State of California

State and Consumer Services Agency

MEDICAL BOARD OF CALIFORNIA

January 30 - February 1, 2013

Panel A	January 30	2:30 p.m. – 5:30 p.m.
Panel A	January 31	8:30 a.m. – 12:30 p.m.
Panel B	January 31	11:00 a.m. – 12:30 p.m.
Enforcement Committee	January 31	1:15 p.m. – 1:45 p.m.
Licensing Committee	January 31	1:45 p.m. – 2:15 p.m.
Executive Committee	January 31	2:15 p.m. – 3:30 p.m.
Full Board	January 31	3:30 p.m. – 5:30 p.m.
Application Review Committee	February 1	8:45 a.m. - 9:00 a.m.
Full Board	February 1	9:00 a.m. – 3:00 p.m.

MEDICAL BOARD OF CALIFORNIA
BOARD MEETING SCHEDULE

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

January 30 – February 1, 2013

Wednesday, January 30

- **2:30 p.m. – 5:30 p.m.** — **Panel A – Contra Costa**
  (Members: Yaroslavsky (Chair), Salomonson (Vice Chair), Bishop, Diego, Serrano Sewell)

Thursday, January 31

- **8:30 a.m. – 12:30 p.m.** — **Panel A – Mendocino & Burlingame**
  (Members: Yaroslavsky (Chair), Salomonson (Vice Chair), Bishop, Diego, Serrano Sewell)
- **11:00 a.m. – 12:30 p.m.** — **Panel B –Santa Cruz**
  (Members: Low (Chair), GnanaDev (Vice Chair), Levine, Pines, Schipske)
- **12:30 p.m. – 1:15 p.m.** — ***Lunch Break***
- **1:15 p.m. – 1:45 p.m.** — **Enforcement Committee – Mendocino & Burlingame**
  (Members: Low (Chair), GnanaDev, Levine, Schipske, Serrano Sewell)
- **1:45 p.m. – 2:15 p.m.** — **Licensing Committee – Santa Cruz**
  (Members: Salomonson (Chair), Bishop, Diego, Pines, Schipske)
- **2:15 p.m. – 3:30 p.m.** — **Executive Committee – Mendocino & Burlingame**
  (Members: Levine (Chair), Schipske, Diego, Low, Salomonson, Yaroslavsky)
- **3:30 p.m. – 5:30 p.m.** — **Full Board Meeting – Mendocino & Burlingame**
  (All Members)

Friday, February 1

- **8:45 a.m. – 9:00 a.m.** — **Application Review Committee – Mendocino & Burlingame**
  (Schipske (Chair), Diego, Low)
- **9:00 a.m. – 3:00 p.m.** — **Full Board Meeting – Mendocino & Burlingame**
  (All Members)

MEDICAL BOARD OF CALIFORNIA
QUARTERLY BOARD MEETING AGENDA

MEMBERS OF THE BOARD
Sharon Levine, M.D., President
Michael Bishop, M.D.
Silvia Diego, M.D.
Dev GnanaDev, M.D.
Reginald Low, M.D.
Denise Pines
Janet Salomonson, M.D.
Gerrie Schipske, R.N.P., J.D.
David Serrano Sewell, J.D.
Barbara Yaroslavsky

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

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

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

Thursday, January 31, 2013
3:30 p.m. – 5:30 p.m.
(or until the conclusion of Business)

Friday, February 1, 2013
9:00 a.m. – 3:00 p.m.
(or until the conclusion of Business)

ORDER OF ITEMS IS SUBJECT TO CHANGE.

Thursday, January 31

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

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

3. Designation of the *Decision In the Matter of the Accusation Against Edward Spencer* (Case Number 12-2010-205496) as a Precedential Decision – Ms. Dobbs

4. Presentation on the Aging Physician (4:00 p.m.) – Dr. Norcross and Dr. Perry

5. Licensing Committee Update; Consideration of Committee Recommendations – Dr. Salomonson

6. Enforcement Committee Update – Dr. Low

7. Executive Committee Update; Consideration of Committee Recommendations – Dr. Levine

8. Update on Health Professions Education Foundation – Ms. Yaroslavsky and Dr. Diego

9. Physician Assistant Board Update – Mr. Schunke

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

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.

11. CLOSED SESSION (5:15 p.m.)
Pursuant to Section 11126(e)(1) of the Government Code, the Board will meet in closed session to confer with its counsel regarding the following litigation:
PICKUP v. BROWN, CASE # CIV 2:12-CV-02497-KJN-EFB UNITED STATES DISTRICT COURT; EASTERN DISTRICT OF CALIFORNIA; SACRAMENTO DIVISION.

WELCH v. BROWN, CASE # CIV 2:15-CV-02484 – WBS-KGN UNITED STATES DISTRICT COURT; EASTERN DISTRICT OF CALIFORNIA; SACRAMENTO DIVISION.

Recess
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Friday, February 1

12. 9:00 a.m. Call to Order / Roll Call

13. 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)]

14. Approval of Minutes from the October 25-26, 2012 Meeting

15. Update on Activities of the Board of Pharmacy – Ms. Herold

16. Update on Joint Forum to Promote Appropriate Prescribing and Dispensing – Ms. Whitney and Ms. Herold

17. Presentation and Consideration of the Organ Donor License Plate Sponsorship – Ms. Zettel

18. Legislation/ Regulations – Ms. Simoes
    A. 2013 Legislation
    B. Status of Regulatory Action

19. Board Member Communications with Interested Parties – Dr. Levine

20. President's Report – Dr. Levine

21. Update on Federation of State Medical Boards – Dr. Levine and Ms. Whitney

22. Executive Director's Report – Ms. Whitney
    A. Update on Staffing and Administration
    B. Budget Overview – Ms. Kirchmeyer

23. BreEZe Update (11:00 a.m.) – Mr. Rutschmann

24. Licensing Chief's Report – Mr. Worden
    A. Staffing
    B. Program Statistics
    C. Status of International Medical School Program
    D. Status of Free Health Care Event Program

25. Review and Consideration of Request for Recognition; Medical University of Warsaw – English Language Program – Mr. Worden and Dr. Silva

26. Midwifery Advisory Council Update and Consideration of Council Recommendations – Ms. Sparrevohn

27. Update on Outpatient Surgery Centers Program – Mr. Worden and Ms. Threadgill

28. 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

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

30. Discussion and Consideration of the Draft Supplemental Report on Sunset Review – Ms. Kirchmeyer and Ms. Robinson

31. Discussion and Consideration of Teleconferencing of Medical Board Meetings – Ms. Kirchmeyer and Mr. Heppler

32. Agenda Items for April 25-26, 2013 Meeting in the Los Angeles Area

33. 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.

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
LEGAL AFFAIRS
1625 North Market Blvd., Suite S 309
P (916) 574-8220 F (916) 574-8623

MEMORANDUM

DATE	January 22, 2013
TO	Members Medical Board of California
FROM	Dianne R. Dobbs Senior Staff Counsel Department of Consumer Affairs
SUBJECT	**PROPOSED PRECEDENTIAL DECISION – *In the Matter of the Accusation Against Edward L. Spencer, M.D.*; Case No. 12-2010-205496; OAH No. 2011070380**

In accordance with the procedure adopted by the Division of Medical Quality in July 2004 (Exhibit 1), the Office of the Attorney General has recommended that several sections of the above-captioned decision be designated as precedential. The executive director, chief of enforcement and I all agree with this recommendation.

Procedural Background

Dr. Spencer ("respondent") was the recipient of an Accusation. The matter was heard before Administrative Law Judge Nancy L. Rasmussen, who submitted a Proposed Decision to the Medical Board of California ("Board") on September 28, 2011. A panel of the board adopted that decision.

Facts/Findings of the Case

The relevant facts are as follows:

Complainant filed a Petition for Order Compelling Psychiatric Examination of respondent under Business and Professions Code ("BPC") section 820. The petition alleged that respondent's ability to safely practice medicine may be impaired due to mental illness. Supporting documents included an 805 report received from respondent's employer. Respondent was not provided a copy of the petition, nor was he offered an opportunity to present argument in opposition to the petition.

Respondent refused to meet with and be interviewed by the board investigator. The Board granted the petition and issued an Order Compelling Psychiatric Examination under section 820. The order directed respondent to submit to a psychiatric examination within 30 days to determine whether he was mentally ill to such an extent as to affect his ability to safely practice medicine. Respondent failed to appear for the scheduled examination, and

subsequently, filed Petition for Administrative Writ seeking to set aside the board's Order Compelling Psychiatric Examination. At the time of the administrative hearing, no court proceeding was scheduled on the Writ and no such hearing has subsequently occurred.

In the administrative hearing on the accusation, respondent contended that he could not be disciplined for failing to comply with the Order Compelling Psychiatric Examination because the order was improperly obtained, was overbroad, and was not authorized by statute.

The ALJ found these contentions meritless, and found that BPC section 820 did not require the Board to provide respondent with a copy of the petition before issuing its order compelling examination. The opinion further addresses why respondent's claims of due process violations failed.

Portions of Decision to be Designated as Precedential

The recommendation is that the following portions of the decision be designated as precedential:

Factual Findings 1, 2, 5, 6, 7, and 8 and
Legal Conclusions 1, 2, 3, 4, and 5.

If the Board approves the request to designate the above portions of the decision as precedential, those portions not accepted for publication will be redacted and replaced with asterisks. Exhibit 2 is the redacted version of the decision and is what those viewing the precedent decision would see. Exhibit 3 is the decision in its entirety.

Rationale

16 Cal. Code Regs. 1364.40(a) authorizes the division to designate, as a precedent decision, "any decision or part of any decision that contains a significant legal or policy determination of general application that is likely to recur."

Business and Professions Code section 820 authorizes the Board to order a mental or physical examination of any licensee, certificate or permit holder who appears to be unable to practice his or her profession safely due to mental or physical imparity. Due to concerns for public safety, the process is commenced by the filing of a petition which usually contains some investigative facts regarding the suspected impairment and frequently is accompanied by an expert opinion that states the licentiate should be examined by a board appointed expert to determine whether he or she is safe to practice. The board, based on the petition and supporting evidence can issue an order compelling the examination.

Because in these circumstances public protection requires expedient action, the petition and supporting documents are not provided to the licentiates prior to the ordering of the examination. In recent years, and with increasing regularity, this procedure has been challenged with claims that the board's failure to provide the licentiate with the petition and supporting documents prior to ordering the examination deprives the licentiate of due process.

This decision addresses why BPC section 820 does not require the board to provide the petition documents to respondents prior to the board granting the petition, and provides case law to support why the procedure survives a due process challenge.

The facts presented in this case are very likely to be a recurring issue. For this reason, we believe that the portions of the decision proposed to be designated as precedent contain significant legal determinations and would provide guidance to counsel for respondent and complainant as well as guidance to the Office of Administrative Hearings.

Attachments

EXHIBIT 1

Memorandum

To : **Carlos Ramirez, Asst. DAG**
Tom Reilly, DAG
Mary Agnes Matyszewski, DAG
Health Quality Enforcement Section
Office of the Attorney General

Date: July 28, 2004

Joan

From : **Joan M. Jerzak**
Chief, Enforcement Program

Subject: **Precedential Decisions Revised Procedures**

As a follow-up to our meeting on July 21, 2004, with DCA Legal Counsel Anita Scuri, Board Counsel Nancy Vedera, Interim Executive Director Dave Thornton and me, the attached Precedent Decision Procedure was revised. I believe it incorporates all the offered suggestions and will serve as a guide for Board staff as decisions are selected for precedential designation.

Thank you all for your assistance.

PRECEDENT DECISION PROCEDURE

July 2004

Introduction

The purpose of this policy is to establish a procedure for identifying potential precedential decisions and reviewing and acting upon recommendations to designate decisions as precedential. Under the Administrative Procedure Act (APA) a decision that contains a significant legal or policy determination of general application that is likely to recur may be designated as precedential. (See Government Code (GC) Section 11425.60; Attachment 1) Once a decision is designated as precedential, the Division of Medical Quality (hereinafter "Division") may rely on it, and parties may cite to such decision in their argument to the Division and courts. Furthermore, it helps ensure consistency in decision-making by institutionalizing rulings that the Board feels reflects its position on various issues. The Division has adopted section 1364.40, Title 16, California Code of Regulations, to implement its authority to designate decisions as precedential.

Step 1: Identifying Potential Precedential Decisions

A decision or part of a decision that contains significant legal or policy determination of general application that is likely to recur may be recommended for designation as a precedential decision. Section 11425.60 does not preclude the Board from designating as precedential a decision that is already in effect. The recommendation shall be made to Board Counsel, giving the reasons why the person believes the decision meets the criteria to be designated as a precedential decision. Their recommendation shall be accompanied by a copy of the decision.

Step 2: Review of Recommendation

If the Executive Director, after consultation with the Chief of Enforcement and the Board Counsel, concludes that the Division should consider the decision for precedential designation, the matter will be placed on the Division's agenda for action. The agenda serves as public notice that the Division will consider the decision as a precedential decision.

Step 3: Preparation for Board Review

Board Counsel will then prepare or will arrange with the appropriate staff to prepare the precedential designation proposal for presentation to the Division for review and consideration.

The Board's Discipline Coordination Unit shall maintain a log of the decisions proposed to the Division for precedential designation. The log shall show the date of the Board meeting, decision number, respondent's name, a general description of the legal or policy issue, and whether the precedential decision was approved or not. A copy of the Board Counsel memorandum and minutes of the Board meeting (when the decision was discussed) will be maintained with the log.

If the Division adopts a decision as precedential, it will be assigned a precedential designation number. The precedential designation number shall begin with "MBC" and uses the calendar year and sequential numbering beginning with "01" for each year, followed by lettering for the Division designating the decision, DMQ (Division of Medical Quality) and DOL (Division of Licensing), (i.e., MBC-2004-01-DMQ for year 2004).

