users – licensees, applicants, schools, etc.

Implementation Release 1

Roll Out Date – Fall 2012

- Board of Registered Nursing
- Board of Barbering & Cosmetology
- Medical Board of California
- Board of Behavioral Sciences
- Board of Psychology
- Physician Assistant Committee
- Osteopathic Medical Board of California
- Board of Podiatric Medicine
- Respiratory Care Board
- Naturopathic Medicine Board

Subsequent Release

Roll Out Date: Spring – Fall 2013

- Proposed Interface with the Department of Justice, Attorney General's Office (ProLaw)

QUESTIONS?

EDMUND G. BROWN JR. • GOVERNOR
915 L STREET ■ SACRAMENTO CA ■ 95814-3706 ■ WWW.DOF.CA.GOV

Transmitted via e-mail

May 31, 2012

Ms. Linda Whitney, Executive Director
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

Dear Ms. Whitney:

Final Report—Medical Board of California Financial Status

The Department of Finance, Office of State Audits and Evaluations, has completed its audit of the Medical Board of California's (Board) financial status as of June 30, 2011.

The enclosed report is for your information and use. The Board agreed with our results and its response is incorporated into this final report. This report will be placed on our website.

We appreciate the assistance and cooperation of the Board. If you have any questions regarding this report, please contact Kimberly Tarvin, Manager, or Jennifer Arbis, Supervisor, at (916) 322-2985.

Sincerely,

David Botelho, CPA
Chief, Office of State Audits and Evaluations

Enclosure

cc: Ms. Kimberly Kirchmeyer, Deputy Director, Medical Board of California
Ms. Pam Wortman, Deputy Director, Administrative and Information Services, Department of Consumer Affairs
Ms. Janice Shintaku, Fiscal Officer, Department of Consumer Affairs

Audit Report

Medical Board of California
Financial Status
as of June 30, 2011

Prepared By:
Office of State Audits and Evaluations
Department of Finance

121390099 SCN

April 2012

MEMBERS OF THE TEAM

Kimberly Tarvin, CPA
Manager

Jennifer Arbis
Supervisor

Staff
Wrenna Finche
Toni Silva

Final reports are available on our website at http://www.dof.ca.gov

You can contact our office at:

Department of Finance
Office of State Audits and Evaluations
300 Capitol Mall, Suite 801
Sacramento, CA 95814
(916) 322-2985

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BACKGROUND, SCOPE AND METHODOLOGY

BACKGROUND

The Medical Board of California (Board) protects health care consumers through the proper licensing and regulation of physicians and surgeons and certain allied health care professions; enforcement of the Medical Practice Act; and promoting access to quality medical care through the Board's licensing and regulatory functions.[1] The Board operates under the oversight of the Department of Consumer Affairs (DCA) and administers the Contingent Fund of the Medical Board of California (Fund). Additionally, DCA performs the accounting and budgeting functions for the Board including monitoring the Board's legal spending authority.[2] The Board's operations are funded through licensing fees paid by California physicians and surgeons. During the fiscal year ended June 30, 2009, a $6 million loan was made from the Fund to the state General Fund.

SCOPE

In accordance with California Business and Professions Code section 2435, the Department of Finance, Office of State Audits and Evaluations (Finance), reviewed the Board's financial status as of June 30, 2011 including the following:

- The Board's projections related to revenues, expenditures, and reserves.
- The impact of the $6 million loan from the Fund to the state General Fund.

Subsequent to June 30, 2011, an additional $9 million loan was made to the state General Fund. Although not required by statute, this report includes the impact of this loan on the Fund.

METHODOLOGY

To evaluate the Board's financial projections and the impact of the loans, Finance performed the following:

- Interviewed Board administrative and budget staff, former Board budget staff, and DCA budget staff regarding the following:
  - Roles and responsibilities
  - Budget development processes and policies
  - Program development process and status
- Reviewed and analyzed financial reports.
- Reviewed the fund condition statement projection methodology.
- Compared fund condition statement projections to actual year-end financial statements.

[1] From the Medical Board's website: http://mbc.ca.gov/
[2] Ibid

- Compared the appropriated and actual revenues, expenditures, and fund balances as reported in the Governor's Budgets for a ten year period ending June 30, 2011.
- Reviewed the Board's projections through June 30, 2015 to identify any significant changes in projected revenues, expenditures, or fund balance.
- Assessed the status of Board programs under development.
- Reviewed year-end fund balances and projections to analyze the months of operating expenditures in reserve.
- Evaluated the impact of the loans through June 30, 2015 by comparing the following:
  - Months of operating expenditures in reserve—with the loans
  - Months of operating expenditures in reserve—without the loans

Except as noted, this audit was conducted in accordance with generally accepted government auditing standards, issued by the Comptroller General of the United States. In connection with this audit, there are certain disclosures required by government auditing standards. Finance is not independent of the Board, as both are part of the State of California's Executive Branch. As required by various statutes within the California Government Code, Finance performs certain management and accounting functions. These activities impair independence. However, sufficient safeguards exist for readers of this report to rely on the information contained herein. This audit was conducted during the period January 2012 through April 2012.

Overall, the Board's revenue projections have generally reflected the actual revenues. However, the authorized appropriations have exceeded actual expenditures an average of $3.7 million per year over the last 10 years. As a result, excess funds accumulated in the Board's fund balance. The Board anticipates that expenditures will exceed revenues in the near future due to the BreEZe information technology system, permanent establishment of the Operation Safe Medicine Unit, and the current recruitment effort to fill vacancies. Descriptions of these anticipated expenditures are included below.

Based on the Board's projections, the Board's operations would not be affected by the $6 million and $9 million loans made from the Fund to the State General Fund until fiscal year 2013-14, at which time it would be below its mandated reserve level.

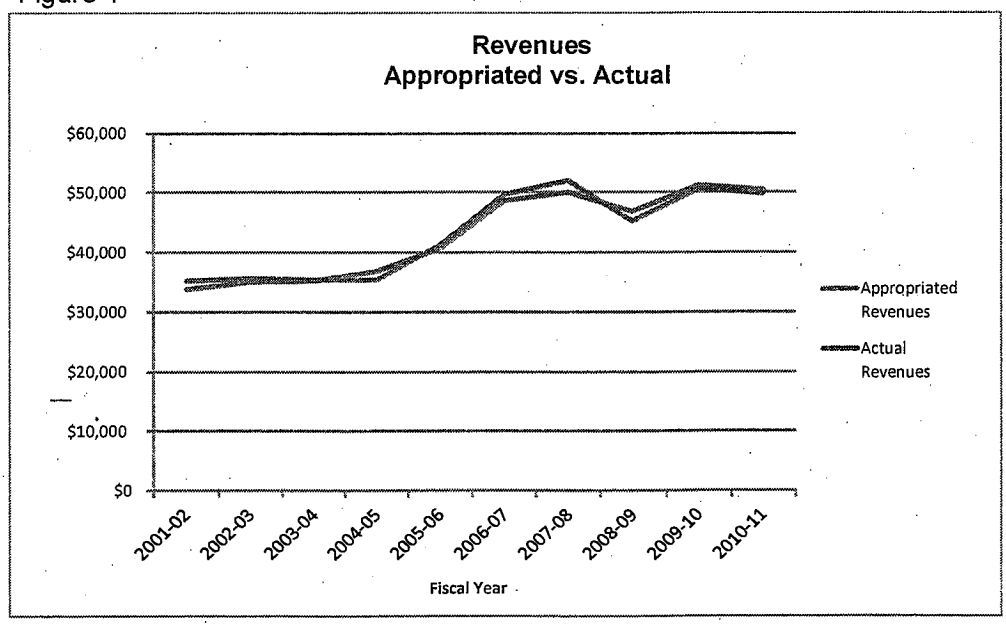
FUND STATUS

Finance compared the appropriated and actual revenues and expenditures during the 10-year period ending June 30, 2011 to determine whether the revenues and expenditures generally reflected the projections. See Appendix A for more information regarding the budget development process.

Revenues

With input from the Board, DCA develops the revenue projections reflected in the Governor's Budget. Over the last 10 years the revenue projections have generally reflected the actual revenues. See Figure 1 below for comparison of the appropriated and actual revenues.

Figure 1

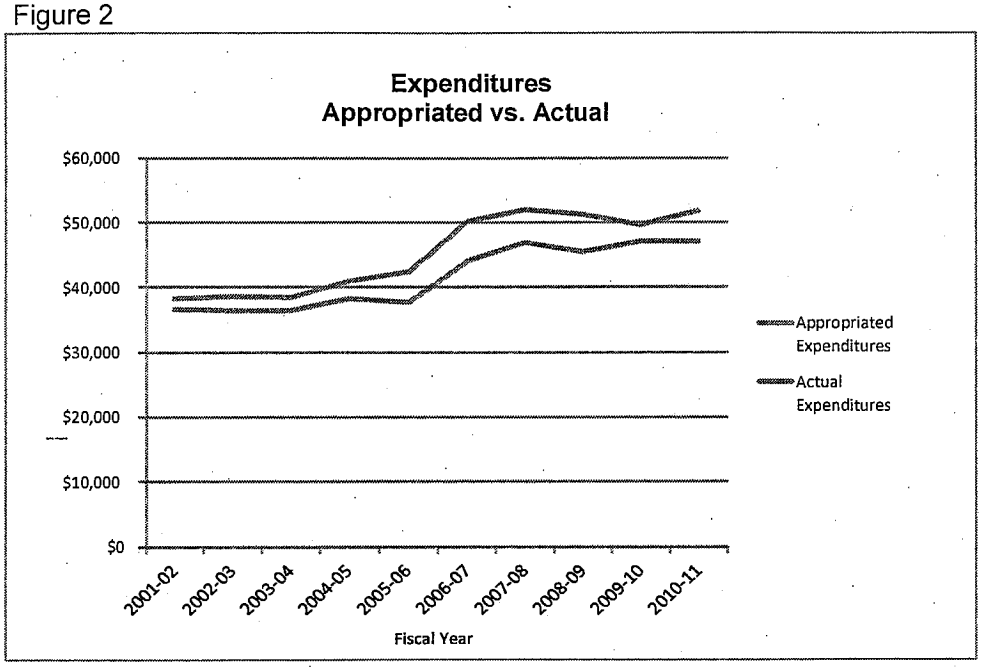


Source: Governor's Budget for fiscal years 2002-03 through 2012-13

Expenditures

The Board's expenditure projection process begins with DCA adjusting the annual Budget Act for Budget Change Proposals, Budget Letters, and other changes authorized by the Department of Finance. For each subsequent year, expenditures have been projected to increase by two percent each year. Over the last 10 years, the Board's actual expenditures were an average of $3.7 million less than the appropriated expenditures each year. The Board indicated that recent statewide hiring freezes combined with a high turnover rate of enforcement staff resulted in a high number of vacant positions, resulting in lower than anticipated expenditures. See Figure 2 for comparison of the appropriated and actual expenditures.