Step 4: Designation of a Precedential Decision

Board Counsel will prepare an order designating the decision, or portion(s) of the decision, as precedential for signature by the Division President. The effective date is the date the date the decision was designated as a precedential decision. (See Attachment 2 for an example of a Designation as Precedential Decision.)

Board Counsel will send a copy of the signed Designation as a Precedential Decision, including a copy of the decision, to the Office of Administrative Hearings. (The Office of Administrative Hearings maintains a file of precedential designations for reference by Administrative Law Judges.)

Step 5: Indexing

Under Government Code section 11425.60(c), the Division is required to maintain an index of significant legal and policy determinations made in precedential decisions. The Board's Discipline Coordination Unit will maintain the index.

The index shall be divided into three sections (Attachment 3) :

1) Decisions by fiscal year, including: the precedential designation number, the respondent's name, the MBC case number, the OAH case number and the precedential designation date (effective date).

2) Subject matter, followed by a general description of legal and/or policy issue, the precedential designation number and the respondent's name.

3) Code section number, followed by a general description of the section, the precedential designation number and the respondent's name.

NOTE: As decisions are added to the index, an asterisk will be entered after the cases, showing if they were appealed to the Superior Court, Court of Appeals or Supreme Court. Two asterisks following the case, will reflect the case was reversed as a precedential decision by the Board.

A copy of each precedential designation shall be maintained with the index and on the Board's website. The index shall be updated every time a decision is designated as precedential. The index is a public record, available for public inspection and copying. It shall be made available to the public by subscription and its availability shall be published annually in the California Regulatory Notice Register. Each January, Board staff will submit the index to the Office of Administrative Law for publication in the California Regulatory Notice Register.

Step 6: Reversal of Precedential Designation

The Executive Director, after consultation with the Chief of Enforcement and Board Counsel, may recommend that the Division reverse its designation of all or portion(s) of the precedential designation on a decision. The matter will then be placed on the agenda for action. Board Counsel will prepare or arrange with the appropriate staff to prepare the order, "Reversal of Precedential Designation," (Attachment 4). Board Counsel will then send a copy of the signed Reversal of Precedential Designation, including a copy of the decision to the Office of Administrative Hearings.

§ 11425.60. Decisions relied on as precedents

(a) A decision may not be expressly relied on as precedent unless it is designated as a precedent decision by the agency.

(b) An agency may designate as a precedent decision a decision or part of a decision that contains a significant legal or policy determination of general application that is likely to recur. Designation of a decision or part of a decision as a precedent decision is not rulemaking and need not be done under Chapter 3.5 (commencing with Section 11340). An agency's designation of a decision or part of a decision, or failure to designate a decision or part of a decision, as a precedent decision is not subject to judicial review.

(c) An agency shall maintain an index of significant legal and policy determinations made in precedent decisions. The index shall be updated not less frequently than annually, unless no precedent decision has been designated since the last preceding update. The index shall be made available to the public by subscription, and its availability shall be publicized annually in the California Regulatory Notice Register.

(d) This section applies to decisions issued on or after July 1, 1997. Nothing in this section precludes an agency from designating and indexing as a precedent decision a decision issued before July 1, 1997.

HISTORY:

Added Stats 1995 ch 938 §21 (SB 523), operative July 1, 1997; Amended by Stats 1996 ch 390 §8 (SB 794), operative July 1, 1997.

Added "and indexing" in subd (d).

Law Revision Commission Comments:

1995_Section 11425.60 limits the authority of an agency to rely on previous decisions unless the decisions have been publicly announced as precedential.

The first sentence of subdivision (b) recognizes the need of agencies to be able to make law and policy through adjudication as well as through rulemaking. It codifies the practice of a number of agencies to designate important decisions as precedential. See Sections 12935(h) (Fair Employment and Housing Commission), 19582.5 (State Personnel Board); Unemp. Ins. Code 409 (Unemployment Insurance Appeals Board). Section 11425.60 is intended to encourage agencies to articulate what they are doing when they make new law or policy in an adjudicative decision. An agency may not by precedent decision revise or amend an existing regulation or adopt a rule that has no adequate legislative basis.

Under the second sentence of subdivision (b), this section applies notwithstanding Section 11340.5 ("underground regulations"). See 1993 OAL Det. No. 1 (determination by Office of Administrative Law that agency designation of decision as precedential violates former Government Code Section 11347.5 [now 11340.5] unless made pursuant to rulemaking procedures). The provision is drawn from Government Code Section 19582.5 (expressly exempting the State Personnel Board's precedent decision designations from rulemaking procedures). See also Unemp. Ins. Code 409 (Unemployment Insurance Appeals Board). Nonetheless, agencies are encouraged to express precedent decisions in the form of regulations, to the extent practicable.

The index required by subdivision (c) is a public record, available for public inspection and copying.

Subdivision (d) minimizes the potential burden on agencies by making the precedent decision requirements prospective only.

Attachment 1

SAMPLE

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: NAME	)	OAH No.
	)	MBC Case No.
Physician's and Surgeon's Certificate No.	)	PRECEDENTIAL DECISION No. MBC-2004-01-DMQ
Respondent.	)	

DESIGNATION AS A PRECEDENTIAL DECISION

Pursuant to Government Code Section 11425.60, the Division of Medical Quality, Medical Board of California, hereby designates as precedential Decision No. MBC-2004-01-DMQ (or those sections of the decision listed below) in the Matter of the Accusation Against NAME.

1) Findings of Fact Nos. 3-6; and
2) Determination of Issues No. 5.

This precedential designation shall be effective July 30, 2004.

LORIE RICE, President
Division of Medical Quality
Medical Board of California

Attachment 2

SAMPLE

2004

Medical Board of California
Precedential Decisions

Index

MBC-2004-01-DMQ ***Ridgill, Edward***, MBC Case No. 06-1997-78021; OAH Number E-123545, July 30, 2004

Attachment 3
1 of 2 pages

SAMPLE

Medical Board of California
Precedential Decisions

Index 2004

by Subject Matter

Petition for Penalty Relief
Evidence of rehabilitation, or lack of, 2004-01-DMQ

Rehabilitation
Petitioner's burden, 2004-01-DMQ

by Code Section

Business and Professions Code

Section 2307 - Modification or Termination of Probation –
2004-01-DMQ, *Ridgill*

SAMPLE

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: NAME	)	OAH No.
	)	MBC Case No.
Physician's and Surgeon's Certificate No.	)	PRECEDENTIAL DECISION No. MBC-2004-01-DMQ
Respondent.	)	

WITHDRAWAL OF PRECEDENTIAL DECISION

Pursuant to Government Code Section 11425.60, the Division of Medical Quality, Medical Board of California, hereby orders the withdrawal of precedential Decision No. DMQ-2004-01-DMQ (or those sections of the decision listed below) in the Matter of the Accusation Against NAME.

1) Findings of Fact Nos. 3-6; and
2) Determination of Issues No. 5.

The withdrawal of this precedential designation shall be effective July 30, 2005.

LORIE RICE, President
Division of Medical Quality
Medical Board of California

Attachment 4

EXHIBIT 2

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
EDWARD L. SPENCER, M.D.	Case No. 12-2010-205496
Physician's and Surgeon's Certificate No. G 11138	OAH No. 2011070380
Respondent.	

PROPOSED DECISION

Administrative Law Judge Nancy L. Rasmussen, State of California, Office of Administrative Hearings, heard this matter on August 23, 2011, in Oakland, California.

Deputy Attorney General Jane Zack Simon represented complainant Linda K. Whitney, Executive Director of the Medical Board of California.

John L. Fleer, Attorney at Law, represented respondent Edward L. Spencer, M.D., who was not present.

The record was held open for submission of written argument. On September 2, 2011, respondent's closing argument was received and marked as Exhibit A for identification. On September 8, 2011, complainant's reply argument was received and marked as Exhibit 13 for identification. The record was closed and the matter was deemed submitted for decision on September 8, 2011.

FACTUAL FINDINGS

1. On August 24, 1965, the Medical Board of California issued physician's and surgeon's certificate no. G 11138 to respondent Edward L. Spencer, M.D. The current expiration date is December 31, 2011.

2. On March 24, 2011 complainant filed with the board a Petition for Order Compelling Psychiatric Examination of Licensee, under Business and Professions Code

section 820.[1] The petition alleged that respondent's ability to safely practice medicine may be impaired due to mental illness. In support of this allegation, the petition detailed information the board received from Petaluma Valley Hospital (PVH) in a March 8, 2010, report filed under section 805 and in PVH documents later subpoenaed by a board investigator. When complainant filed her petition with the board, respondent was not given a copy of the petition, nor was he offered an opportunity to present argument in opposition to the petition.

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5. On April 7, 2011, pursuant to complainant's petition filed on March 24, 2011, the board issued an Order Compelling Psychiatric Examination, under section 820. The order directed respondent to submit to a psychiatric examination within 30 days to determine whether he "is mentally ill to such an extent as to affect his ability to practice medicine." The order required respondent to "cooperate with the examination" and "permit prompt access to any treatment records or sources of information deemed necessary by the examiner(s)."

The order and a letter asking respondent to contact the board's Pleasant Hill office were sent to respondent at his address of record. Respondent did not contact the board's Pleasant Hill office, so Investigator Scully went to respondent's residence on April 18, 2011, and personally served him with a copy of the order. Scully also gave respondent a letter informing him that the psychiatric examination was scheduled for May 2, 2011, at 10:00 a.m., with Randall L. Solomon, M.D.

6. Respondent failed to appear for the psychiatric examination on May 2, 2011, and Scully later received a voice mail message from respondent's attorney saying that he planned on filing a petition for writ of mandate challenging the Order Compelling Psychiatric Examination.

7. On May 31, 2011, Investigator Scully served respondent and Nancy Spencer, respondent's wife or ex-wife, with investigative subpoenas requiring them to appear for questioning at the board's Pleasant Hill office on June 8 and June 7, respectively.

On June 4, 2011, respondent's attorney faxed and mailed to Scully a letter objecting to the investigative subpoenas and stating that neither respondent nor Nancy Spencer would appear in response to the subpoenas. He also stated: "I have filed a petition for writ of mandate as to the Board's order compelling a psychiatric examination of Dr. Spencer. (Copy attached.) That matter is pending. Any discovery should occur

[1] All further statutory references are to the Business and Professions Code.

as part of that proceeding. I object to any attempt to circumvent same by way of an 'investigation.'"

8. On May 6, 2011, in the San Francisco Superior Court, respondent's attorney filed on respondent's behalf a Verified Petition for Administrative Writ against the board seeking a peremptory writ of mandate to set aside the Order Compelling Psychiatric Examination. Although Investigator Scully received a copy of this petition with the June 4 letter, the petition has not been legally served on the board. There have been no court proceedings on the petition and no proceedings are scheduled.

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LEGAL CONCLUSIONS

1. Sections 820 and 821 provide:

Section 820

Whenever it appears that any person holding a license, certificate or permit under this division or under any initiative act referred to in this division may be unable to practice his or her profession safely because the licentiate's ability to practice is impaired due to mental illness, or physical illness affecting competency, the licensing agency may order the licentiate to be examined by one or more physicians and surgeons or psychologists designated by the agency. The report of the examiners shall be made available to the licenciate and may be received as direct evidence in proceedings conducted pursuant to Section 822.[2]

Section 821

The licentiate's failure to comply with an order issued under Section 820 shall constitute grounds for the suspension or revocation of the licentiate's certificate or license.

2. Respondent's failure to comply with the Order Compelling Psychiatric Examination issued under section 820 constitutes cause to suspend or revoke his physician's and surgeon's certificate under section 821.

[2] Section 822 authorizes the board to take action against a licentiate when it has determined that the licentiate's ability to practice safely is impaired because of mental illness, or physical illness affecting competency.

3. Respondent's failure to comply with the Order Compelling Psychiatric Examination also constitutes unprofessional conduct, for which his physician's and surgeon's certificate is subject to disciplinary action under section 2234.

4. Respondent contends that he cannot be disciplined for failing to comply with the Order Compelling Psychiatric Examination, because the order "was improperly obtained, is overbroad, and is not authorized by statute." These contentions are without legal merit.

Respondent asserts that his due process rights were violated by not being provided a copy of complainant's petition before the board's order was issued, but section 820 does not require such notice. A due process challenge to section 820 was rejected in *Alexander D. v. State Board of Dental Examiners* (1991) 231 Cal.App.3d 92. The court reasoned that the property interest or license of the dentist who had been ordered to undergo a psychiatric examination would not be at stake unless an action was brought under section 822, and in that adjudicatory proceeding he would have full due process rights. (*Id.* at p. 98.) Furthermore, the licensee's privacy was protected if there was insufficient evidence to bring an action under section 822, because section 828 mandates that all agency records regarding the psychiatric examination would then be kept confidential. (*Ibid.)* Respondent points out factual differences between that case and his, i.e., the dentist in *Alexander D.* was served with both the order and the petition, there were complaints against him of substandard practice, and the order under section 820 did not include "a requirement that the licensee waive all rights to privacy regarding his medical records." These differences do not advance respondent's position.

For the board to compel a psychiatric examination under section 820, there must be information from which "it appears that any person holding a license, certificate or permit...may be unable to practice his or her profession safely because the licentiate's ability to practice is impaired due to mental illness." There need be no evidence of substandard practice or patient harm. In this case, the board had information from which it appears that respondent may be impaired by mental illness and unable to safely practice. The purpose of the psychiatric examination is to determine whether in fact this is the case. The provisions in the order requiring respondent to "cooperate with the examination" and "permit prompt access to any treatment records or sources of information deemed necessary by the examiner(s)" are reasonable to assure a thorough examination.

5. The mere filing of a petition for writ of mandate does not deprive the board of authority to discipline respondent's license for failing to comply with the Order Compelling Psychiatric Examination. Respondent has not legally served the petition on the board, much less obtained a stay or other court order.

****

Dated: September 28, 2011

NANCY L. RASMUSSEN
Administrative Law Judge
Office of Administrative Hearings

EXHIBIT 3

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
Edward L. Spencer, M.D.	)	Case No. 12-2010-205496
Physician's and Surgeon's Certificate No. G 11138	)	
Respondent	)	

DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on December 1, 2011.

IT IS SO ORDERED November 2, 2011.

MEDICAL BOARD OF CALIFORNIA

By: _____
Hedy Chang, Chair
Panel B

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: EDWARD L. SPENCER, M.D. Physician's and Surgeon's Certificate No. G 11138 Respondent.	Case No. 12-2010-205496 OAH No. 2011070380

PROPOSED DECISION

Administrative Law Judge Nancy L. Rasmussen, State of California, Office of Administrative Hearings, heard this matter on August 23, 2011, in Oakland, California.

Deputy Attorney General Jane Zack Simon represented complainant Linda K. Whitney, Executive Director of the Medical Board of California.

John L. Fleer, Attorney at Law, represented respondent Edward L. Spencer, M.D., who was not present.

The record was held open for submission of written argument. On September 2, 2011, respondent's closing argument was received and marked as Exhibit A for identification. On September 8, 2011, complainant's reply argument was received and marked as Exhibit 13 for identification. The record was closed and the matter was deemed submitted for decision on September 8, 2011.

FACTUAL FINDINGS

1. On August 24, 1965, the Medical Board of California issued physician's and surgeon's certificate no. G 11138 to respondent Edward L. Spencer, M.D. The current expiration date is December 31, 2011.

2. On March 24, 2011 complainant filed with the board a Petition for Order Compelling Psychiatric Examination of Licensee, under Business and Professions Code

section 820.[1] The petition alleged that respondent's ability to safely practice medicine may be impaired due to mental illness. In support of this allegation, the petition detailed information the board received from Petaluma Valley Hospital (PVH) in a March 8, 2010, report filed under section 805 and in PVH documents later subpoenaed by a board investigator. When complainant filed her petition with the board, respondent was not given a copy of the petition, nor was he offered an opportunity to present argument in opposition to the petition.

3. Information from PVH indicates the following: Respondent is a neurologist who held consultant privileges at PVH. On March 3, 2010, he resigned from the PVH medical staff following notice of summary suspension of his clinical privileges on February 22, 2010, and the decision of the Medical Staff Executive Committee to investigate concerns regarding his mental health and ability to practice safely. The issues involved what PVH medical and executive staff considered to be respondent's increasingly irrational thought processes and his rejection of efforts by the Physician Well Being Committee to obtain psychiatric and neuropsychological evaluations. In a document accusing the Physician Well Being Committee of slander, respondent wrote: "There is no scientific proof psychiatry has any basis in logical reasoning to come up with the 'assessment' or 'evaluation' other than the name calling that it is, by agreement of a group of psychiatrists." In a letter to the Executive Committee on March 1, 2010, respondent wrote: "Mind control technology can confound any psychiatric or neurological evaluation." Because of respondent's resignation, the Executive Committee discontinued its investigation and reached no conclusions regarding the issues.

4. Board investigator Dennis Scully made arrangements with respondent's attorney to interview respondent on March 3, 2011. On February 24, 2011, respondent sent Scully a largely unintelligible writing which appeared to dispute the board's right to investigate him. On March 2, 2011, respondent's attorney notified Scully that respondent would not be attending the scheduled interview.

5. On April 7, 2011, pursuant to complainant's petition filed on March 24, 2011, the board issued an Order Compelling Psychiatric Examination, under section 820. The order directed respondent to submit to a psychiatric examination within 30 days to determine whether he "is mentally ill to such an extent as to affect his ability to practice medicine." The order required respondent to "cooperate with the examination" and "permit prompt access to any treatment records or sources of information deemed necessary by the examiner(s)."

The order and a letter asking respondent to contact the board's Pleasant Hill office were sent to respondent at his address of record. Respondent did not contact the board's Pleasant Hill office, so Investigator Scully went to respondent's residence on April 18, 2011, and personally served him with a copy of the order. Scully also gave respondent a letter

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[1] All further statutory references are to the Business and Professions Code.

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informing him that the psychiatric examination was scheduled for May 2, 2011, at 10:00 a.m., with Randall L. Solomon, M.D.

6. Respondent failed to appear for the psychiatric examination on May 2, 2011, and Scully later received a voice mail message from respondent's attorney saying that he planned on filing a petition for writ of mandate challenging the Order Compelling Psychiatric Examination.

7. On May 31, 2011, Investigator Scully served respondent and Nancy Spencer, respondent's wife or ex-wife, with investigative subpoenas requiring them to appear for questioning at the board's Pleasant Hill office on June 8 and June 7, respectively.

On June 4, 2011, respondent's attorney faxed and mailed to Scully a letter objecting to the investigative subpoenas and stating that neither respondent nor Nancy Spencer would appear in response to the subpoenas. He also stated: "I have filed a petition for writ of mandate as to the Board's order compelling a psychiatric examination of Dr. Spencer. (Copy attached.) That matter is pending. Any discovery should occur as part of that proceeding. I object to any attempt to circumvent same by way of an 'investigation.'"

8. On May 6, 2011, in the San Francisco Superior Court, respondent's attorney filed on respondent's behalf a Verified Petition for Administrative Writ against the board seeking a peremptory writ of mandate to set aside the Order Compelling Psychiatric Examination. Although Investigator Scully received a copy of this petition with the June 4 letter, the petition has not been legally served on the board. There have been no court proceedings on the petition and no proceedings are scheduled.

9. The parties stipulated that respondent is not currently rendering medical services, i.e., he is not engaged in any activities for which a physician's and surgeon's certificate is required.

LEGAL CONCLUSIONS

1. Sections 820 and 821 provide:

Section 820

> Whenever it appears that any person holding a license, certificate or permit under this division or under any initiative act referred to in this division may be unable to practice his or her profession safely because the licentiate's ability to practice is impaired due to mental illness, or physical illness affecting competency, the licensing agency may order the licentiate to be examined by one or more physicians and surgeons or psychologists designated by the agency. The report of the examiners shall be made available to the licentiate and may be

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received as direct evidence in proceedings conducted pursuant to Section 822.[2]

Section 821

The licentiate's failure to comply with an order issued under Section 820 shall constitute grounds for the suspension or revocation of the licentiate's certificate or license.

2. Respondent's failure to comply with the Order Compelling Psychiatric Examination issued under section 820 constitutes cause to suspend or revoke his physician's and surgeon's certificate under section 821.

3. Respondent's failure to comply with the Order Compelling Psychiatric Examination also constitutes unprofessional conduct, for which his physician's and surgeon's certificate is subject to disciplinary action under section 2234.

4. Respondent contends that he cannot be disciplined for failing to comply with the Order Compelling Psychiatric Examination, because the order "was improperly obtained, is overbroad, and is not authorized by statute." These contentions are without legal merit.

Respondent asserts that his due process rights were violated by not being provided a copy of complainant's petition before the board's order was issued, but section 820 does not require such notice. A due process challenge to section 820 was rejected in *Alexander D. v. State Board of Dental Examiners* (1991) 231 Cal.App.3d 92. The court reasoned that the property interest or license of the dentist who had been ordered to undergo a psychiatric examination would not be at stake unless an action was brought under section 822, and in that adjudicatory proceeding he would have full due process rights. (*Id.* at p. 98.) Furthermore, the licensee's privacy was protected if there was insufficient evidence to bring an action under section 822, because section 828 mandates that all agency records regarding the psychiatric examination would then be kept confidential. (*Ibid.*) Respondent points out factual differences between that case and his, i.e., the dentist in *Alexander D.* was served with both the order and the petition, there were complaints against him of substandard practice, and the order under section 820 did not include "a requirement that the licensee waive all rights to privacy regarding his medical records." These differences do not advance respondent's position.

For the board to compel a psychiatric examination under section 820, there must be information from which "it appears that any person holding a license, certificate or permit . . . may be unable to practice his or her profession safely because the licentiate's ability to practice is impaired due to mental illness." There need be no evidence of substandard

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[2] Section 822 authorizes the board to take action against a licentiate when it has determined that the licentiate's ability to practice safely is impaired because of mental illness, or physical illness affecting competency.

practice or patient harm. In this case, the board had information from which it appears that respondent may be impaired by mental illness and unable to safely practice. The purpose of the psychiatric examination is to determine whether in fact this is the case. The provisions in the order requiring respondent to "cooperate with the examination" and "permit prompt access to any treatment records or sources of information deemed necessary by the examiner(s)" are reasonable to assure a thorough examination.

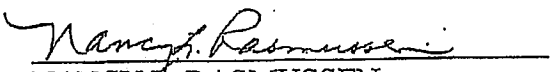
5. The mere filing of a petition for writ of mandate does not deprive the board of authority to discipline respondent's license for failing to comply with the Order Compelling Psychiatric Examination. Respondent has not legally served the petition on the board, much less obtained a stay or other court order.

6. It would be pointless to suspend respondent's physician's and surgeon's certificate when there is no reason to believe that he will comply with the board's Order Compelling Psychiatric Examination. The only appropriate measure of discipline is revocation.

ORDER

Physician's and surgeon's certificate no. G 11138 issued to respondent Edward L. Spencer, M.D., is revoked.

Dated: September 28, 2011



NANCY L. RASMUSSEN
Administrative Law Judge
Office of Administrative Hearings

134.22

Assessing the Aging Physician: Neuropsychological and Psychological Factors Pertaining to Fitness for Duty

William Perry, Ph.D.
University of California, San Diego

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PACE PROGRAM

The aging physician population

Around the world there are growing concerns about the dependence on aging medical professionals.

In Canada, the percentage of doctors aged 65 or above is expected to reach 20% by 2026.

25% of Australia's medical workforce is at least 55 years old.

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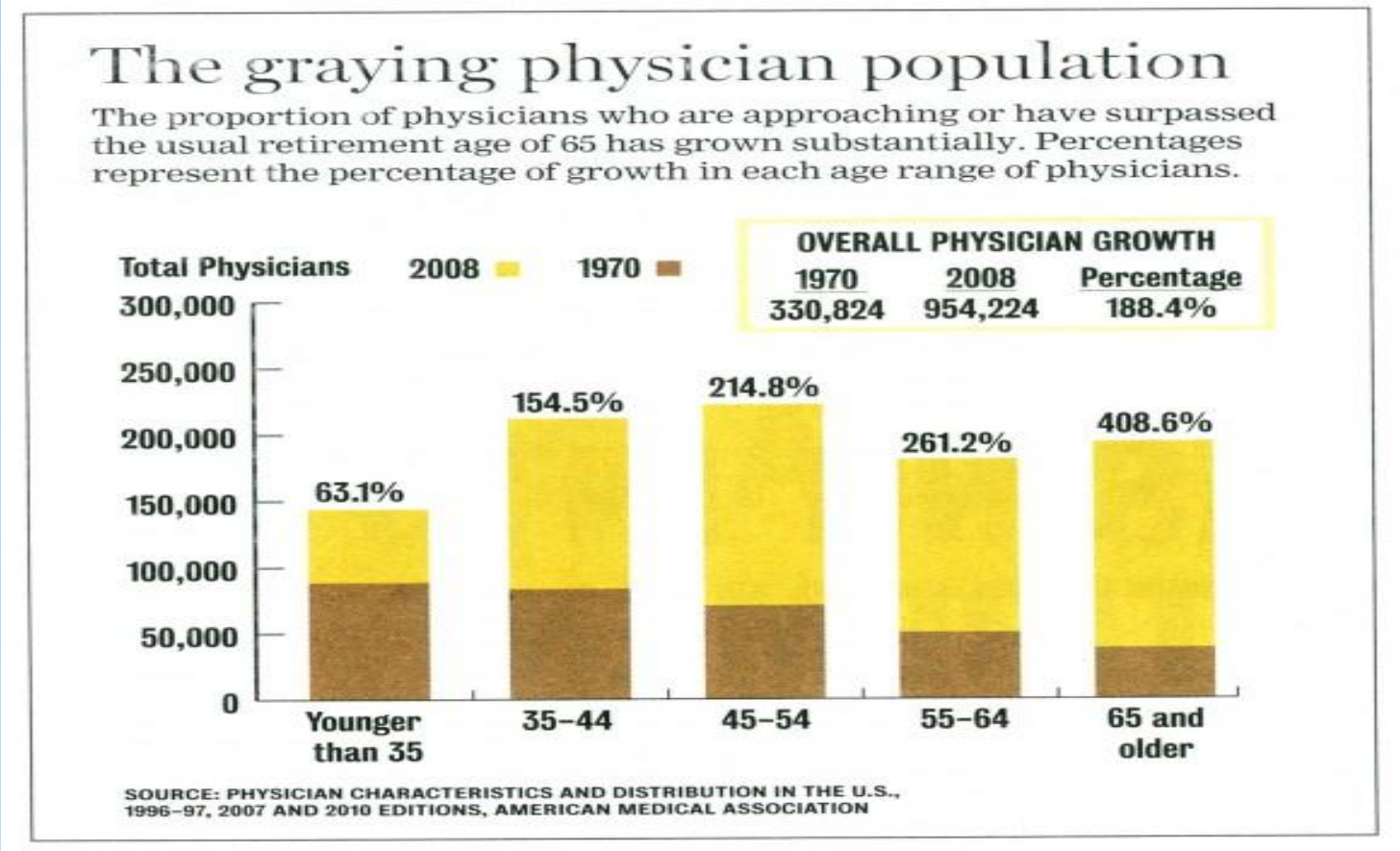
Aging Physicians in the United States

20.3 % are over the age of 65



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Conventional wisdom about physician expertise generally holds that the longer a physician has been in practice, the better honed his or her clinical skills become

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The aging physician population: Ageism?