Figure 2



Source: Governor's Budget for fiscal years 2002-03 through 2012-13.

Anticipated Expenditure Increases

The Board expects expenditures to increase due to the following:

- DCA's BreEZe information system.
- Operation Safe Medicine Unit.
- Current recruitment efforts.

BreEZe Information System
DCA is in the process of implementing the BreEZe information system to be used by all of DCA's boards and bureaus for tracking licensing and enforcement activities. Subsequent to June 30, 2011, DCA obtained authorizations for the Board's portion of these costs of $200,000 and $1.3 million for fiscal years 2011-12 and 2012-13, respectively. DCA will seek to obtain approval of the ongoing BreEZe costs estimated to be $1.3 million.

Operation Safe Medicine Unit
Operation Safe Medicine enables the Board to fulfill its enforcement mandate through the investigation of complaints of unlicensed medical activity. The Board received authorization from the Department of Finance to permanently establish the Operation Safe Medicine Unit

effective July 1, 2012. The Board will redirect current resources to fund the six approved positions. Beginning 2012-13, the Board projects yearly costs of approximately $583,000.

Recruitment Efforts
The Board indicated that it is actively recruiting and in the process of filling all vacant positions.

If costs related to BreEZe and Operation Safe Medicine are incurred as projected and the Board fills its vacancies, the Board's expenditures will likely reflect the projected expenditures through 2014-15.

Fund Balance

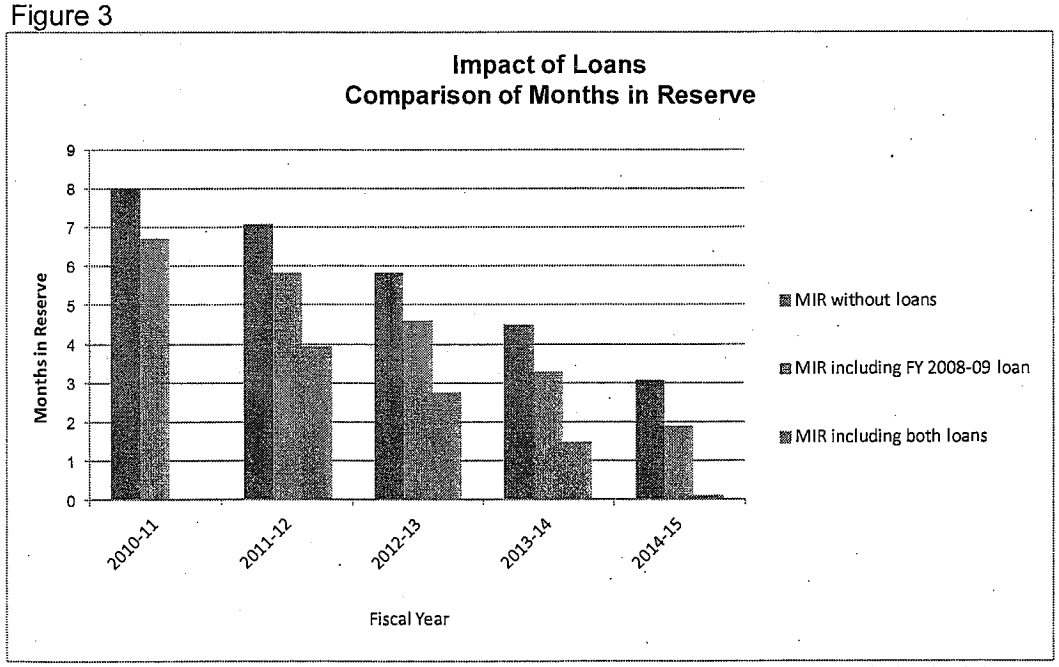
The fund balance, also referred to as the reserve, displays the resources available to sustain the Board's current operations. Per California Business and Professions Code section 2435, the Board is currently required to maintain a reserve level between two to four months of operating expenditures. Since 2001-02, the Board maintained an average of 4.7 months in reserve (MIR). The Board projects the MIR for future years by dividing the projected year-end fund balance by one-twelfth of the subsequent year's projected annual expenditures. See the Impact of the Loans section below for the projected MIRs.

IMPACT OF LOANS

Two loans of $6 million and $9 million were made from the Fund to the General Fund per the 2009 and 2011 Budget Acts, respectively. Figure 3 illustrates the actual impact of the loan for fiscal year 2010-11 and projected impact of both loans for 2011-12 through 2014-15 as follows:

- MIR without loans
- MIR with the $6 million loan
- MIR with both loans totaling $15 million

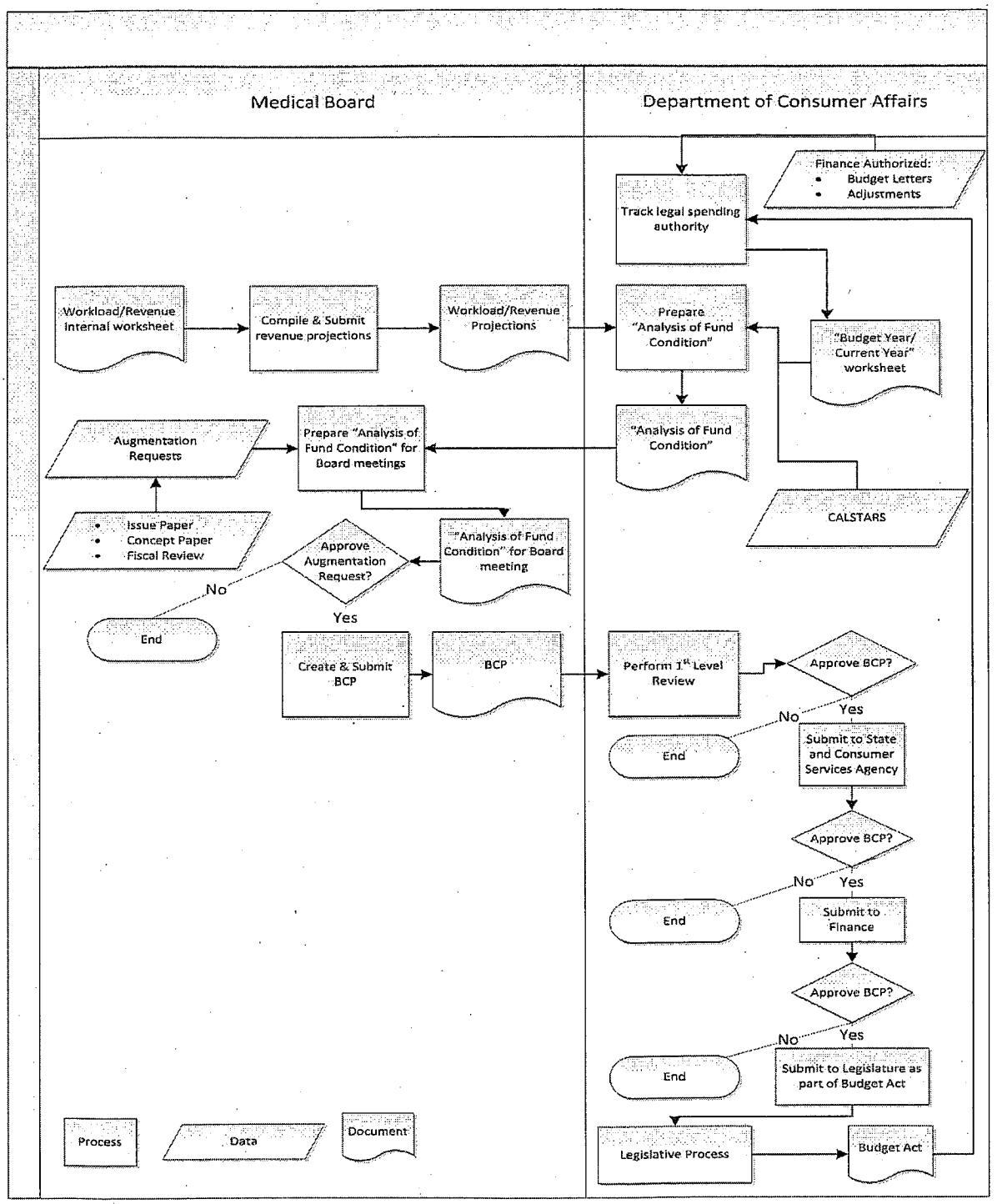
Figure 3



Source: Board Analysis of Fund Condition report, dated October 26, 2011, which includes both loans, and anticipated expenditures noted in the Anticipated Expenditure Increases section of this report.
Note: The yellow bar (between two and four months) highlights the Board's mandated level of reserve.

Currently, the loans have not impacted the Board's ability to operate. However, if the loans are not repaid and the anticipated increase in expenditures occurs, the MIR will fall below the minimum mandated reserve level of two months of operating expenditures in 2013-14. If the loans are not fully repaid, are partially repaid, or the anticipated increase in expenditures do not occur, the MIR will be impacted accordingly.

MEDICAL BOARD OF CALIFORNIA'S BUDGET PROCESS



MEDICAL BOARD OF CALIFORNIA
Executive Office

May 16, 2012

David Botelho, CPA, Chief
Office of State Audits & Evaluations
915 L Street, Suite 801
Sacramento, CA 95814

RE: Draft Report – Medical Board of California Financial Status

Dear Mr. Botelho:

The Medical Board of California (Board) is in receipt of your draft report dated April 2012 entitled "Medical Board of California Financial Status as of June 30, 2011". The Board would like to thank you for conducting this audit and for providing this report.