- Hobus et al. (1987) presented physicians with short case histories consisting of a patient's picture, previous disease history, and presenting complaint.
- A strong positive correlation between experience and diagnostic accuracy (r = .68).
- Their initial hypotheses however was correct only 38% of the time.

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WHAT ARE THE CONCERNS?

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What Are The Concerns?

Choudry, Fletcher & Soumerai Ann Intern Med. 2005;142:260-273.

Physicians with more experience are generally believed to have accumulated knowledge and skills during years in practice and therefore to deliver high-quality care. However, evidence suggests that there is an inverse relationship between the number of years that a physician has been in practice and the quality of care that the physician provides.

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Systematic Review: The Relationship between Clinical Experience and Quality of Health Care

Choudry, Fletcher & Soumerai Ann Intern Med. 2005;142:260-273

Of 62 published studies that measured physician knowledge or quality of care and described time since medical school graduation or age, more than half suggested that physician performance declined over time for all outcomes measured (including screening for cancer, depression adherence to standards of care).

Only 1 study showed improved performance for all outcomes measured.

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What are the concerns ?

Waljee and colleagues (2006) found that patients undergoing a complex operation, such as pancreas removal or heart bypass, are more likely to die within 30 days of surgery if the surgeon is 60 or older (Ann Surg;244[3]:353-362).

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Norcini, et al. (2000) Certification and specialization: do they matter in the outcome of acute MI?

- Studied 4546 physicians
- Acute MI mortality increased by 0.5% for every year since graduation from medical school

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Surgeon characteristics associated with mortality and morbidity following carotid endarterectomy. O'Neill L, Lanska DJ, Hartz A Neurology. 2000;55:773–781

- They studied the relationship between years since licensure of the surgeon (and other factors) and death, or complications short of death, for the procedure of carotid endarterectomy. The study included 12,725 operations in 284 hospitals. Increased years since surgeon licensure predicted increased rate of patient death but did not predict nonfatal complications.

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So the question has to be asked

WHY?

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Errors are part of life

- It was reported in the New York Times that a Kaiser Foundation health plan medical director said that “three to five percent of the nation’s then 425,000 practicing physicians, have an ‘impairment’ of some degree from a wide variety of causes.”

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Is it incompetence-really?

- In his book, The Blind Eye, James B Stewart stated that in 1986 “five out of every 100 doctors are so incompetent, drunk, senile or otherwise impaired that they should not be practicing medicine without some form of restriction”

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Are we picking on physicians ?

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Added Responsibility when working in high-risk environment with unforgiving human error

The commercial airline pilot must have:

- a first class medical certificate every 6 months.
- must submit to random breathalyzer and urine tests for substance abuse.
- must check out in a simulator at least once a year, and there are additional checkouts required by the airline carriers.

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Pilots versus Physicians

- The commercial airline pilot must submit to unannounced checkouts by an air carrier inspector (FAA).
- The medical evaluation of the commercial pilot is quite extensive and includes 11 pages in the FAA manual on the neurologic evaluation alone, checking for seizures, vertigo, cerebrovascular accidents, demyelinating diseases, multiple sclerosis, collagen disease, degenerative diseases, infections.

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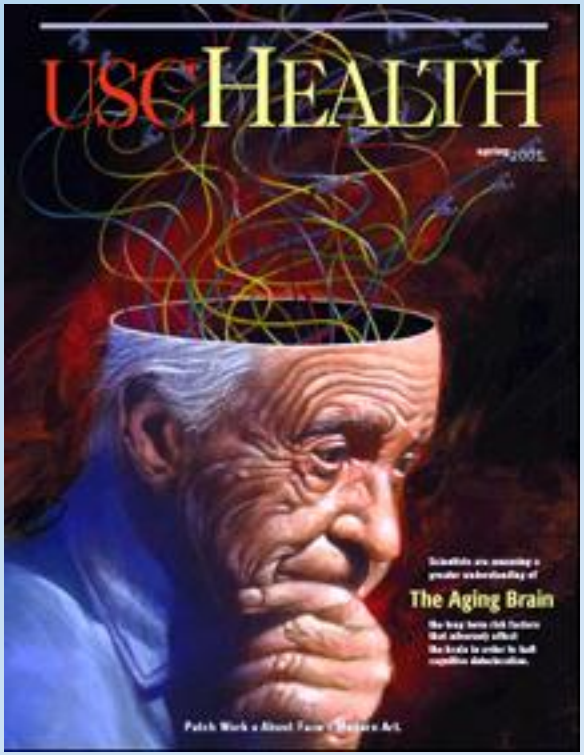
Aging and the Brain



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Aging and the Brain

- Brain weight and volume decrease. On average, the brain loses 5-10 percent of its weight between the ages of 20 and 90
- A decrease in grey matter volume
- Dendritic spines and cortical neurons decrease in size and number
- Inflammatory proteins occur in maturing adults (including the hippocampus, responsible for forming new memories)
- Age-related changes in dopamine synthesis

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The Question: Does age effect competence?

Facts of aging;

- Cardiovascular changes (hypertension)
- Renal Changes (strong relationship BMI and Memory)
- Pulmonary Changes
- Urogenital changes
- Decreased visual acuity
- Often decreased hearing
- Decreased physical strength and stamina

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The Question: Does age effect competence?

Facts of aging on cognition;

- Decreased reaction time
- Decreased fine motor skills/ dexterity
- Difficulty learning new concepts and skills
- Decreased comprehension of complex information
- Decreased analytic processing

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Understanding the cognition-performance link in older physicians

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Understanding the cognition-performance link in older physicians

It is well documented that some (but not all) cognitive abilities decline with age in adults (Craik & Salthouse, 1992).

Information- processing speed, for example, slows, and the capacity to hold information in working memory may also decline with age (Cerella, 1994).

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Crystalized vs. Fluid Knowledge

- Crystalized knowledge involves accumulated knowledge and expertise and relies on long term memory…habitual procedures, which tend to hold up well as we age.

- Fluid knowledge involves novel problem solving, spatial manipulation, mental speed, and identifying complex relations among stimulus patterns.

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Crystalized Abilities

Crystalized abilities increase during the lifespan through education, occupational and cultural experience and exposure to culture and intellectual pursuits.

They are less affected by aging and disease and often remain intact in the early stages of dementia or after brain injury.

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Fluid Abilities

The developmental trajectory of fluid abilities follow neurological maturation, peaking in the mid 20s and declining gradually until the 60s when a more rapid decline takes place.

Fluid abilities are affected by neurological insult, genetics and biological aging processes.

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The Aging Physician and Changes in Cognitive Processing and Their Impact on Medical Practice

Eva & Barnes (2002) Acad Med,77:S1-S

- Analytic processing tends to decline with age whereas nonanalytic processing remains stable.
- Older physicians tend to do less well when dealing with novel, conflicting, and complex patient situations.
- The more individuals rely on their prior experience, the less of a tendency there will be to critically incorporate novel conflicting information.

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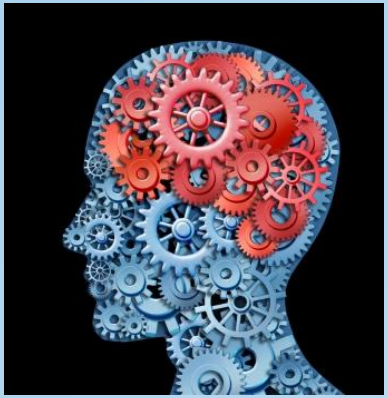
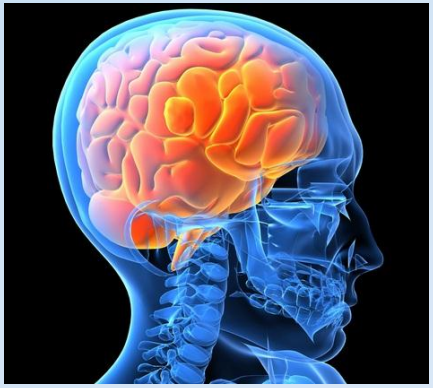
Assessment of Cognitive Abilities: determining competence using neuropsychological assessment





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Goals of a Neuropsychological/Fitness for Duty Evaluation

- Physicians are among those special groups who operate in an environment unforgiving of human error, where cognitive failure can lead to catastrophic consequences.
- Neuropsychological testing is one means of selecting capable doctors. It is also a means of screening for covert disease, and it can be used to establish baseline performance data and provide ongoing monitoring of health.

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Goals of a Neuropsychological/Fitness for Duty Evaluation

- To aid in diagnosing a neuropsychological/neurological condition (dementia, Mild Cognitive Impairment, Significant Attentional Disorder).
- To determine if a primary health condition (cardiovascular /pulmonary/ hepatic and renal changes) is impacting his/her cognitive functioning.
- To determine if cognitive traits or deficits, personality traits or stress reactions are causing or contributing to problem behavior or substandard performance.

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Impairment vs. Cognitive Weakness

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Impairment defined

- Physician impairment is defined by the Federation of State Medical Boards as “the inability to practice medicine with reasonable skill and safety because of physical or mental illness including, but not limited to aging, alcoholism, drug dependence, and habitual or excessive alcohol or chemical use or abuse” (Rassekh, 1996, p. 213)

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Cognitive Weakness ≠ Impairment

- Cognitive strengths refer to the underlying brain skills needed for a particular task. These are the skills that allow us to process the huge influx of information.
- Imagine trying to run the latest software on an outdated computer? Or asking a computer with a small processor or insufficient memory to handle several complex tasks at once?
- Underlying systems aren't up to speed.

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Neuropsychological Domains and its Relationship to Medical Practice

Neuropsychological Function	Medical Practice
Premorbid intelligence and reading skills	• Indication of a decline in function over time. • The ability to profit from continuing education.

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Neuropsychological Domains and its Relationship to Medical Practice

Neuropsychological Function	Medical Practice
Attention	• The ability to attend and determine what is critical and salient. • To sustain auditory and visual attention over a sustained period of time. • The ability to inhibit incorrect responses

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Neuropsychological Domains and its Relationship to Medical Practice

Neuropsychological Function	Medical Practice
Learning and Memory	• The ability to learn and integrate new information and draw from past experience. • The ability to recognize and recall information efficiently and quickly, without irrelevant information impeding.

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Neuropsychological Domains and its Relationship to Medical Practice

Neuropsychological Function	Medical Practice
Perceptual-motor skills	• The ability to perform physical tasks. • Eye-hand coordination. • The ability to manipulate instruments with fine-accuracy

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Neuropsychological Domains and its Relationship to Medical Practice

Neuropsychological Function	Medical Practice
Executive Function Skills	• recognize the significance of unexpected situations in order to quickly make alternative plans when unusual events arise. • planning or decision making abilities. • error correction or troubleshooting.

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MicroCog: Assessment of Cognitive Functioning

Powell, D. H., Kaplan, E. F., Whitla, D., Catlin, R., and Funkenstein, H. H. (1993).

Developed by the The Risk Management Foundation of the Harvard Medical Institutions.

Their original purpose was to produce an instrument that could screen elderly physicians for cognitive impairment and thereby reduce their malpractice liability.

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MicroCog: Brief Description

- Computer-administered and -scored test of cognitive functions.
- Intended as a screening device for cognitive impairment or diagnostic tool for use as part of a general neuropsychological examination.
- Designed to be sensitive to detecting cognitive impairment across a wide age range.
- Takes into account levels of premorbid intellectual functioning by providing age- and education-level adjusted norms.

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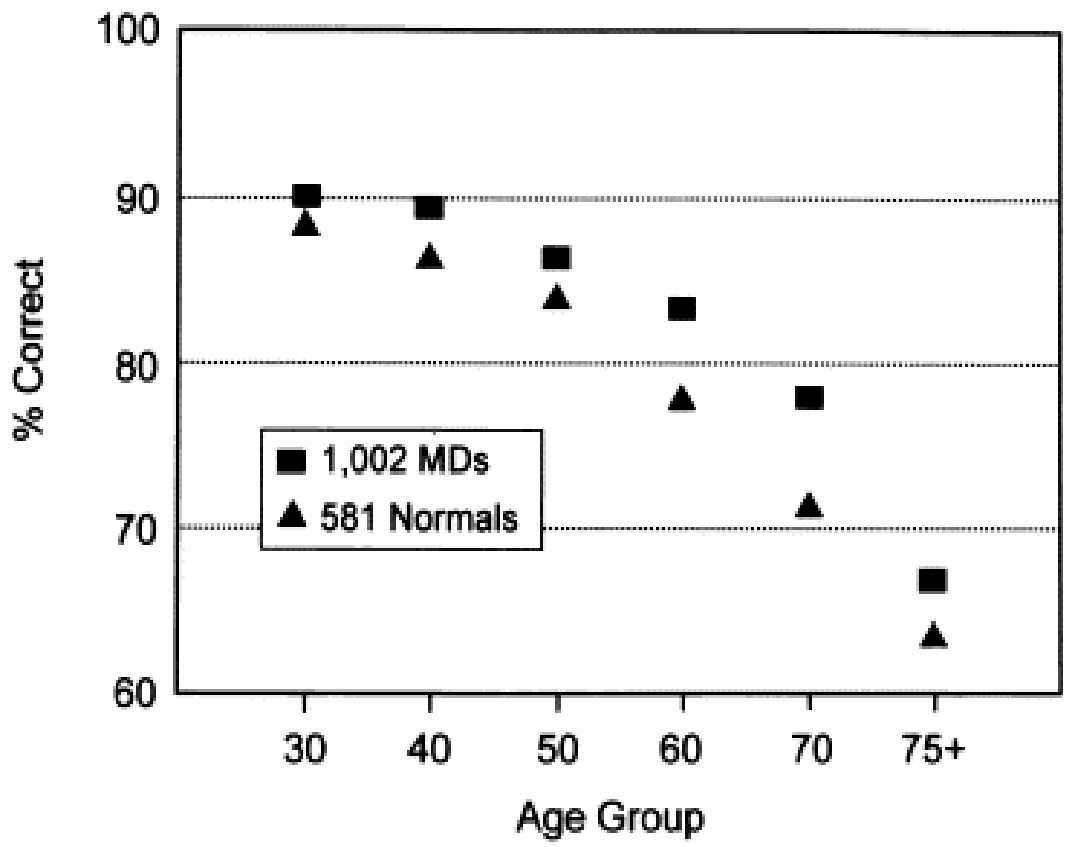
MicroCog Validity from Powell D. Profiles in Cognitive Aging. Cambridge, MA (1994)