As stated in the report, the Board was mandated to be audited by the Department of Finance pursuant to California Business and Professions Code section 2435, which states:

> *Not later than January 1, 2012, the Office of State Audits and Evaluations within the Department of Finance shall commence preliminary review of the board's financial status, including, but not limited to, its projections related to expenses, revenues, and reserves, and the impact of the loan from the Contingent Fund of the Medical Board of California to the General Fund made pursuant to the Budget Act of 2008.*

Based upon requests from the audit team, the Board and the Department of Consumer Affairs provided the fiscal documents and information that assisted in the preparation of this draft report. The draft report has accurately captured the information provided and the mandate of the legislature.

The Board would like to thank the audit team for their professionalism during this process and appreciates the thoroughness of the team's work.

Sincerely,

Linda K. Whitney
Executive Director

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • GOVERNOR EDMUND G. BROWN JR.
ADMINISTRATIVE AND INFORMATION SYSTEMS DIVISION
OFFICE OF ADMINISTRATION, BUDGET OFFICE
1625 N. Market, Suite S-103 Sacramento, CA 95834
P 916-574-7177 F 916-574-8660

MEMORANDUM

DATE	May 24, 2012
TO	David Botelho, CPA Chief, Office of State Audits and Evaluations
FROM	Taylor Schick, Budget Officer Department of Consumer Affairs
SUBJECT	**RESPONSE TO DOF DRAFT REPORT OF THE MEDICAL BOARD OF CALIFORNIA FINANCIAL STATUS**

The Department of Consumer Affairs (Department) Budget Office is submitting this memo in response to the Office of State Audits and Evaluations (OSAE) May 10, 2012 Draft Report of the Medical Board of California (MBC) Financial Status. The Budget Office has concerns with some of the terminology used in the report. These concerns are outlined below and are mainly focused on the use of the term "expenditure projections" where we believe different terms would be more appropriate. (headlines correspond to sections of the draft report)

Methodology

"expenditure projections have exceeded actual expenditures an average of $3.7 million per year over the last 10 years"

The term "expenditure projections" is more accurately referred to as "authorized appropriations". It is assumed the point is to address a comparison between authorized appropriations and actual expenditures.

Expenditures

"Expenditure projections are initially developed by DCA based on spending authority in the annual Budget Act with adjustments made for Budget Change Proposals, Budget Letters, and other changes authorized by the Department of Finance. For each subsequent year, expenditures have been projected to increase by two percent each year."

Again, the term "expenditure projections" is more accurately referred to as "authorized appropriations". Additionally, the "authorized appropriations" are not "initially developed" but rather "adjusted" by DCA.

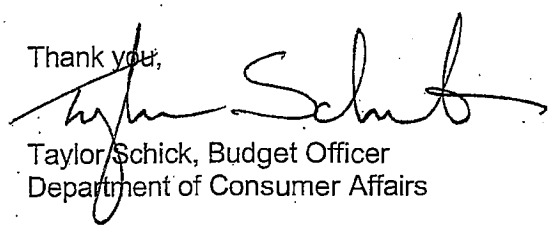
The reference to expenditures projected to increase by two percent each year refers only to internal fund condition scenarios. The only 'official' fund condition would be as it is reflected in each year's Proposed Governor's Budget, and would include only prior year actual expenditures, current year authorized, and budget year proposed.

"If costs related to BreEZe and Operation Safe Medicine are incurred as projected and the Board fills its vacancies, the Board's expenditures will likely reflect the projected expenditures through 2014-15."

The term "projected expenditures" should be replaced with "authorized appropriation".

We ask that our concerns be noted and that revisions are considered prior to public release. Please contact me at 916-574-7177 with any questions.

Thank you,



Taylor Schick, Budget Officer
Department of Consumer Affairs

cc: Jennifer Osborn, Deputy Secretary, Fiscal Operations, State and Consumer Services Agency
Kim Kirchmeyer, Deputy Director, Medical Board of California
Denise Brown, Director, Department of Consumer Affairs
Awet Kidane, Chief Deputy Director, Department of Consumer Affairs
Reichel Everhart, Deputy Director, Board and Bureau Relations, Department of Consumer Affairs
Sandra Mayorga, Deputy Director, Office of Administrative Services, Department of Consumer Affairs
Ms. Janice Shintaku, Fiscal Officer, Department of Consumer Affairs

EVALUATION OF RESPONSE

The Department of Finance, Office of State Audits and Evaluations reviewed the draft report responses from the Medical Board of California, dated May 16, 2012, and the Department of Consumer Affairs (DCA), dated May 24, 2012. In response to DCA's concern regarding some terminology, we revised the report as follows:

- Results Section - In the first paragraph, the term expenditure projections was changed to authorized appropriations.

- Expenditures Section - The expenditure projection process was clarified in the first paragraph.

For the Anticipated Expenditure Increases section, the terminology remains as projected expenditures instead of the term authorized appropriations suggested by DCA. This portion of the report discusses expenditure projections beyond the proposed budget which are not authorized appropriations.

STATE AND CONSUMER SERVICES AGENCY - *Department of Consumer Affairs* Edmund G. Brown, Jr., *Governor*

MEDICAL BOARD OF CALIFORNIA
Executive Office

PROPOSED BOARD MEETING DATES FOR 2013

January 31-February 1	San Francisco Bay Area
April 25-26 or May 3-4	Los Angeles Area
July 25-26	Sacramento Area
October 24-25 or October 31-November 1	San Diego Area

State Pay Period Calendar for 2013

JANUARY 2013
22 Days 176 Hours

SU	M	TU	W	TH	F	SA
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

FEBRUARY 2013
21 Days 168 Hours

SU	M	TU	W	TH	F	SA
				31	1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28		

MARCH 2013
21 Days 168 Hours

SU	M	TU	W	TH	F	SA
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

APRIL 2013
22 Days 176 Hours

SU	M	TU	W	TH	F	SA
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

MAY 2013
22 Days 176 Hours

SU	M	TU	W	TH	F	SA
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

JUNE 2013
21 Days 168 Hours

SU	M	TU	W	TH	F	SA
					31	1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

JULY 2013
22 Days 176 Hours

SU	M	TU	W	TH	F	SA
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

AUGUST 2013
22 Days 176 Hours

SU	M	TU	W	TH	F	SA
			31	1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29		

SEPTEMBER 2013
22 Days 176 Hours

SU	M	TU	W	TH	F	SA
					30	31
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

OCTOBER 2013
22 Days 176 Hours

SU	M	TU	W	TH	F	SA
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

NOVEMBER 2013
22 Days 176 Hours

SU	M	TU	W	TH	F	SA
				31	1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

DECEMBER 2013
22 Days 176 Hours

SU	M	TU	W	TH	F	SA
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

NOTE: Holidays and pay periods may be subject to applicable memoranda of understanding, statutes and regulations.

WORKLOAD REPORT

as of June 30, 2012

CONSUMER INFORMATION UNIT FY 11/12					
	FY 11/12	Q1	Q2	Q3	Q4
Total Calls Answered	**89,497**	15,725	20,456	28,061	25,255
Calls Requesting Call Back	**14,923**	4,647	5,022	3,229	2,025
Calls Abandoned	**13,448**	4,356	4,616	2,657	1,819
Address Changes Completed	**8,894**	3,451	2,133	1,909	1,401

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	**6,629**	1,711	1,666	1,862	1,390
Initial Reviews Completed	**6,729**	1,491	1,689	1,979	1,570
Total Pending	**N/A**	4,012	4,325	4,515	3,823
Reviewed	**N/A**	3,273	3,530	3,928	3,423
Not Reviewed	**N/A**	739	795	587	400
(SR2s Pending)	**N/A**	108	121	124	109
Licenses Issued	**5,351**	1,358	1,203	1,419	1,371
Renewals Issued	**64,351**	16,092	14,067	17,835	16,357

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	**86**	30	12	27	17
PG/Medical Knowledge	**188**	59	40	60	29
Convictions	**100**	43	18	16	23
Other	**179**	92	44	21	22

WORKLOAD REPORT

as of June 30, 2012

FISCAL YEAR 2011-2012

	FY 11/12	Q1	Q2	Q3	Q4
Schools Pending Recognition at Beginning of Quarter	**N/A**	43	62	75	90
Pending Self-Assessment Reports (included above)	**N/A**	3	5	6	7
New Self-Assessment Reports Received	**4**	2	0	1	1
New Unrecognized Schools Received	**102**	22	15	18	47
School Recognized Pursuant to CCR 1314(a)(1)	**47**	4	2	4	37
School Recognized Pursuant to CCR 1314(a)(2)	**1**	1	0	0	0
TOTAL Schools Pending Recognition at End of Quarter	**N/A**	62	75	90	101

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**	0	3	3	10
School Recognized Pursuant to CCR 1314(a)(2)	**2**	0	0	2	0

LICENSED MIDWIVES FY 11/12

	FY 11/12	Q1	Q2	Q3	Q4
Applications Received	**33**	9	5	13	6
Applications Pending	**N/A**	6	3	5	4
Licenses Issued	**31**	4	8	10	9
Licenses Renewed	**125**	24	31	33	37

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	**1,397**	384	380	315	318
P&S - FNP Pending	**N/A**	59	63	72	94
Podiatric FNP Issued	**23**	3	9	7	4
Podiatric FNP Pending	**N/A**	0	0	0	2

FICTITIOUS NAME PERMITS FY 10/11

	FY 10/11	Q1	Q2	Q3	Q4
P&S - FNP Issued	**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

WORKLOAD REPORT

as of June 30, 2012

RESEARCH PSYCHOANALYST FY 11/12					
	FY 11/12	Q1	Q2	Q3	Q4
RP Applications Received	**2**	1	0	1	0
RP Licenses Issued	**4**	3	0	0	1

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	0
Applications Pending	**N/A**	1	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	**48**	10	9	8	21
Pending Applications Business	**N/A**	30	30	18	23
Out-of-State Business Registrations Issued	**1**	0	0	0	1
Pending Applications Out of State Bus.	**N/A**	0	0	0	1
Spectacle Lens Registrations Issued	**192**	47	29	72	44
Pending Applications-Spectacle Lens	**N/A**	78	107	29	57
Contact Lens Registrations Issued	**85**	13	11	43	18
Pending Applications-Contact Lens	**N/A**	22	33	15	18
Spectacle Lens Registrations Renewed	**991**	216	217	276	282
Contact Lens Registrations Renewed	**420**	95	79	112	134

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

WORKLOAD REPORT

as of June 30, 2012

POLYSOM FY 11/12 **					
	FY 11/12	Q1	Q2	Q3	Q4
Polysomnographic Trainee Applications Received	**0**	0	0	0	0
Polysomnographic Technician Applications Received	**1**	0	0	0	1
Polysomnogrpahic Technologist Applications Received	**29**	0	0	0	29

** Program began accepting applications April of 2012

WORKLOAD REPORT

as of June 30, 2012

SPECIAL PROGRAMS FY 11/12

Permit	Applications Received				Applications Reviewed				Permits Issued				Permits Renewed				Total Pending				Applications Withdrawn or Denied			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2111	8	2	3	11	9	5	3	9	3	7	2	5	5	2	3	3	10	15	10	16	0	0	1	0
2112	0	0	0	1	0	0	0	1	1	0	0	1	0	0	0	0	1	1	1	1	0	0	0	0
2113	5	6	9	6	5	8	9	6	14	4	4	7	6	11	14	7	8	10	14	13	0	0	1	0
2168	3	0	1	1	1	1	1	1	0	2	0	0	3	0	1	1	3	1	2	3	0	0	0	0
2072	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1327	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0

SPECIAL PROGRAMS FY 10/11

Permit	Applications Received				Applications Reviewed				Permits Issued				Permits Renewed				Total Pending				*Applications Withdrawn or Denied			
	Q1	Q2	Q3	Q4	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)

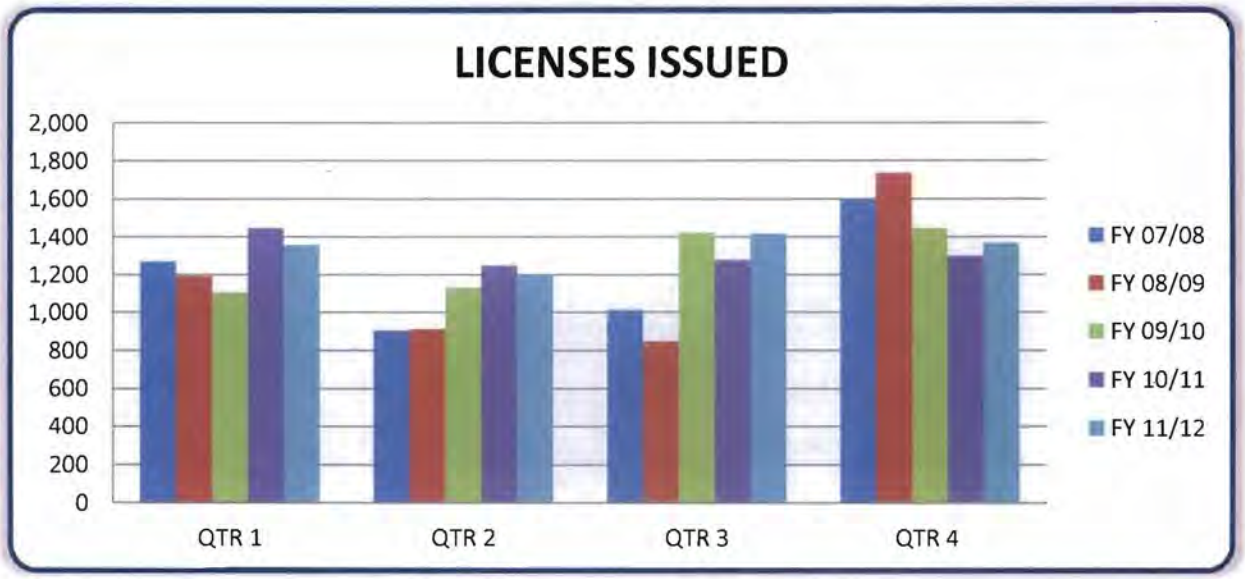
2072 - Special Permit - Correctional Facility

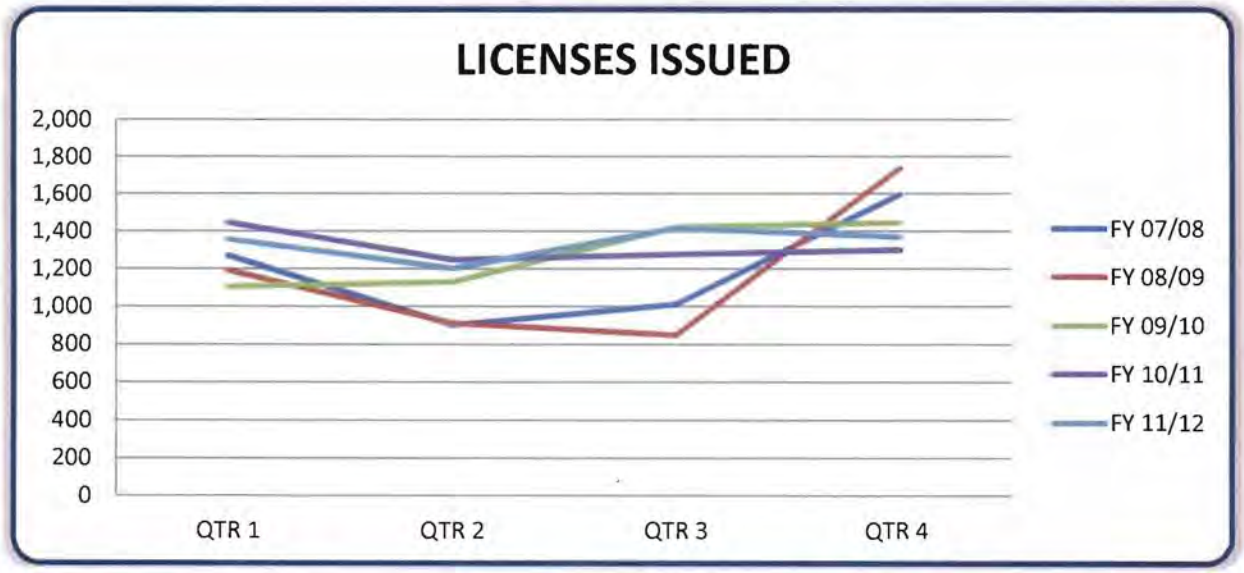
1327 - Medical Student Rotations - Non-ACGME Hospital Rotation

* Information not available FY 2010/2011

PHYSICIAN'S AND SURGEON'S LICENSES ISSUED
Five Fiscal Year History

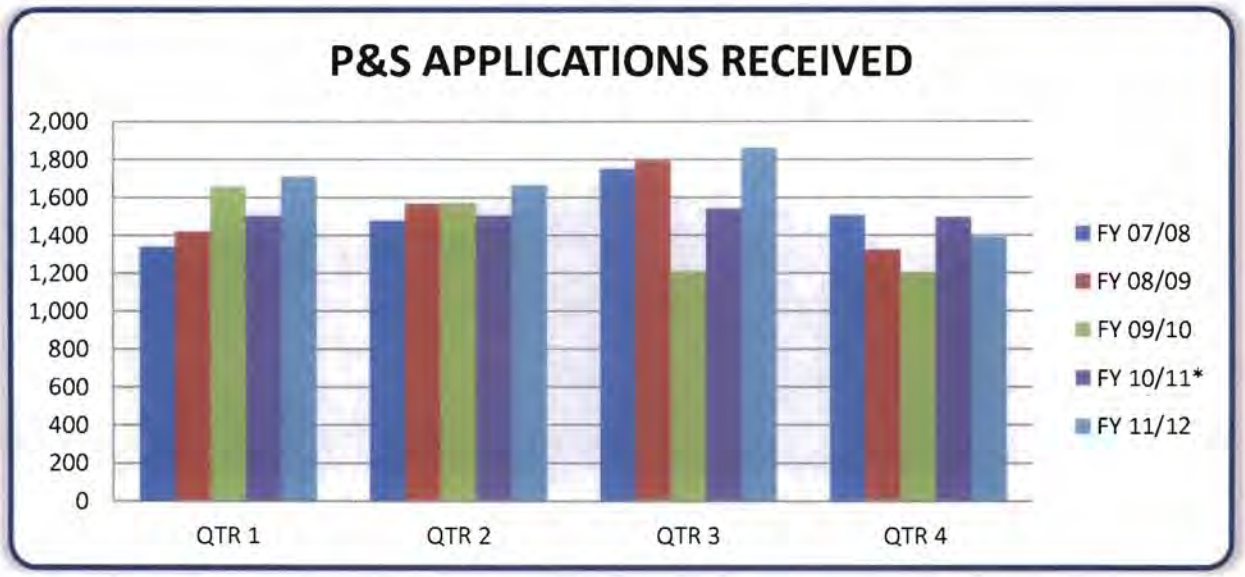
Fiscal Year	QTR 1	QTR 2	QTR 3	QTR 4	TOTAL
FY 11/12	1,358	1,203	1,419	1,371	***5,351***
FY 10/11	1,447	1,248	1,277	1,300	***5,272***
FY 09/10	1,107	1,132	1,424	1,447	***5,110***
FY 08/09	1,192	912	849	1,735	***4,688***
FY 07/08	1,271	904	1,014	1,598	***4,787***