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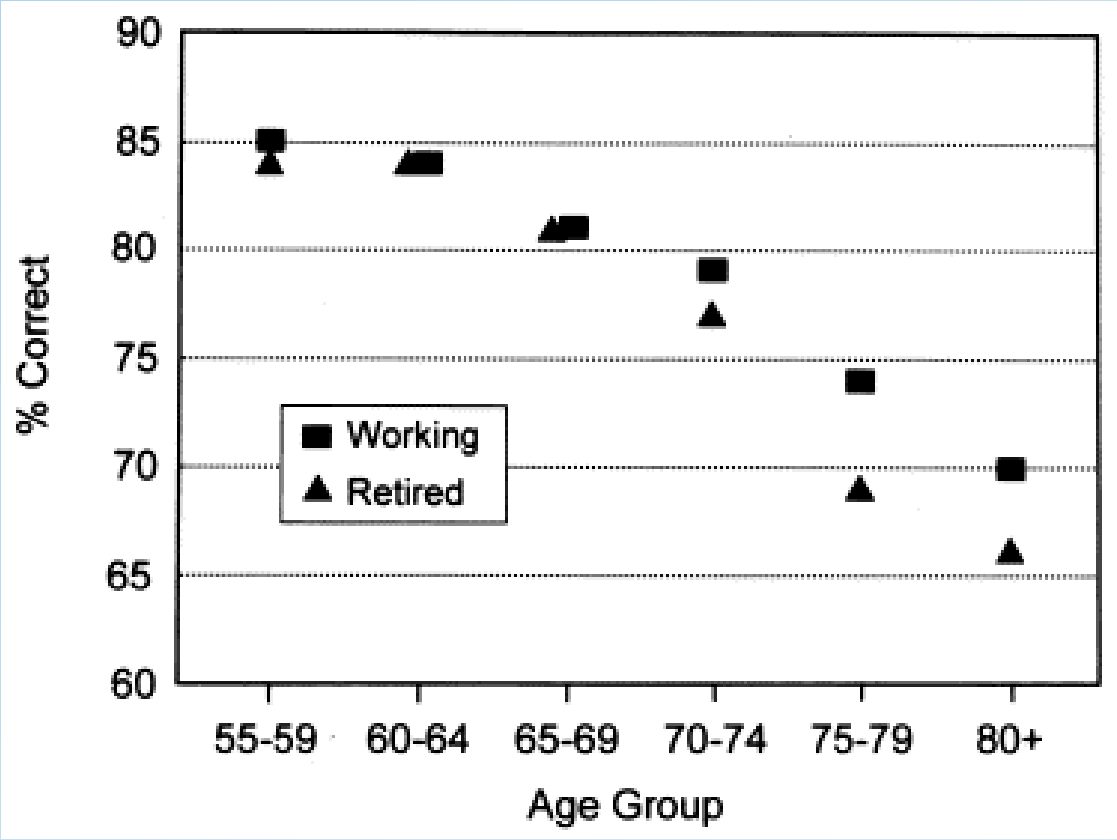
MicroCog scores of working and retired MDs



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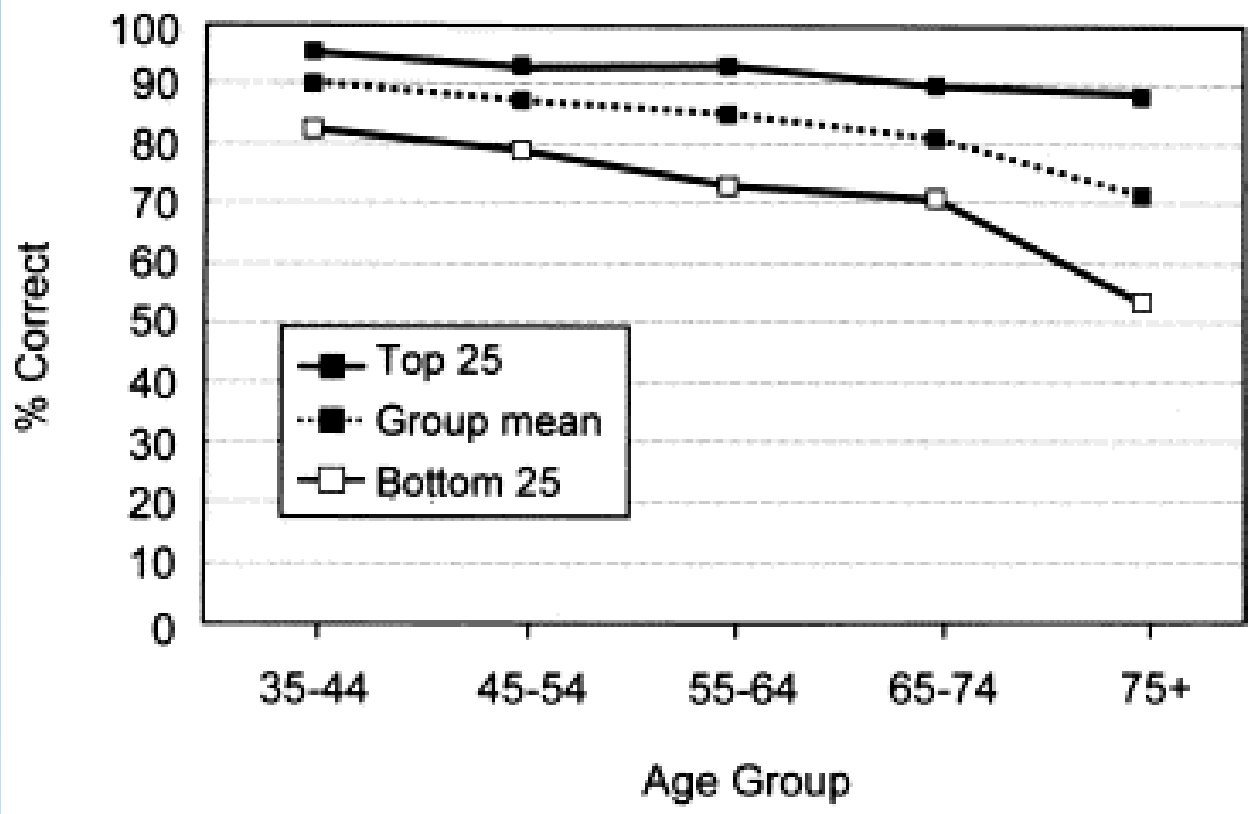
MicroCog: Average attention scores of top and bottom 25 MDs compared with age group means



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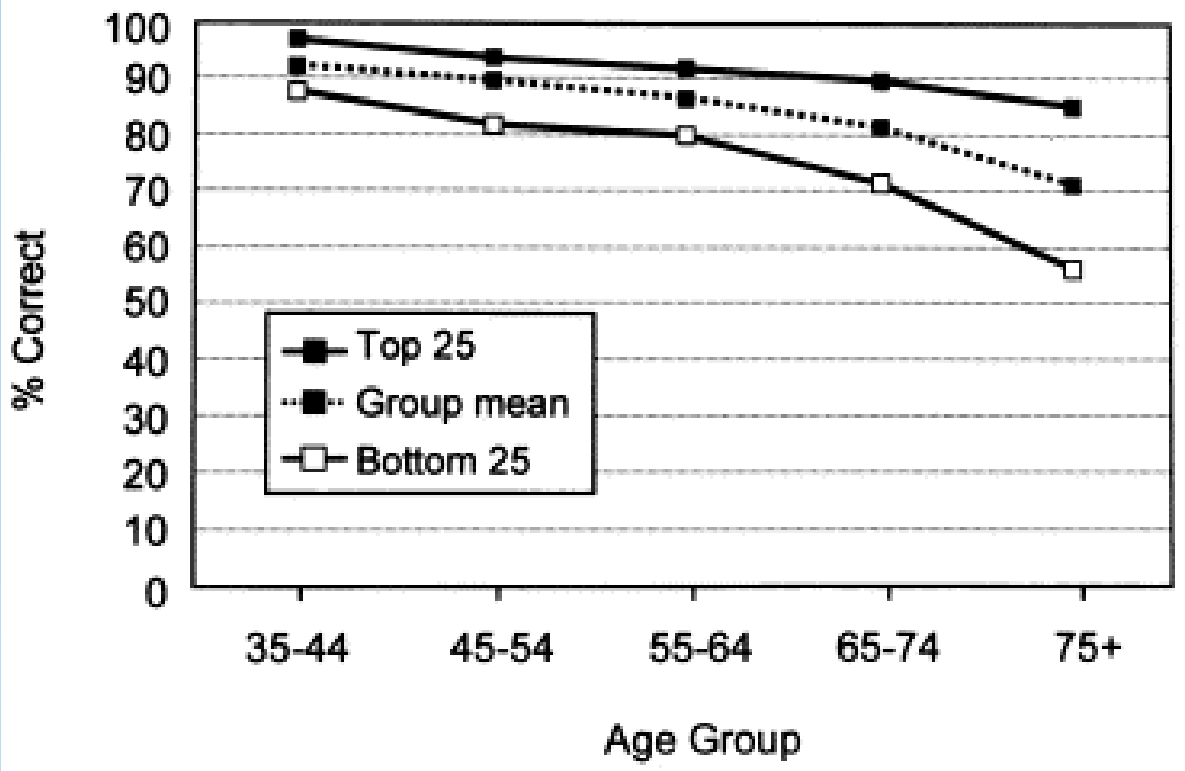
MicroCog:Average verbal memory scores of top and bottom 25 MDs compared with age group means



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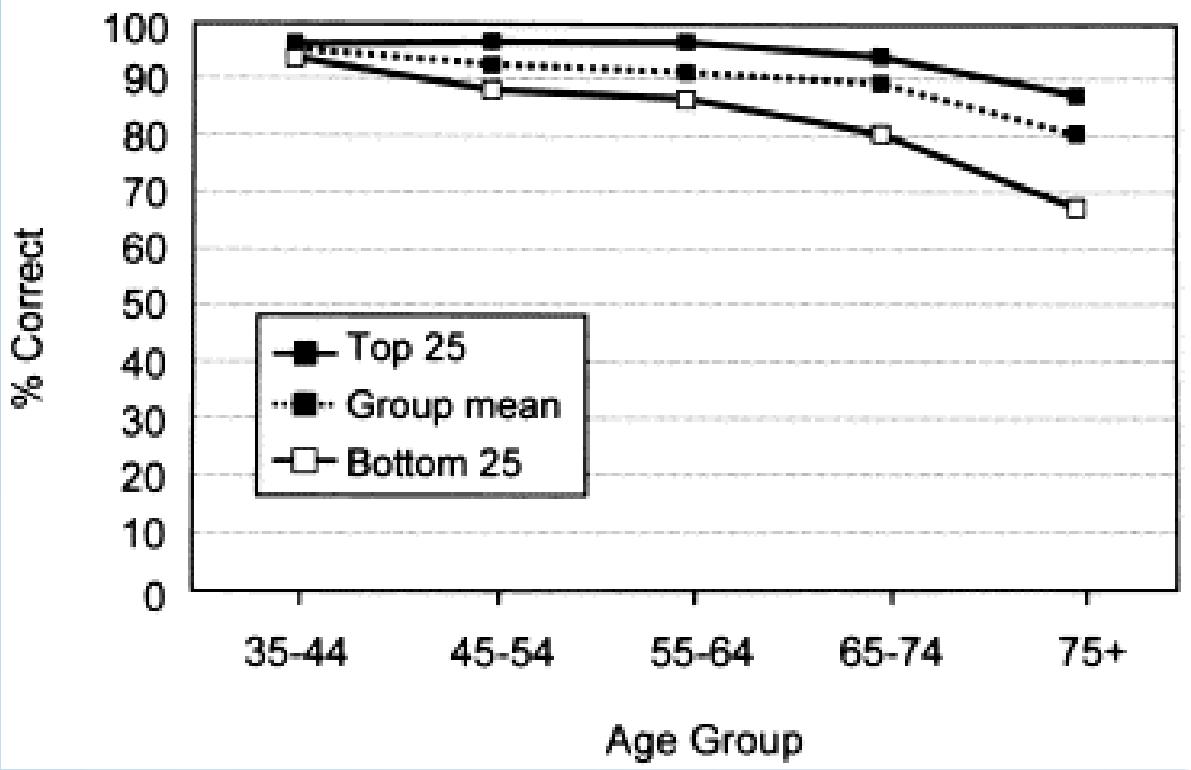
MicroCog:Average visuospatial scores of top and bottom 25 MDs compared with age-group means



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Neuropsychological research on physicians

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Why do we need neuropsychological assessment anyway? Can’t we just talk to peers?

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Psychomotor testing predicts rate of skill acquisition for proficiency-based laparoscopic skills training.

Stefanidis D, Korndorffer JR Jr, Black FW, Dunne JB, Sierra R, Touchard CL, Rice DA, Markert RJ, Kastl PR, Scott DJ. Surgery. 2006 Aug;140(2):252-62

The Relationship between Tests of Neurocognition and Performance on a Laparoscopic Simulator.