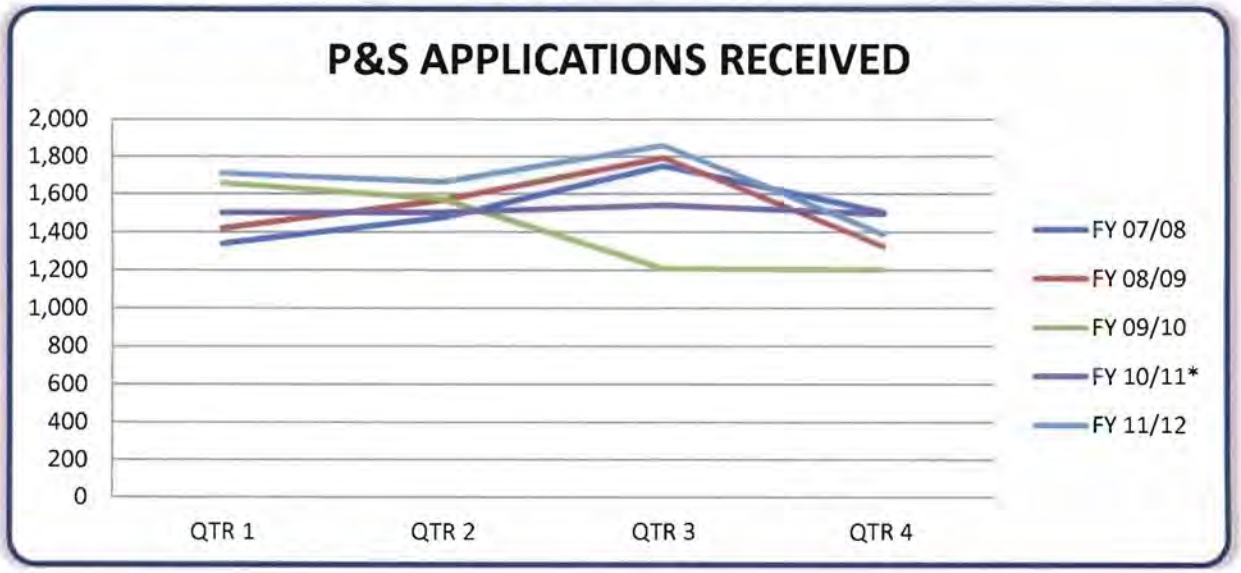




*PHYSICIAN'S AND SURGEON'S LICENSE AND PTAL APPLICATIONS RECEIVED Five Fiscal Year History					
Fiscal Year	**QTR 1**	**QTR 2**	**QTR 3**	**QTR 4**	**TOTAL**
FY 11/12	1,711	1,666	1,862	1,390	***6,629***
FY 10/11*	1,503	1,505	1,543	1496	***6,047***
FY 09/10	1,658	1,573	1,211	1,203	***5,645***
FY 08/09	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 June 30, 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**	1	6	2	0
Number of Week Per Quarter / Total Weeks	**52**	13	13	13	13
Highest # of Days Initial Review Goal Exceeded	**N/A**	3	7	5	0

PHYSICIAN'S AND SURGEON'S APPLICATIONS RECEIVED AND LICENSES ISSUED

Fiscal Year - 2011/2012

2011 - 2012 -->	Applications Received (License & PTAL)					Percentage				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
US/CAN	984	1,196	1,300	794	4,274	57.51%	71.79%	69.82%	57.12%	64.47%
IMG - License	271	243	337	352	1,203	15.84%	14.59%	18.10%	25.32%	18.15%
IMG - PTAL	456	227	225	244	1,152	26.65%	13.63%	12.08%	17.55%	17.38%
TOTAL	1,711	1,666	1,862	1,390	6,629	100.00%	100.00%	100.00%	100.00%	100.00%

2011 - 2012 -->	Licenses & PTAL Issued					Percentage				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
US/CAN	969	888	1,131	1,023	4,011	71.35%	73.82%	79.70%	74.62%	74.96%
IMG - License	389	315	288	348	1,340	28.65%	26.18%	20.30%	25.38%	25.04%
TOTAL	1,358	1,203	1,419	1,371	5,351	100.00%	100.00%	100.00%	100.00%	100.00%
Total PTAL Issued	338	349	204	324	1,215					

Fiscal Year - 2010/2011

2010 - 2011 -->	Applications Received (License & PTAL)					Percentage				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
US/CAN	899	1,056	1,104	814	3,873	59.81%	70.17%	71.55%	59.72%	65.49%
IMG - License	202	192	250	226	870	13.44%	12.76%	16.20%	16.58%	14.71%
IMG - PTAL	402	257	189	323	1,171	26.75%	17.08%	12.25%	23.70%	19.80%
TOTAL	1,503	1,505	1,543	1,363	5,914	100.00%	100.00%	100.00%	100.00%	100.00%

2010 - 2011 -->	Licenses & PTAL Issued					Percentage				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
US/CAN	1,094	898	968	964	3,924	75.60%	71.96%	75.80%	74.15%	74.43%
IMG - License	353	350	309	336	1,348	24.40%	28.04%	24.20%	25.85%	25.57%
TOTAL	1,447	1,248	1,277	1,300	5,272	100.00%	100.00%	100.00%	100.00%	100.00%
Total PTAL Issued	472	417	261	306	1,456					

REQUESTS FOR NEW SCHOOL CODES
IMG Applicants

COUNTRY	Medical School Name	Date Request Received	Letter Mailed to Medical School	Medical School Response	Status of Application	CCR 1314.1(a)(1)	Chief & Legal Approval (Per CCR 1314.1(a)(1)	Self Assessment Report Received	CCR 1314.1(a)(2)	Comments/Decision
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).
Australia	Bond University Faculty of Health Sciences and Medicine	2/16/2012	4/4/2012 5/17/2012	5/3/2012	Recognized	X	6/19/2012			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Australia	Griffith University School of Medicine	4/18/2012	5/8/2012		Pending	?			?	Letter sent on 5/8/12 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	?		1/17/2012	?	Staff needs to review Self-Assessment Report
Australia	University of Notre Dame Australia School of Medicine, Fremantle	2/16/2012	4/4/2012	6/11/2012	Recognized	X	6/19/2012			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Austria	Medical University of Innsbruck	6/2/2011	3/27/2012	5/7/2012	Recognized	X	5/15/2012			Verified medical school is eligible 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 6/19/2012	5/29/2012	Pending	?			?	Additional information requested from school on 6/19/2012.
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).
Bolivia	Universidad Privada del Valle Facultad de Ciencias de la Salud	5/2/2012	5/9/2012 5/29/2012	5/18/2012	Pending				X	School informed on 5/29/12 they will need to submit Self-Assessment Report since the school is a private, for profit university.
Brazil	Centro Universitario Serra dos Orgaos Faculdaded Unificadas (UNIFESO)	1/4/2012	3/12/2012	5/3/2012	Recognized	X	6/5/2012			Verified medical school is eligible 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 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).

REQUESTS FOR NEW SCHOOL CODES
IMG Applicants

COUNTRY	Medical School Name	Date Request Received	Letter Mailed to Medical School	Medical School Response	Status of Application	CCR 1314.1(a)(1)	Chief & Legal Approval (Per CCR 1314.1(a)(1)	Self Assessment Report Received	CCR 1314.1(a)(2)	Comments/Decision
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	Capital University of Medicine	5/14/2012	5/18/2012		Pending	?			?	Letter sent on 5/18/12 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	5/24/2012	Recognized	X	6/5/2012			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
China	Nanjing Medical University	6/5/2012	6/191/2012		Pending	?			?	Letter sent on 6/19/12 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 5/17/2012	4/21/2012 5/9/2012	Recognized	X	6/5/2012			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
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 5/17/2012	3/20/2012	Recognized	X	6/5/2012			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
China	Tianjin Medical University	7/19/2011	3/15/2012 5/17/2012	3/20/2012	Recognized	X	6/5/2012			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1)
China	Tongji Medical College of Huazhong University of Science and Technology	8/31/2011	3/8/2012 6/11/2012	6/4/2012 6/19/2012	Recognized	X	6/28/2012			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
China	Xi'an Jiaotong University College of Medicine	6/21/2010	4/9/2012		Pending	?			?	Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
China	XinXiang Medical College	1/13/2012	3/30/2012	4/19/2012	Recognized	X	4/26/2012			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Dominican Republic	Universidad Iberoamericana (UNIBE)	08/22/2008	3/12/2012		Pending			8/22/2008	X	Additional information was requested from UNIBE on 3/12/12 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		Recognized	X	4/19/2012			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).

REQUESTS FOR NEW SCHOOL CODES
IMG Applicants

COUNTRY	Medical School Name	Date Request Received	Letter Mailed to Medical School	Medical School Response	Status of Application	CCR 1314.1(a)(1)	Chief & Legal Approval (Per CCR 1314.1(a)(1)	Self Assessment Report Received	CCR 1314.1(a)(2)	Comments/Decision
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	October 6 University, Faculty of Medicine	9/27/2011			Pending	?		9/26/2011	?	Staff needs to review Self-Assessment Report
Egypt	Tanta University Faculty of Medicine	6/8/2012	6/26/2012		Pending	?			?	Letter sent on 6/26/12 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).
El Salvadore	Universidad Evengelica de El Salvadore, Faculty of Medicine	6/6/2012	6/19/2012		Pending	?			?	Letter sent on 6/19/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
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).
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	5/30/2012	Recognized	X	6/5/2012			Verified medical school is eligible 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	6/1/2011			Verified medical school 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	6/1/2011			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
India	Dr. Bhim Rao Ambedkar University, Agra, Subharati Medical College / Swami Vivekanand Subharti University, Subharti Medical College	7/25/2011	3/8/2012 5/1/2012	4/25/2012 6/25/2012	Recognized	X	6/26/2012			Verified medical school is eligible 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	Madurai Kamaraj University, Madurai Medical College	4/12/12	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).
India	Maharashtra University of Health Sciences, Lokmanya Tilak Municipal Medical College	8/26/2011	3/8/2012	4/13/2012	Recognized	X	4/27/2012			Verified medical school 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	4/9/2012	Recognized	X	4/27/2012			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).