Kuzbari O, Crystal H, Bral P, Atiah RA, Kuzbari I, Khachani A, Aslam MF, Minkoff H.
Minim Invasive Surg. 2010;2010:486174.

Visuo-spatial ability in colonoscopy simulator training.

Luursema JM, Buzink SN, Verwey WB, Jakimowicz JJ.
Adv Health Sci Educ Theory Pract. 2010 Dec;15(5):685-94.

Laparoscopic performance is related to Neuropsychological test performance.

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A retrospective review of the neuropsychological test performance of physicians referred for medical infractions.

Perry W, Crean RD.

Source

Department of Psychiatry, University of California, San Diego, 9500 Gilman Drive, La Jolla, CA 92093-8218, USA. wperry@ucsd.edu

Abstract

Physician-related errors are rising, resulting in an increase in disciplinary actions by licensing medical authorities. It has been previously reported that cognitive impairment may be responsible for 63% of all physician-related medical adverse events. In this paper we examine neuropsychological testing results from 148 physicians referred for assessment by the California Medical Board (CMB) for various infractions. The neuropsychological test performance of the physicians was compared to normative reference samples. Overall, they performed in the average range on most measures; however, they demonstrated relative deficits on tests of sequential processing, attention, logical analysis, eye-hand coordination, verbal and non-verbal learning. These findings reveal that this cohort of physicians is performing lower than expected on tests of intellectual and neuropsychological functioning. Applying a neuropsychological framework to the assessment of physicians may uncover potential cognitive factors that contribute to medical practice errors.

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Cognitive Changes and Retirement among Senior Surgeons (CCRASS): Results from the CCRASS Study

Linas A Bieliauskas, MS, PhD, Scott Langenecker, MS, PhD, Christopher Graver, PhD, H Jin Lee, MSC, PhD, Jillian O'Neill, MPH, MBA, Lazar J Greenfield, MD, FACS

BACKGROUND: Because individuals age cognitively at different rates, there is considerable interest in ways to assure that older surgeons have the physical and mental stamina, coordination, reaction time, and judgment to provide appropriate care. To clarify potential relationships between cognitive changes related to aging, the decision to retire, and changes in patterns of surgical practice, this study aimed to identify specific parameters of cognitive change among senior surgeons.

STUDY DESIGN: Computerized cognitive tasks measuring sustained attention, reaction time, visual learning, and memory were administered to 359 surgeons at the annual meetings of the American College of Surgeons over a 6-year period. A self-report survey was also administered to assess subjective cognitive changes and the status of surgical practice and retirement decisions.

RESULTS: Expected age-related cognitive decline was demonstrated on all measures, although measured reaction time was notably better than age-appropriate norms. There was a marked relationship between self-reported subjective cognitive change and retirement status, but not to changes in surgical practice. There was no notable relationship, however, between subjective cognitive change and objective cognitive measures. There were marked relationships between age and retirement decision or status and between age and changes in surgical practice.

CONCLUSIONS: These results suggest that although self-perceived cognitive changes play a role in the decision to retire, they are not related to objective measures of cognitive change, and are not reliable in the decision to retire. The development of readily accessible measures of cognitive changes related to aging may serve to assist decisions either to continue surgical practice or to retire. (J Am Coll Surg 2008;207:69–79. © 2008 by the American College of Surgeons)

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Cognitive functioning, retirement status, and age: results from the Cognitive Changes and Retirement among Senior Surgeons study.

Drag LL, Bieliauskas LA, Langenecker SA, Greenfield LJ.
J Am Coll Surg. 2010 Sep;211(3):303-7

- They concluded that the majority of practicing senior surgeons performed at or near the level of their younger peers on all cognitive tasks, as did almost half of the retired senior surgeons. This suggests that older age does not inevitably preclude cognitive proficiency.

Number of tests	Age group								Total
	60–64		65–69		70–74		75+		
	n	%	n	%	n	%	n	%	
0	43	78	14	48	7	47	2	22	66
1	10	18	11	38	7	47	7	78	35
2	2	4	4	14	1	6	0		7
3	0		0		0		0		0
Total	55	100	29	100	15	100	9	100	108

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Cognitive difficulties are not only due to neuropsychological problems

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Doctors' Toughest Diagnosis: Own Mental Health

ERICA GOODE Published in New York Times : July 08, 2003

- Reluctant to call attention to their plight, doctors who become depressed often try to act as their own psychiatrists, in many cases prescribing for themselves inadequate doses of antidepressants.

- "Most of the physicians who come to see me for their depression fight it out themselves first," said Dr. J. John Mann, a professor of psychiatry and radiology at Columbia. "They come in because the treatment wasn't working and the depression became so severe they couldn't handle it."

- Yet the biggest obstacle to depressed doctors' dealing openly with their illness, experts say, is that such openness carries the risk of serious consequences

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Doctors and Suicide

Over several decades, studies have consistently shown that physicians have higher rates of suicide than the general population — 40 percent higher for male doctors and 130 percent higher for female doctors.

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CASE EXAMPLE

Case 1

Dr. XXXX, M.D., is a 68-year-old, married, right-handed male who was referred for a Fitness for Duty/neuropsychological evaluation as part of the Physician Assessment and Clinical Education program (PACE). He was referred by his hospital medical group where he has been practicing since the mid 1990s. Dr. XXXX was referred to the PACE program after 4 accounts of apparent “wrong site” spinal surgery operation. Each account was easily explained by the physician.

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Case 1

Dr. XXXX enjoyed an outstanding career and earlier had the position of Chief of Surgery at a prestigious teaching hospital. He was of reasonably good health and did not have a history of psychological difficulties, substance use or physical trauma. He was well-liked by his colleagues and had a solid home life.

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Case 1 Performance on FFD assessment

- He was extremely articulate and clearly put forth his best effort.
- The results of the evaluation indicated that that his general level of intellectual functioning was above-average range.
- His strengths were in tests of verbal ability.
- In contrast he performed poorly on spatial, non-verbal tests.
- His profile, however, was notable for committing a high number of omission errors under time-demand and for taking an unusually long time initiating moves on certain tasks that involve complex-decision making.
- Furthermore, he performed poorly on a test of manual dexterity, was relatively slow with regard to speed of information processing and his motor speed was slow when compared to his peer group.

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Case 1 Determination

- “Overall, this pattern of impairment is not suggestive of a dementia. Furthermore, some low scores are commonly observed on extensive neuropsychological batteries even among healthy individuals. However, Dr. XXXX’s below-average performance across numerous non-verbal and speeded measures is atypical when compared to the general public as well as those persons with similar years of education.”

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Case 1: Conclusion

- Poor attention to salient detail, slow processing and poor dexterity can potentially be problematic and affect one's ability to perform surgical procedures, given that surgery requires consistent attentional control and highly skilled, fine manual movements.
- "The deficits observed on testing may emerge and be especially problematic when Dr. XXXX is faced with complex situations where sustained attention to critical details, mental flexibility, and problem solving of abstract situations under time-demand is required."

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Case 1 Follow Up

- While travelling to visit us for his evaluation his home institution conducted an intensive focused review of his surgical cases and uncovered 9 more examples of below SOC practice.

- With this information, in addition to the results from our assessment, the physician surrendered his license and retired.

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Questions

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State of California
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, Ca 95815
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Memorandum

Date: December 31, 2012

To: Board Members

From: Kevin A. Schunke
Staff Liaison to the Physician Assistant Board

Subject: Service by Physician Assistants; Delegated Service Agreements

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At the October, 2012, Medical Board meeting, questions were asked about physician assistants (PAs): professional activities between graduation from a PA program and licensure, and the requirement of a delegated service agreement (DSA).

Following that meeting, Board staff met with staff and legal counsel from the Physician Assistant Committee (PAC), now the Physician Assistant Board, and were able to determine the following information.

For physicians after graduation from medical school, there is a period during which the person remains unlicensed and must complete some postgraduate training before being eligible for licensure. Depending on whether a person is a graduate of a medical school in the US/Canada (US/CAN), or if the person is an international medical graduate (IMG), the graduate is allowed to practice medicine without a license for up to 24 months (US/CAN) or for up to 36 months (IMGs) so long as the person is enrolled in an approved postgraduate training program.

A similar interim period of unlicensed service does not exist for PAs. Once a PA has graduated from the education program, the person cannot work as a PA until the license is issued. There is no mandatory postgraduate training period that is a pre-requisite to licensure. Once a PA has graduated and is licensed, the PA can go work in the "real world" or can pursue an optional postgraduate training program that is a furthering of professional development. Any professional service offered by a PA can only be accomplished via a DSA with a supervising physician(s).

Following are a series of questions and answers related to that inquiry.

1. Do PA-residents need a DSA, or, by virtue of being in a training program, are they exempt from a DSA?

   Answer: Because all PAs are licensed, even those enrolled in a postgraduate training program, they must have a DSA in place to perform their duties.

2. Do PA-residents need designated supervising physician, or, by virtue of being in a training program, are they exempt from being supervised by designated physicians because their program director oversees their training?

   Answer: Because all PAs are licensed, even those enrolled in a postgraduate training program, they must have a designated supervising physician in addition to a program director who oversees the training aspect of their work.

3. When PA-residents are rotating thru the various components (core and elective clinical courses) of their PG training, do they need a new DSA for every rotation?

   Answer: If the PA-resident's duties change based on the various rotations of the training program, then a new DSA is required to outline the new duties. It can be with the same supervising physician or a new physician.

4. If PA-residents are rotating through a high-energy department (such as the Emergency Department), and doctors on call are coming and going, who is supervising the PA-resident and is a DSA required?

   Answer: As stated before, a DSA always is required. As explained by PAC staff, PAs seldom are assigned to the Emergency Department. Instead, they are assigned to, for example, the Surgery Department, are supervised by a surgeon, and only work on-loan to the Emergency Department.

5. Can a PA-resident be supervised by a licensed medical resident?

   Answer: Yes. Any licensed physician can supervise a PA.

6. Can a PA-resident be supervised by an unlicensed medical resident?

   Answer: No. Only licensed physicians can supervise a PA.

MEDICAL BOARD OF CALIFORNIA

QUARTERLY BOARD MEETING

Sheraton San Diego Hotel and Marina
Fairbanks A & B
1380 Harbor Island Drive
San Diego, CA 92101

October 25-26, 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

Dr. Levine called the meeting of the Medical Board of California (Board) to order on October 25, 2012 at 3:00 p.m. A quorum was present and notice had been sent to interested parties.

Members Present:

Sharon Levine, M.D., President
Michael Bishop, M.D.
Silvia Diego, M.D.
Dev GnanaDev, M.D.
Denise Pines
Janet Salomonson, M.D.
Gerrie Schipske, R.N.P., J.D.
David Serrano Sewell, J.D.
Barbara Yaroslavsky, President

Members Absent:

Reginald Low, M.D.

Staff Present:

Angela Chang, Investigator
Dianne Dobbs, Department of Consumer Affairs' Legal Counsel
Tim Einer, Administrative Assistant
Kurt Heppler, Staff Counsel
Kimberly Kirchmeyer, Deputy Director
Armando Melendez, Business Services Analyst
Regina Rao, Business Services Analyst
Letitia Robinson, Research Specialist
Kevin Schunke, Outreach Manager
Barbara Shakowski, Investigator
Jennifer Simoes, Chief of Legislation
Laura Sweet, Deputy Chief of Enforcement
Renee Threadgill, Chief of Enforcement

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See Vang, Business Services Analyst
Linda Whitney, Executive Director
Curt Worden, Chief of Licensing

Members of the Audience:

Teresa Anderson, California Academy of Physician Assistants
Hilma Balaian, Kaiser Permanente
Yvonne Choong, California Medical Association (CMA)
Zennie Coughlin, Kaiser Permanente
Julie D'Angelo Fellmeth, Center for Public Interest Law (CPIL)
Long Do, California Medical Association (CMA)
Jack French, Consumers Union CA Safe Patient Network
Doreathea Johnson, Department of Consumer Affairs' Legal Affairs
Lisa McGiffert, Consumers Union CA Safe Patient Network
Carole Moss, Consumers Union CA Safe Patient Network/Nile's Project
Ty Moss, Consumers Union CA Safe Patient Network/Nile's Project
Maryann O'Sullivan, Consumers Union CA Safe Patient Network
Carlos Ramirez, Senior Assistant Attorney General, Office of the Attorney General
Loren Reed, Department of Consumer Affairs, Public Affairs Office
Harrison Robbins, M.D.
Kathryn Scott, Lenscrafters
Carrie Sparrevohn, Midwifery Advisory Council
Charlene Zettel, Donate Life California

Prior to agenda item two, Dr. Levine introduced and welcomed the two new Board members. Denise Pines and David Serrano Sewell, J.D., appointed to the Board by Governor Brown on August 29, 2012.

David Serrano Sewell is a Deputy Chief Attorney for the city of San Francisco. He recently completed seven years of service with the California Institute for Regenerative Medicine, the state agency responsible for awarding $3 billion for stem cell research.

Denise Pines is from Los Angeles and is responsible for strategic planning and business development for her company, Denise Pines Incorporated. Prior to founding her business, Ms. Pines served as the President of the Smiley Group.

Agenda Item 2 Public Comment on Items not on the Agenda

Charlene Zettel from Donate Life California, urged the Board to consider sponsoring a specialty license plate that promotes organ and tissue donation. She requested that the members place this item on an upcoming agenda.

Jack French from Consumers Union Safe Patient Project, wished to pose several issues related to the Board's responsibility for physician owned ambulatory surgery centers. Due to the recently enacted SB 100, it requires the Board to post information on the Web site regarding ambulatory surgery centers. The Board is also including the final inspections on the Website as well. Access to this information should be more consumer friendly and public education to address this was encouraged. There is also a concern that adverse events that occur at these centers is to be reported and fines levied in the event that these reporting requirements are ignored. The Board was urged to notify ambulatory surgery centers and physicians now and periodically of these new reporting requirements and associated fines. There was also a suggestion that

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at a future meeting staff should report on the respective role that the Board and the California Department of Public Health would have to coordinate the receipt of this adverse action information.

Carole Moss from Consumers Union Safe Patient Project, shared concern with issues related to the statute of limitations. This official process is something that remains unclear to consumers. The Board was encouraged to review the impact of the statute to see how often the Board finds extreme departure or failing by a physician and then drops the case because the statute of limitation has run out.

Agenda Item 5 Consideration and Approval of Sunset Review Report Final Draft
Prior to Ms. Kirchmeyer and Ms. Robinson beginning their report, Dr. Levine provided a short explanation of the Sunset Review process. The Sunset Review is a periodic opportunity where the Legislature reviews the authorizing statutes under which the Board carries out its mission. This periodic review allows confirmation that legislation and regulations have kept up with what is happening with the practice of medicine and the delivery of care.

Ms. Kirchmeyer presented that this Sunset Review report was prepared in response to the questionnaire provided to the Board by the Senate Business and Professional Economic Development Committee. In addition to the report, there are three binders that will be presented to the Committee. These binders include Board studies and publications. Every four years the Board goes through a review to determine effectiveness and if there is a need to extend the sunset date of the Board.

The Medical Board statutes state that the Board will remain in effect until January 1, 2014. Therefore, Legislation must be introduced in 2013 to extend the Board's sunset date in order for the Board to continue. The Sunset Review process starts with the completion of the report that must be submitted to the Senate by November 1, 2012. The Senate Policy Committee will review the document and provide information back to the Board based upon the review. A hearing will be held in Spring 2013, at which time the Board will present responses to these findings.

This is also the Board's opportunity to reexamine the laws of the Board and make enhancements in order to make the Board more effective and increase consumer protection. The Board has identified 22 issues that will improve the licensing, enforcement, and overall Board functions.

Ms. Robinson began by reviewing seven new issues for Licensing Program enhancements that will ensure the laws are written to accommodate the continuing evolution of medical training and testing in the United States and worldwide.

The first issue would be for the Board to recommend to the Legislature to revise the laws to allow for changes that will take place in the USMLE examination process, specifically to address the step three migration into two parts, with two separate examination scores.

Ms. Robinson continued with the next issue that would recommend to the Legislature revising laws to allow for the evolving method of teaching medical students in year round classes with shortened academic year requirements and competency based training methods. This would allow for training in various settings, not just hospital based training.

The third issue that the Board would recommend to the Legislature is that the Board continue its

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review of the Federation of State Medical Boards Maintenance of Licensure Program and it could propose solutions in future Legislation or at the next Sunset Review.

The next issue presented would be to recommend that the Legislature revise the laws regarding the non practice reentry into medical licensure to ensure public protection.

The fifth recommendation to the Legislature by the Board would be to require licensees to provide, and keep current, an email address for notifications.

The next recommendation to the Legislature would be to eliminate the requirement for the Board to post on the Web site post graduate training information.

The final Licensing recommendation to the Legislature would be a revision to the laws to clarify that unlicensed residents in accredited resident fellowship programs in California are exempt from corporate practice laws.

Dr. GnanaDev made a motion to accept the seven issues to improve the Licensing Program and to move these forward to the Legislature as issues for the Medical Board; furthermore, the fifth recommendation should include a revision that email addresses will remain confidential, and to strike the word unlicensed in the final recommendation; s/Yaroslavsky.

Public comment was received for this agenda item.

Yvonne Choong, from CMA commented that by not posting post graduate training that could eliminate a key piece of information for many patients. Currently, the post graduate training is verified by the Board whereas, the board certification specialty is self-reported by the physician.

Dr. Levine called for the vote. Motion carried.

Ms. Kirchmeyer continued that the Enforcement Program sections would be split into two separate sections. The first three issues would enhance consumer protection related to prescription drug use.

Ms. Kirchmeyer reported that the Board has reason to believe that numerous deaths have occurred in the state that are related to prescription drug overdoses. In the last fiscal year, the Board received only four coroner reports and only one of them was due to a drug related death. Business and Professions Code §802.5 requires a coroner to make a report to the Board when he or she believes information based on the findings of a pathologist indicate that a death may be the result of a physician's gross negligence or incompetence. The decrease in coroners reports could be due to the fact that coroners have to make this determination. In order to alleviate coroners from making this determination, the Board would recommend all deaths related to prescription overdoses should be reported to the Board for further investigations. This would allow the Board to determine if the prescribing physicians were treating the patient in an appropriate or negligent manner.

Ms. Kirchmeyer continued that the CURES system is a monitoring system that enables prescribers and dispensers to obtain a patient history or evaluation report to assist in identifying patients who might be doctor shopping. There currently is not enough funding to make necessary improvements to the computer system to make it more user friendly and improve consumer protection.

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It is recommended that all licensees who prescribe or dispense pay an additional minimal fee to support the necessary enhancements to the computer and staffing to run the system. Once the enhanced system is operational, all prescribers should be required to perform a CURES lookup prior to all Schedule II and III prescriptions.

Ms. Yaroslavsky made a motion that the Board move forward with coroner reporting and changing the layout to neutral wording; it was also recommended to move forward with CURES with a revision that states the system needs to have adequate funding, and it be provided by individuals who prescribe or dispense, pharmaceutical companies, and the public; s/GnanaDev.

Public comment was received for this agenda item.

Yvonne Choong suggested that the CMA recommends that the Board change the recommendation of reporting prescription drug overdoses to be contingent upon more data study, and educating coroner offices of their responsibilities rather than jumping immediately to require that the coroner report all deaths to the Board. Ms. Choong continued that the CMA is in agreement with the CURES funding and believes that this should be a shared cost, not just a fee added to licensees.

Lisa McGiffert, Consumers Union CA Safe Patient Network spoke that the recommendation regarding the coroners reports could be a valuable tool. This information could help identify trends or commonalities if a certain physician's name were to come up repeatedly.

Julie D'Angelo Fellmeth, Center for Public Interest Law (CPIL) spoke in support of a proposal requiring coroner reporting for prescription drug overdose deaths.

Dr. Levine called for the vote. Motion carried.

Ms. Schipske made a motion to remove the issue requiring physicians to access the CURES system; s/GnanaDev; motion carried.

Ms. Kirchmeyer continued with discussing enforcement and consumer protection enhancements and suggested that the Board recommend to the Legislature that all malpractice settlements be posted.

Julie D'Angelo Fellmeth, CPIL provided public comment by reviewing with the Board the history of medical malpractice settlements in excess of $30,000.

Dr. Salomonson made a motion to withdraw the recommendation from the Sunset Report to post all malpractice settlements. It is requested that more research be done on how to better use the malpractice information that is received by the Board to appropriately report to consumers and provide valuable information; s/Bishop.

Public comment was received for this agenda item.

Lisa McGiffert, Consumers Union CA Safe Patient Network requested that the Board consider moving this forward. This is pertinent information that consumers would turn to the Board to view this public information.

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Yvonne Choong, CMA stated they support the motion to bring this back after more information is compiled.

Dr. Levine called for the vote; motion carried.

Ms. Kirchmeyer reviewed that the next recommendation pertained to quality of care and it is suggested that the Board should receive an exception for malpractice cases from the upfront review required pursuant to Business and Professions Code §2220.08.

The next item presented related to physician availability, knowledge, and training. The Board would recommend that legislation be passed requiring regulations be implemented to define physician availability in other settings and outline a physician's training and knowledge needed when supervising other healthcare providers.

Ms. Kirchmeyer continued with a recommendation of requiring physicians to notify patients to when their license is placed on probation with monitoring requirements.

After discussion from the members, it was decided to remove the patient notification recommendation from the report. This item will be brought back as an agenda item at a future meeting for a broader discussion.

Ms. Kirchmeyer next discussed consistency in the time to provide medical records. The Board should recommend that the law be amended to require a facility to provide medical records within 15 days upon request, if the facility has electronic health records.

The next item discussed was the decline in the number of 805 reports received by the Board. It is recommended that an amendment to existing law be made to require the California Department of Public Health and hospital accrediting agencies to send reportable peer review incidences found during an inspection of the facility to the Board. The Board would also recommend a requirement that these entities notify the Board if the hospital is not performing peer review.

Ms. Kirchmeyer continued with the recommendation to eliminate the ten year posting requirement in order to ensure transparency to the public.

Dr. Levine stated that this is somewhat two fold. One would be for the Legislature to decide if the removal of items after ten years should be eliminated, and the other is to clarify when the clock begins on the ten years.

The next item presented for recommendation was the expert reviewer opinions. The first change would require the respondent to produce expert reports addressing each of the quality of care issues raised in the pending accusation. Second, the deadline for both sides to make the required disclosures under §2334 is only 30 calendar days prior to the commencement date of the hearing, if the deadline is not met, it can result in a delay to an early settlement of these cases. Lastly, the term commencement date as used in that section should be legislatively defined. This should be the first hearing date initially set by the Office of Administrative Hearing, regardless of any subsequent continuances of the hearing.

Dr. Levine clarified that there should be specificity to the timeframes.

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Ms. Yaroslavsky made a motion that the Board should receive an exemption for malpractice cases from the upfront review required pursuant to Business and Professions Code §2220.08; require the establishment, by regulation, of training knowledge and availability of physicians in specified practice settings; require that health facilities with electronic health records produce patient reports in 15 days; require California Department of Public Health and other accrediting agencies to send peer review reportable actions; eliminate the requirement to remove Board actions over ten years; require production of the full respondents expert report and examine defining a term commencement of the hearing and define the number of days that production of information is required. s/Serrano Sewell.

Public comment was received for this agenda item.

Hilma Balaian, Kaiser Permanente, voiced concern with some of the newly licensed doctors might have a probationary status on their license. By being required to disclose this to their patients, their training could be in jeopardy if the patient refuses to be examined by them.

Lisa McGiffert, Consumers Union CA Safe Patient Network, wished to go on the record with several issues. One is that when a physician is on probation, it is important and critical for patients to know when these situations are present. The other item would be eliminating public information from the Web site after ten years; this should remain on the internet and be available forever for the public to see the whole history.

Teresa Anderson, California Academy of Physician Assistants wished to comment that for PAs, there is legislation or regulation that governs how they are supervised. In terms of availability, they are able to be supervised either in person or electronically.

Harrison Robbins, M.D. discussed procedures of laser and IPLs as a significant problem that is easily overlooked.

Dr. Levine called for the vote. Motion carried.

Ms. Robinson then continued with presenting the next recommendations. She explained that unless physicians are certified by a specialty board as defined by law, they are prohibited from using the term board certified in their advertisements. The Board would recommend elimination of the Board approving specialty boards equivalent to the American Board of Medical Specialties, leaving those that are currently recognized as approved for advertising purposes.

The next recommendation would involve the requirement that all medical assistants be certified by an approved organization.

Dr. Levine discussed that she would actually like to remove this item from the recommendation until more information could be obtained.

Ms. Robinson discussed that the next recommendation would be to transfer the Registered Dispensing Optician (RDO) program to the Optometry Board.

The last issue discussed in this section encompasses three items in the Sunset Review that pertain to

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the Midwifery Program. The Board will recommend addressing in legislation the ongoing issues related to Midwifery including supervision, medical devices and drugs necessary for the profession, and student apprenticeships and assistants.

Ms. Yaroslavsky made a motion to recommend inclusion in the Sunset Review: the elimination of the specialty board, review by the Board, transfer of the RDO program, and the three licensed midwife program issues; s/Schipske.

Public comment was received for this agenda item.

Kathryn Scott, representing Lenscrafters communicated that the suggestion to move the RDO program to the Optometry Board creates serious concerns and at the end of the day, the consumer will pay if the industry is regulated in a way that compresses the market. Ms. Scott suggested that perhaps her organization and the Board could have a dialogue to discuss this in more detail.

Carrie Sparrevohn, Chair of the Midwifery Advisory Council, spoke that there are several ongoing issues. One is the medication issue. Midwives are trained to use certain drugs and devices but, they cannot obtain them unless there is physician supervision. The other issue is the student issue that was not really thought out when the original legislation was written and now needs some clarifying pieces. Ms. Sparrevohn stressed that legislation is needed and she is available to provide whatever support that staff might need to work through these issues.

Yvonne Choong stated that they look forward to having the supervision issue be more defined. Being more vague is probably going to be less helpful than being more specific.

Ms. Yaroslavsky, the maker of the motion, requested that the issues that were presented be separated for voting purposes. Ms. Schipske, the second on the motion, agreed to the amended motion.

Dr. Levine called for the vote for the approval of the elimination of the specialty board. Motion carried.

Dr. Levine called for the vote for moving forward with the licensed midwife program issues. Motion carried.

Dr. GnanaDev made a motion to retract the recommendation of sending the RDO program to the Optometry Board, but to see if there is an alternative agency that is appropriate, such as the Department of Consumer Affairs; s/Schipske. Motion carried.

Prior to the conclusion of the meeting, Julie D'Angelo Fellmeth, CPIL provided public comment. Ms. D'Angelo Fellmeth wished to make comments on Vertical Enforcement (VE) and identify some omissions. One point is that she feels that the Board should be embracing VE in this report and seeking its extension with improvements to better protect patients. She discussed that the Board should rethink the tone of Section five and the critique of the AG's office and share some of the responsibility for the continuing VE implementation problems. She believes that the report should not only focus on the cost of VE but, on the improvements that it is making to the Enforcement Program. The Board needs to quantify the benefits of VE instead of just counting the dollar costs.

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Dr. Levine adjourned the meeting at 6:52 p.m. and announced that the Board Meeting would reconvene on Friday October 26, 2012 at 9:00 am.