REQUESTS FOR NEW SCHOOL CODES
IMG Applicants

COUNTRY	Medical School Name	Date Request Received	Letter Mailed to Medical School	Medical School Response	Status of Application	CCR 1314.1(a)(1)	Chief & Legal Approval (Per CCR 1314.1(a)(1)	Self Assessment Report Received	CCR 1314.1(a)(2)	Comments/Decision
India	Maharashtra University of Health Sciences, Shri Bhausahab Hire Government Medical College		5/1/2012		Pending	?			?	Letter sent on 5/1/12 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	6/25/2012	Pending	?			?	Initial review completed by staff on 6/25/2012. Chief and Legal counsel need to review information submitted by school.
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	Mahatma Gandhi University, Pushpagiri Institute of Medical Sciences / Kerala University of Health and Applied Sciences, Thrissur, Pushpagiri Institute of Medical Sciences	4/12/2012	4/13/2012	5/11/2012	Recognized	5/5/2012	6/5/2012			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
India	NTR University of Health Sciences, Chalmeda Anand Rao Institute of Medical Sciences	5/21/2012	6/6/2012		Pending	?			?	Letter sent on 6/6/12 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	4/26/2012	Recognized	X	5/15/2012			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
India	NTR University of Health Sciences, M.N.R. Medical College and Hospital	4/16/2012	4/30/2012	6/2/2012	Pending	X	6/5/2012			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
India	NTR University of Health Sciences, Osmania Medical College	3/30/2012	4/11/2012 6/11/2012		Pending	?			?	Letter sent on 4/11/12 and resent on 6/11/12 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 4/18/2012	4/18/2012	Pending	?			?	Additional information requested from school on 4/30/12.
India	NTR University of Health Sciences, Sri Venkateswara Medical College, Vijayawada	2/7/2012	4/5/2012	4/4/2012	Recognized	x	4/27/2012			Verified medical school is eligible 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).
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, Al-Ameen Medical College	3/28/2012	4/30/2012		Pending	?			?	Letter sent on 4/30/12 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).

REQUESTS FOR NEW SCHOOL CODES
IMG Applicants

COUNTRY	Medical School Name	Date Request Received	Letter Mailed to Medical School	Medical School Response	Status of Application	CCR 1314.1(a)(1)	Chief & Legal Approval (Per CCR 1314.1(a)(1)	Self Assessment Report Received	CCR 1314.1(a)(2)	Comments/Decision
India	Rajiv Gandhi University of Health Sciences, Sri Siddhartha Medical College	4/20/2012	4/30/2012		Pending	?			?	Letter sent on 4/30/12 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	5/7/2012	Recognized	X	6/19/2012			Verified medical school is eligible 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	5/2/2012	Recognized	X	5/8/2012			Verified medical school 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).
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	6/28/2011			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
India	Tamil Nadu Dr. M.G.R. Medical University Tirunelveli Medical College	4/19/2012	4/30/2012		Pending	?			?	Letter sent on 4/30/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	University of Kashmie, Jehlum Valley College of Medical Sciences	8/10/2011	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	West Bengal University of Health Sciences, Nilratan Sircar Medical College	7/19/2011	4/5/2012		Pending	?			?	Letter sent on 4/5/12 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	Tabriz University of Medical Sciences	6/4/2012	6/19/2012		Pending	?			?	Letter sent on 6/19/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
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).

REQUESTS FOR NEW SCHOOL CODES
IMG Applicants

COUNTRY	Medical School Name	Date Request Received	Letter Mailed to Medical School	Medical School Response	Status of Application	CCR 1314.1(a)(1)	Chief & Legal Approval (Per CCR 1314.1(a)(1)	Self Assessment Report Received	CCR 1314.1(a)(2)	Comments/Decision
Iraq	University of Baghdad, Alkindy College of Medicine	6/6/2012	6/19/2012		Pending	?			?	Letter sent on 6/19/12 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	University of Limerick Graduate Entry Medical School	4/25/2012	4/30/2012		Pending	?			?	Letter sent on 4/30/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Italy	Universita degli Studi di Milano Bicocca Faculty of Medicine and Surgery	9/9/2011	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	Ehime University School of Medicine	6/8/2012	6/19/2012		Pending	?			?	Letter sent on 6/19/12 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	4/20/2011	Recognized	X	4/28/2011			Verified medical school is eligible 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 6/26/2012	6/5/2012	Pending	?			?	Additional information requested from school.
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).
Kenya	Moi University College of Health Sciences, School of Medicine	5/22/2012	6/6/2012		Pending	?			?	Letter sent on 6/6/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Libya	Benghazi Medical University	6/20/2012	6/26/2012		Pending	?			?	Letter sent on 6/26/12 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).

REQUESTS FOR NEW SCHOOL CODES
IMG Applicants

COUNTRY	Medical School Name	Date Request Received	Letter Mailed to Medical School	Medical School Response	Status of Application	CCR 1314.1(a)(1)	Chief & Legal Approval (Per CCR 1314.1(a)(1)	Self Assessment Report Received	CCR 1314.1(a)(2)	Comments/Decision
Malaysia	University Sains Malaysia School of Medical Sciences	6/15/2012	6/26/2012		Pending	?			?	Letter sent on 6/26/12 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	6/26/2012	Pending	?			?	Staff completed initial review. Additional information requested from school on 6/28/12.
Mexico	Centro de Estudios Universitarios Xochicalco, Escuela de Medicina Tijuana	3/8/2012	4/30/2012	5/7/2012	Recognized	X	6/28/2012			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Myanmar	University of Medicine, Mandalay	4/19/2012	5/8/2012	6/25/2012	Recognized	X	6/28/2012			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Nepal	Kathmandu University, College of Medical Sciences, Bharatpur	8/12/2011	3/9/2012	5/7/2012	Recognized	X	5/15/2012			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Nepal	Kathmandu University, Kathmandu Medical College	6/4/2012	6/7/2012	6/19/2012	Pending	?			?	Staff completed initial review on 6/25/2012. Chief and legal counsel need to review information submitted by school.
Nepal	Universal College of Medical Sciences, Paklihawa Campus	7/15/2011			Pending	?		7/15/2011	?	Staff needs to review Self-Assessment Report
Netherlands	Leiden University Medical Center	3/15/2012		3/22/82012	Recognized	X	4/26/2012			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Neves	Medical University of the Americas	3/19/2012			Pending			3/19/2012	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 eligibilty 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	5/21/2012	Recognized	X	6/5/2012			Verified medical school is eligible 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	5/31/2012	Recognized	X	6/5/2012			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Pakistan	Dow University of Health Sciences, Sindh Medical College	2/7/2012	4/5/2012	5/31/2012	Recognized	X	6/5/2012			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Pakistan	Foundation University Medical College				Pending	?		5/29/2012	?	Staff needs to review Self-Assessment Report

REQUESTS FOR NEW SCHOOL CODES
IMG Applicants

COUNTRY	Medical School Name	Date Request Received	Letter Mailed to Medical School	Medical School Response	Status of Application	CCR 1314.1(a)(1)	Chief & Legal Approval (Per CCR 1314.1(a)(1)	Self Assessment Report Received	CCR 1314.1(a)(2)	Comments/Decision
Pakistan	Karachi Medical and Dental College, University of Karachi Faculty of Medicine	4/9/2012	4/10/2012	5/30/2012	Recognized	X	6/5/2012			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Pakistan	King Edward Medical University	5/11/2011	1/14/2012	1/28/2012	Recognized	X	4/3/2012			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Pakistan	National University of Sciences & Technology, Army Medical College	4/20/2012	5/18/2012		Pending	?			?	Letter sent on 5/18/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Pakistan	University of Health Sciences Lahore, Nishtar Medical College and Hospital (NMCH)	9/1/2010	5/17/2011 5/21/2012	7/19/2011	Pending	?			?	Letter sent on 5/21/12 requesting additional information from school.
Pakistan	University of Health Sciences, Lahore, Punjab Medical College	5/31/2012	6/6/2012		Pending	?			?	Letter sent on 6/6/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Pakistan	University of Health Sciences Lahore, Quaid-E-Azam Medical College	1/24/2012	3/20/2012	4/23/2012	Recognized	X	4/27/2012			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Pakistan	University of the Punjab, Fatima Jinnah Medical College for Women		6/26/2012		Pending	?			?	Letter sent on 6/26/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Philippines	De La Salle Health Sciences Institute College of Medicine	5/18/2012	5/18/2012	6/25/2012	Recognized	X	6/28/2012			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Poland	Medical University of Bialystok	1/4/2012	3/12/2012 5/22/2012	5/16/2012 6/20/2012	Recognized	X	6/28/2012			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Poland	Medical University of Warsaw English Language Program		3/12/2012		Pending			4/15/2010	X	Additional information was requested on 3/12/12 based on medical consultant's review of self-assessment report.
Poland	Wroclaw University Faculty of Medicine	6/21/2012	6/26/2012		Pending	?			?	Letter sent on 6/26/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Romania	University of Medicine and Pharmacy in Timisoara (Now known as: Universitatea de Medicina si Farmacie Victor Babes)	5/1/2012	5/29/2012 6/11/2012	6/8/2012 6/18/2012	Recognized	X	6/19/2012			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Russia	Moscow State University of Medicine & Dentistry	3/20/2012	3/27/2012		Recognized	X	5/15/2012			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Russia	Novosibirsk State Medical Academy	2/7/2012	3/27/2012		Recognized	X	5/1/2012			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Russia	Volgograd State Medical University	5/21/2012	6/6/2012		Pending	?			?	Letter sent on 6/6/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).

REQUESTS FOR NEW SCHOOL CODES
IMG Applicants

COUNTRY	Medical School Name	Date Request Received	Letter Mailed to Medical School	Medical School Response	Status of Application	CCR 1314.1(a)(1)	Chief & Legal Approval (Per CCR 1314.1(a)(1)	Self Assessment Report Received	CCR 1314.1(a)(2)	Comments/Decision
Russia	Yaroslavl State Medical Academy	5/10/2011	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).
Senegal	Cheikh Anta Diop University, Faculty of Medicine, Pharmacy and Odontology	3/27/2012	5/18/2012		Pending	?			?	Letter sent on 5/18/12 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	6/20/2012	Pending	?			?	Initial review completed by staff. Chief and Legal Counsel need to review information from schoo.l
South Korea	Catholic University of Korea College of Medicine	6/30/2011	3/9/2012	3/26/2012	Recognized	X	4/3/2012			Verified medical school 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	5/16/2011	Recognized	X	5/17/2011			Verified medical school is eligible 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 6/19/2012	6/13/2012	Pending	?			?	Letter sent on 6/19/12 requesting additional information from school.
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).
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).
Taiwan	Taipei Medicine University, School of Medicine	5/10/2012	5/18/2012		Pending	?			?	Letter sent on 5/18/12 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		4/21/2011	Recognized	X	4/28/2011			Verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Turkey	Gulhane Asken Tip Akademisi (Gulhane Medical Military Academy)	4/12/2012	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).

REQUESTS FOR NEW SCHOOL CODES
IMG Applicants

COUNTRY	Medical School Name	Date Request Received	Letter Mailed to Medical School	Medical School Response	Status of Application	CCR 1314.1(a)(1)	Chief & Legal Approval (Per CCR 1314.1(a)(1)	Self Assessment Report Received	CCR 1314.1(a)(2)	Comments/Decision
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).
Ukraine	Vinnica State Medical University	5/16/2012	5/18/2012		Pending	?			?	Letter sent on 5/18/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Uzbekistan	M.I. Kalinin Andizhan State Medical Institute	6/12/2012	6/26/2012		Pending	?			?	Letter sent on 6/26/12 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	5/7/2012	Recognized	X	5/16/2012			Verified medical school is eligible 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).

2065/2066 GME OUTREACH STATISTICS

As of July 11, 2012

Hospitals Participating	40 (four new participants)
Applicants Submitted by Hospital	1016
Applicants Submitted by Analyst	52
Total applicants on Matrix (includes applicants removed)	1068
Applicants removed from programs	51
Total applicants on Matrix	1017
Applications Received	1014
Applications NOT Received	3
Applications Reviewed	1014
Licensed	937
SR1 Total	19
SR1 Pending	4
SR2 Total	14
SR2 Pending	7
Awaiting Birth Month for Licensure	0
IMG applicants	142
US applicants	875

COMPARISON OF HISTORICAL, CURRENT AND GOAL DATA MARKERS

MILESTONE	FY 08/09	FY 09/10	FY 10/11	GOAL Set 7/08
Complete complaint unit processing	75	76	74	90
Complete the investigation	349	328	312	275
Complete the accusation	103	106	107	60
Complete the administrative hearing and adopt proposed decision/stipulation	381	368	417	240
Total time for discipline from receipt of complaint through adjudication	908	878	910	655

Medical Board of California
Expert Reviewer Program Report

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

July 2, 2012

SPECIALTY	Number of cases reviewed/sent to Experts (Jan-June, 2012)	Number of Experts used and how often utilized (Jan-June, 2012)	Active List Experts 944↓
ADDICTION	12	**5 EXPERTS** 3 LIST EXPERTS REVISED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 6 CASES* (*involved companion cases)	13 ↓
ALLERGY & IMMUNOLOGY (A&I)	1	**1 EXPERT** 1 LIST EXPERT	5 ↓
ANESTHESIOLOGY (Anes)	14	**13 EXPERTS** 12 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 5 CASES* (*involved companion cases)	66 ↓
COLON & RECTAL SURGERY (CRS)	1	**1 EXPERT** 1 LIST EXPERT	3 ↓
COMPLEMENTARY/ALTERNATIVE MEDICINE	11	**5 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES	21 ↓
CORRECTIONAL MEDICINE	1	**1 EXPERT** 1 LIST EXPERT	30 ↓
DERMATOLOGY (D)	5	**2 EXPERTS** 1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 4 CASES	10 ↓
EMERGENCY (EM)	3	**3 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE	47 ↓
ETHICS			7
FAMILY (FM)	39	**25 EXPERTS** 14 LIST EXPERTS REVIEWED 1 CASE 7 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES	82 ↓
HAND SURGERY			11
HOSPICE & PALLIATIVE MEDICINE			12

Medical Board of California
Expert Reviewer Program Report

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

July 2, 2012

SPECIALTY	Number of cases reviewed/sent to Experts (Jan-June, 2012)	Number of Experts used and how often utilized (Jan-June, 2012)	Active List Experts 944↓
INTERNAL (General Internal Med)	41	**35 EXPERTS** 30 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 8 CASES* (*involved companion cases)	192 ↓
Cardiovascular Disease (Cv)	16	**13 EXPERTS** 9 LIST EXPERTS REVIEWED 1 CASE 4 LIST EXPERTS REVIEWED 2 CASES	32 ↓
Endocrinology, Diabetes and Metabolism (EDM)	1	**1 EXPERT** 1 LIST EXPERT	8
Gastroenterology (Ge)	5	**3 EXPERTS** 1 LIST EXPERT REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES	14 ↓
Hematology (Hem)	1	**1 EXPERT** 1 LIST EXPERT	4
Infectious Disease (Inf)	2	**2 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE	9 ↓
Medical Oncology (Onc)	4	**2 EXPERTS** 1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES	12
MIDWIFE REVIEWER	2	**1 EXPERT** 1 LIST EXPERT REVIEWED 2 CASES	6 ↓
NEUROLOGICAL SURGERY (NS)	9	**5 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 4 CASES	10 ↓
NEUROLOGY (N)	1	**1 EXPERT** 1 LIST EXPERT	24 ↓
NEUROLOGY with Special Qualifications in Child Neurology (N/ChiN)			3 ↓
NUCLEAR MEDICINE (NuM)			5

Medical Board of California
Expert Reviewer Program Report

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

July 2, 2012

SPECIALTY	Number of cases reviewed/sent to Experts (Jan-June, 2012)	Number of Experts used and how often utilized (Jan-June, 2012)	Active List Experts 944↓
OBSTETRICS & GYNECOLOGY (ObG)	37	**19 EXPERTS** 10 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERTS REVIEWED 4 CASES 3 LIST EXPERTS REVIEWED 5 CASES	79 ↓
OPHTHALMOLOGY (Oph)	5	**4 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES	32 ↓
ORTHOPAEDIC SURGERY (OrS)	8	**7 EXPERTS** 5 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	25 ↓
OTOLARYNGOLOGY (Oto)			24 ↓
PAIN MEDICINE (PM)	23	**11 EXPERTS** 5 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 4 CASES 2 LIST EXPERTS REVIEWED 5 CASES* (*involved companion cases)	22 ↑
PATHOLOGY (Path)	1	**1 EXPERT** 1 LIST EXPERT	9 ↓
PEDIATRICS (Ped)	2	**2 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE	45 ↓
Pediatric Cardiothoracic Surgery	1	**1 EXPERT** 1 LIST EXPERT	
PHYSICAL MEDICINE & REHABILITATION (PMR)	1	**1 EXPERT** 1 LIST EXPERT	11 ↑
PLASTIC SURGERY (PIS)	13	**7 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES	50 ↓
OCCUPATIONAL MEDICINE	1	**1 EXPERT** 1 LIST EXPERT	9

Medical Board of California
Expert Reviewer Program Report

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

July 2, 2012

SPECIALTY	Number of cases reviewed/sent to Experts (Jan-June, 2012)	Number of Experts used and how often utilized (Jan-June, 2012)	Active List Experts 944↓
PSYCHIATRY (Psyc)	41	**28 EXPERTS** 18 LIST EXPERTS REVIEWED 1 CASE 8 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES	81 ↓
RADIOLOGY (Rad)	1	**1 EXPERT** 1 LIST EXPERT	31 ↓
Radiation Oncology (Rad RO)	1	**1 EXPERT** 1 LIST EXPERT	4 ↓
SLEEP MEDICINE (S)			8 ↓
SURGERY (S)	15	**7 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES	47 ↓
Pediatric Surgery (PdS)	1	**1 EXPERT** 1 LIST EXPERT	3
Vascular Surgery (VascS)	2	**2 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE	14
THORACIC SURGERY (TS)	1	**1 EXPERT** 1 LIST EXPERT	15 ↓
(MEDICAL) TOXICOLOGY			3
UROLOGY (U)	8	**6 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	19
TOTAL CASES SENT (Calendar Year to Date)			293
TOTAL EXPERTS UTILIZED (Calendar Year to Date)			205
TOTAL ACTIVE LIST EXPERTS (as of 7/2/2012)			944

/susan

MEDICAL BOARD OF CALIFORNIA
Enforcement Processing Timeframes
2012 Strategic Plan Objective 5.2

Enforcement Process	2008/2009		2009/2010		2010/2011		2011/2012	
	# Cases[1]	AVG[2]	# Cases	AVG	# Cases	AVG	# Cases	AVG
Complaint	6426	75	6563	76	7008	74	7217	83
% of Complaints Below 50 days (Goal: 50-60%)	43%		41%		35%		42%	
Investigation	1100	349	1290	328	1411	312	1545	264
Discipline								
AG Processing to Preparation of an Accusation	240	103	304	106	294	107	333	103
Other Stages of the Legal Process (e.g., after charges filed)	228	381	232	368	216	417	280	396

[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)**

Medical Board of California
Investigation Prosecution Timeframes*

	2005	2006		2007		2008		2009		2010		2011	Qtr 1 2012	Qtr 2 2012
	Prior to VE	All	VE	All	VE	All	VE	All	VE	All	VE	All	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	244
Median	252	285	134	304	269	335	324	346	346	298	297	273	246	196
Record Count	827	703	192	648	539	609	588	673	672	664	663	857	193	186
Calendar Day Age from Request to Suspension Order Granted														
Average	51	44	4	34	38	19	19	52	39	40	40	43	27	50
Median	17	3	2	22	23	10	10	23	23	1	1	17	13	22
Record Count	24	21	11	17	13	21	17	17	16	27	27	31	15	9
Calendar Day Age from Request to Receipt of Medical Records														
Average	58	53	37	59	57	63	58	73	73	64	64	67	55	91
Median	32	31	26	31	31	28	28	32	32	29	29	30	28	31
Record Count	475	376	228	264	259	256	252	243	243	257	257	246	36	30
Calendar Day Age from Request to Physician Interview Completed														
Average	48	51	43	52	50	63	63	52	52	46	46	52	52	39
Median	36	42	38	37	36	41	42	37	37	34	34	38	35	27
Record Count	597	453	172	406	371	473	466	696	696	582	582	729	143	119
Calendar Day Age from Request to Receipt of Expert Opinion														
Average	51	47	35	51	43	50	50	48	48	47	47	58	55	54
Median	41	35	31	36	35	39	38	36	35	37	37	39	44	40
Record Count	519	424	82	344	270	374	359	426	424	415	415	599	118	90
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	496
Median	525	504	120	523	339	541	486	575	569	616	616	533	516	420
Record Count	187	149	17	198	95	157	131	189	186	200	199	239	64	65
Calendar Day Age from Accusation Filed to Disciplinary Outcome**														
Average	608	602	85	576	188	561	243	473	339	426	340	425	471	392
Median	526	466	99	426	182	384	238	351	309	326	304	391	391	375
Record Count	212	195	3	226	29	203	80	198	145	171	156	190	58	61

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

ENFORCEMENT TIMEFRAMES

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	83	64
INVESTIGATION	307	289	324	272	349	309	328	292	312	283	264	225
TOTAL MBC												
DAYS	361	338	385	321	424	372	404	355	386	360	347	289
YEARS	0.99	0.93	1.05	0.88	1.16	1.02	1.11	0.97	1.06	0.99	0.95	0.79
AG PREP FOR ACC	127	76	121	58	103	63	106	66	107	72	103	78
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	394	351
YEARS	1.57	1.17	1.62	1.05	1.33	1.02	1.30	1.04	1.44	1.08	1.08	0.96
TOTAL MBC & AG												
DAYS	934	764	977	703	908	746	878	733	910	756	741	640
YEARS	2.56	2.09	2.68	1.93	2.49	2.04	2.41	2.01	2.49	2.07	2.03	1.75

Years calculated using 365 days per year
Data source: MBC Annual Reports, except 2011-2012

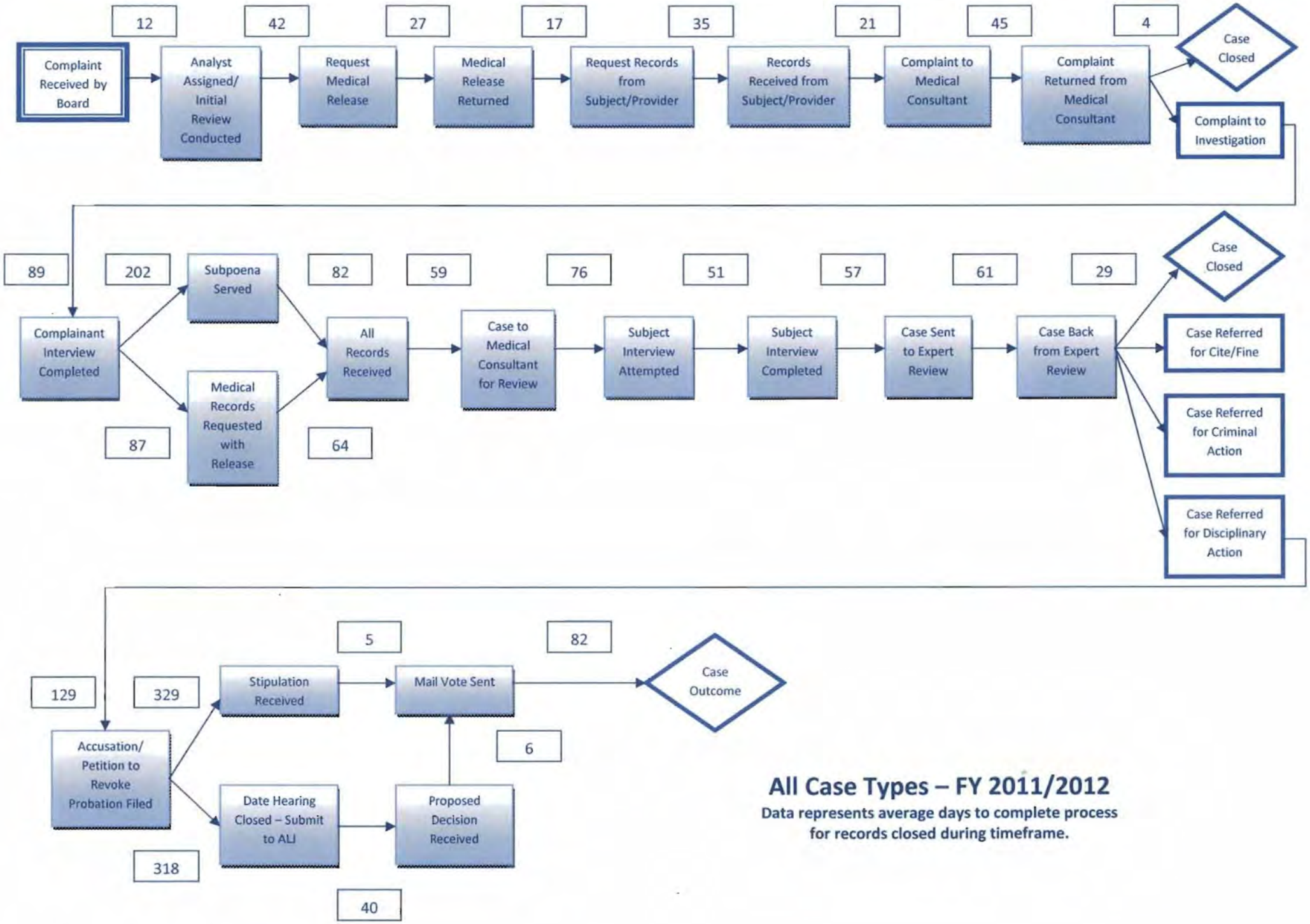
Enforcement Data Markers
All Case Types

Data represents average days to complete Complaint and Investigation processes for records closed during reported time frames.	FY 2008/2009		FY 2009/2010		FY 2010/2011		FY 2011/2012	
	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records
Complaint Processes								
Complaint Received by Board → Analyst Assigned/Initial Review Conducted	10	6761	11	6869	9	7513	12	7699
Analyst Assigned/Initial Review Conducted → Request Medical Release	25	1216	24	1360	28	1567	42	1557
Request Medical Release → Medical Release Returned	29	1044	26	1166	25	1321	27	1281
Medical Release Returned → Request Records from Subject/Provider	7	687	7	802	11	888	17	865
Request Records from Subject/Provider → Records Received from Subject/Provider	39	1759	38	1879	35	1906	35	2015
Records Received from Subject/Provider → Complaint to Medical Consultant	15	1617	16	1865	17	1768	21	1798
Complaint to Medical Consultant → Complaint Returned from Medical Consultant	54	1934	54	2120	52	2129	45	2164
Complaint Returned from Medical Consultant → Case Closed/Complaint to Investigation	7	1932	4	2114	5	2126	4	2151
Investigative Processes								
Complaint to Investigation → Complainant Interview Completed	103	349	102	424	110	490	89	531
Complainant Interview Completed → Subpoena Served	173	42	237	43	172	44	202	45
Complainant Interview Completed → Medical Records Requested with Release	76	141	88	170	59	194	87	203
Subpoena Served → All Records Received	124	120	100	178	88	166	82	146
Medical Records Requested with Release → All Records Received	95	372	92	406	85	420	64	416
All Records Received → Case to Medical Consultant for Review	78	227	84	318	70	369	59	322
Case to Medical Consultant for Review → Subject Interview Attempted	110	374	109	488	77	558	76	532
Subject Interview Attempted → Subject Interview Completed	66	712	53	880	53	961	51	1046
Subject Interview Completed → Case Sent to Expert Review	97	412	81	511	72	580	57	626
Case Sent to Expert Review → Case Back from Expert Review	79	510	72	601	63	658	61	701
Case Back from Expert Review → Case Closed or Referred for Action	39	495	31	585	30	656	29	705

Enforcement Data Markers
All Case Types

Data represents average days to complete Disciplinary processes for records closed during reported time frames.	FY 2008/2009		FY 2009/2010		FY 2010/2011		FY 2011/2012	
	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records
Case Referred for Action → Accusation/Petition to Revoke Probation Filed	121	239	113	237	103	219	129	284
Accusation/Petition to Revoke Probation Filed → Stipulation Received	330	159	291	173	318	142	329	202
Stipulation Received → Mail Vote Sent	6	136	6	132	4	124	5	153
Accusation/Petition to Revoke Probation Filed → Date Hearing Closed - Submit to ALJ	416	25	370	30	393	44	318	45
Date Hearing Closed - Submit to ALJ → Proposed Decision Received	28	35	98	43	39	58	40	63
Proposed Decision Received → Mail Vote Sent	5	54	5	53	6	60	6	72
Mail Vote Sent → Case Outcome	131	206	87	208	111	205	82	262

Data represents overall average days from Receipt to Closure for records closed during reported time frames.	FY 2008/2009		FY 2009/2010		FY 2010/2011		FY 2011/2012	
	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records
Complaint Received → Closure in Complaint Unit	84	5278	84	5247	80	5755	91	5687
Complaint Received → Closure at Field/Referred for Administrative or Criminal Action/Citation Issued	467	1585	464	1747	453	1861	419	2101



All Case Types – FY 2011/2012

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

Medical Board of California
Suspension Orders Issued
by Suspension Type

Suspension Order Type	FY 04/05	FY 05/06	FY 06/07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12
Automatic Suspension Order	5	1	5	0	3	7	4	6
PC 23 Order	8	4	8	6	15	7	12	12
Out of State Suspension Order	15	14	8	11	18	18	21	17
Agreement - No Practice/Restriction	2	6	5	2	3	3	2	0
Suspension/Cease Practice Issued by Chief	5	5	3	1	2	1	3	4
Interim Suspension Order	31	32	22	18	22	22	28	35
Temporary Suspension Order	1	0	0	1	0	0	1	0
Totals	**67**	**62**	**51**	**39**	**63**	**58**	**71**	**74**