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Agenda Item 7 Call to Order/ Roll Call

Dr. Levine called the meeting of the Medical Board of California (Board) to order on October 26, 2012 at 9:00 a.m. A quorum was present and notice had been sent to interested parties.

Members Present:

Sharon Levine, M.D., President
Michael Bishop, M.D.
Silvia Diego, M.D.
Dev GnanaDev, M.D.
Denise Pines
Janet Salomonson, M.D.
Gerrie Schipske, R.N.P., J.D.
David Serrano Sewell, J.D.
Barbara Yaroslavsky, President

Members Absent:

Reginald Low, M.D.

Staff Present:

Dianne Dobbs, Department of Consumer Affairs' Legal Counsel
Tim Einer, Administrative Assistant
Kurt Heppler, Staff Counsel
Kimberly Kirchmeyer, Deputy Director
Armando Melendez, Business Services Analyst
Regina Rao, Business Services Analyst
Letitia Robinson, Research Specialist
Eric Ryan, Supervising Investigator
Kevin Schunke, Outreach Manager
Jennifer Simoes, Chief of Legislation
Pat Stillwell, Investigator
Laura Sweet, Deputy Chief of Enforcement
Renee Threadgill, Chief of Enforcement
See Vang, Business Services Analyst
Linda Whitney, Executive Director
Curt Worden, Chief of Licensing

Members of the Audience:

Teresa Anderson, California Academy of Physician Assistants
Hilma Balaian, Kaiser Permanente
David Bazzo, M.D., UCSD PACE
Yvonne Choong, California Medical Association (CMA)
Zennie Coughlin, Kaiser Permanente
Julie D'Angelo Fellmeth, Center for Public Interest Law (CPIL)

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Jack French, Consumers Union CA Safe Patient Network
Michael Grace, Doc Defender
Alfredo Hueso, CA Citizens for Health Freedom
Doreathea Johnson, Department of Consumer Affairs' Legal Affairs
Kathleen McCallum, Northern CA Aesthetic Nurses Association
Lisa McGiffert, Consumers Union CA Safe Patient Network
Mona Maggio, Board of Optometry
Carole Moss, Consumers Union CA Safe Patient Network/Nile's Project
Ty Moss, Consumers Union CA Safe Patient Network/Nile's Project
William Norcross, M.D., UCSD PACE
Carlos Ramirez, Senior Assistant Attorney General, Office of the Attorney General
Loren Reed, Department of Consumer Affairs, Public Affairs Office
Harrison Robbins, M.D.
Joe Rose, American Health and Safety Institute
Gerri Ryan, Nizhoni Institute of Midwifery
Carrie Sparrevohn, Midwifery Advisory Council
John Valencia, American Society for Dermatological Surgery

Prior to agenda item eight, Dr. Levine returned to agenda item five and requested a motion to approve the Sunset Review Report final draft that was discussed the night before.

Ms. Yaroslavsky made a motion to approve the entire Sunset Review Report as amended, for distribution to the Legislature, with the caveat that members may submit stylistic comments to the Executive Officer or the Deputy Director for inclusion in the report; s/GnanaDev.

Public comment was received for this agenda item.

Mona Maggio, from the Board of Optometry asked the Board to consider the option of the placement of Registered Dispensing Optometrists (RDOs) under the direction of the Board of Optometry. This placement would assist in the streamlining and efficiency of complaints. There is currently a process that requires dual investigations. One complaint could be investigated by their board about the optometrist and within the realm of the same complaint, it could include the RDO and that would need to be investigated by the Medical Board.

Dr. Levine called for the vote. Motion carried.

Agenda Item 8 Public Comment on Items not on the Agenda

Lisa McGiffert, from Consumers Union CA Safe Patient Network addressed concerns about the uniform standards for substance abusing doctors. When the Board is made aware of a doctor with substance abuse issues, this should be addressed in a comprehensive and predictable process that is publicly transparent and has integrity. Currently the Board is not in full compliance with the uniform standards policy that has been adopted for all healing arts boards. Ms. McGiffert requested that a future agenda item should address how the Board is defining substance abusing doctors and to report how it is currently dealing with these physicians when it has been brought to the Board's attention.

Ty Moss, representing Consumers Union CA Safe Patient Network/Nile's Project, requested that the Board should place as a future agenda item, a discussion of an option to teleconference public

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meetings. This could increase the participation in the Board's meetings by allowing consumers to participate remotely.

Alfredo Hueso, on behalf of California Citizens for Health Freedom asked the Board to show their support for the proposed cancer freedom bill that their organization will be introducing next year.

Agenda Item 3 Election of Officers (Vice President and Secretary)
Dr. Salomonson made a motion to nominate Dr. Diego as Board Secretary; s/Yaroslavsky; motion carried.

Ms. Yaroslavsky made a motion to nominate Ms. Schipske as Board Vice President; s/Salomonson; motion carried.

Agenda Item 9 Approval of Minutes from the July 20, 2012 Meeting
Ms. Schipske made a motion to approve the minutes from the July 20, 2012 meeting; s/Yaroslavsky; motion carried.

Agenda Item 4 Executive Committee Update
Dr. Levine reported that the Executive Committee had met in September in Sacramento. The Committee received a presentation from the Board of Pharmacy reflecting the Board of Pharmacy's incorporation of the Medical Board's recommendations in the changes of the Emergency Contraception (EC) protocol. The Committee approved these proposed changes and Dr. Levine reported that these changes were accepted the previous day at the regulatory hearing of the Board of Pharmacy.

The Committee approved the January 31st – February 1st, 2013 meeting dates and it was announced that the meeting will be held in the San Francisco Bay Area.

A review of the progress on the Strategic Plan for 2012 was presented on items that have been completed and anticipated dates of completion for objectives that will be coming due.

Dr. Levine continued that staff requested guidance on various issues in the Sunset Review and those were covered during the afternoon session of the previous day's Board meeting.

Agenda Item 6 Discussion of National Practitioner Data Bank Information
Ms. Kirchmeyer provided background that during public comment at the February 2012 meeting, it was suggested that the Board 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. This data on the feasibility of querying the NPDB was presented at the May 2012 meeting. During this meeting, the Board had several questions and requested that more information be provided regarding the NPDB.

Staff researched the information and also contacted the NPDB to get specific information pertaining to the data that they receive and the actions that they have taken for failing to report information to them.

It was thought that if the Board queried the NPDB at the time of renewal, the Board would obtain additional information regarding the physician that may be cause to take action against the

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physician. Based upon the research completed, it was determined that the Board received the same information provided to the NPDB, if not more.

Staff requested the NPDB provide the Board with all of the Peer Review reports that it received in calendar year 2010 and 2011. The Board found all of the reports in 2010 that were received by the NPDB were also received by the Board. In 2011, the Board received all of the reports with the exception of one report. The Board is looking into the reason that this report was not received and will take appropriate action.

It was also thought that the NPDB received more reports than the Board pertaining to Peer Review. Research actually shows that the Board received more of these reports than the NPDB seven out of the ten years. Further research has determined that the method of counting reports differs between the NPDB and the Board. If an action is taken and then subsequent action occurs, the NPDB counts that as another report. The Board counts that as supplemental information to the original report and would still only count that one time.

A suggestion was made that the reason the NPDB may have received more reports was because the NPDB took more severe action against hospitals who did not report to them. However, the data shows that there is no monetary penalty for not reporting to the NPDB; just that an entities name will be published in the Federal register. To date, the NPDB has not sanctioned any entity for not reporting. Ms. Kichmeyer did mention that the Board can issue a fine from $50,000 to $100,000, depending on the reason for the failure to report to the Board, and has taken six actions against hospitals for not reporting.

For matters pertaining to Medical Malpractice reporting, the research found that the Board receives significant more reports than the NPDB.

Ms. Kirchmeyer stated that it was evident from the data from both the Board and the NPDB, that the number of Peer Review reports and the Medical Malpractice reports have declined in the past ten years. Therefore, staff is recommending outreach activities to the mandated reporters to ensure that they are informed of their responsibility to report actions to the Board. An article was placed in the Summer newsletter explaining the Peer Review reporting requirements and future articles will be written too. Additionally, part of the Strategic Plan includes looking at the decline in the number of 805 reports.

The Board staff will continue to take a proactive approach and request the information from the NPDB that were received for California physicians in the last calendar year and looking at those compared to the Board's data. Staff will ensure that each report was received and if not, the Board will investigate the matter and take appropriate action.

Ms. Yaroslavsky asked if the Board will receive an annual report from staff about the status of the NPDB.

Ms. Kirchmeyer affirmed that this data comparison could definitely be placed as a future agenda item.

Public comment was received for this agenda item.

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Julie D'Angelo Fellmeth, Center for Public Interest Law (CPIL), wished to reinforce what Ms. Kirchmeyer addressed about the dramatic drop in reporting over the last two decades. This possible underreporting is very troubling. The Strategic Plan intends to explore the drop in 805 reports, Ms. D'Angelo Fellmeth stated that the Board should probably expand this to other reporting categories as well.

Agenda Item 12 Presentation on PACE Training Courses

Dr. Levine introduced Dr. William Norcross and Dr. David Bazzo and requested that they provide a presentation on the UC San Diego School of Medicine Physician Assessment and Clinical Education (PACE) Program.

Dr. Levine explained that this item was on the agenda as an opportunity to remind the members of exactly what this program is and what it accomplishes. Many times in the Panel meetings the Board does refer physicians for testing and evaluation to the PACE program and it is important to have a periodic reminder of the program.

Dr. Bazzo began by outlining the PACE Continuing Medical Education (CME) programs that address identified deficiencies. The top five programs at this time include:

- Prescribing
- Medical Record Keeping
- Professional Boundaries
- Anger Management
- Physician Patient Communication

PACE is also able to customize CME. Not everything neatly fits into a particular category and there is no identifiable way to remediate that deficiency. What PACE has done is to create a circumstance where they take educational edicts and adult learning principals and try to evaluate that specific issue that was found to be deficient and try to create a program around that specific deficiency.

PACE takes a different approach to group instruction and caps or limits attendance in order to achieve a true interactive program. This leads to more intense dialogue and it forces the participant to become involved in the education from an adult learning principal.

PACE is dedicated to ongoing simulation of skill assessment and Dr. Norcross provided an update on the new Medical Education and Telemedicine (MET) building that will seek to achieve this goal.

The full presentation may be viewed on the Web cast:
http://www.youtube.com/watch?v=R_xR91ZKYAw&feature=BFa&list=PL6Up7Y6dOLoqwSGAmnhWAQjC6RYPIu74v

Public comment was received for this agenda item.

Michael Grace, of Doc Defender commented that California should be proud of the PACE program. It has performed an unique and valuable service in the reduction of physicians who are facing any manner of discipline and should be commended. Mr. Grace continued that the Board is not the only entity to whom the PACE program can identify. Much of the ground work of identifying

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incompetent or dangerous physicians is currently being done by hospital staff committees through their own disciplinary processes.

Dr. Norcross confirmed that the majority of referrals for the PACE program do come from hospitals and not the Board. This shows that in general, hospitals are identifying physicians that are deficient or need help.

Harrison Robbins, M.D. inquired if attorneys that are central to settlements in final decisions following a case that settles above the $30,000 level are required submit an 805 report.

Dr. Levine requested that Dr. Robbins direct his question to Ms. Threadgill and Mr. Heppler.

Julie D'Angelo Fellmeth, Center for Public Interest Law (CPIL), wished to agree with Mr. Grace's comment about the PACE program being very valuable. She stated that the Board is fortunate to have the PACE program here in California in order to have it available to clinically assess physicians with whom it has concerns with.

Agenda Item 10 REGULATIONS – PUBLIC HEARING

Dr. Levine opened the public hearing on the proposed regulation to adopt Section 1379.50 of Title 16 of the California Code of Regulations, as described in the notice published in the California Regulatory Notice Register and sent by mail to those on the Board's mailing list. This regulatory proposal sets forth the requirements and criteria for the Board to implement, interpret, and make specific the provisions of section 3575, which took effect October 23, 2009, and provides a regulatory framework for applicants for a Polysomnography Registration to have more options to choose from when obtaining the required Basic Life Support certification. The Amendment removes the requirement that Basic Life Support certification can only be provided by the American Heart Association and adds that the requirement may also be met by certification issued by the American Health and Safety Institute. For the record, Dr. Levine stated that the date was October 26, 2012; the hearing began at approximately 10:50 a.m.

Mr. Heppler advised the Board that there was a collective error made by the Board and the petitioner. The formal name of the entity that grants the Basic Life Support certification is the American Safety and Health Institute. It is currently listed incorrectly in the regulations as the American Health and Safety Institute. Mr. Heppler suggested that given this, the Board essentially adopt the changes in the regulations to reflect the correct name of the certificate issuing body. The regulations would be amended to say that everywhere it says American Health and Safety Institute, the correct name of American Safety and Health Institute should be inserted.

Public comment was received for this agenda item.

Joe Rose, American Health and Safety Institute provided oral testimony during the public hearing in support of the amendment that would offer an equally competent provider of Basic Life Support certification.

Dr. Levine closed the hearing.

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Ms. Yaroslavsky made a motion to adopt the regulation as amended with the correct name of the Basic Life Support provider. Furthermore, the Executive Director is instructed to circulate the amended regulations for 15 days; and in the absence of any adverse comments, prepare the rule making file and transmit it to the Office of Administrative Law for approval; s/GnanaDev; motion carried.

Agenda Item 11 REGULATIONS – PUBLIC HEARING

Dr. Levine opened the public hearing on the proposed regulation to adopt sections 1364.50 of Title 16 of the California Code of Regulations, as described in the notice published in the California Regulatory Notice Register and sent by mail to those on the Board's mailing list.

This regulatory proposal sets forth the requirement and criteria for the Medical s Board of California to implement, interpret, and make specific the provisions of section 2023.5 of the Business and Professions Code pursuant to subdivision (c), which 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 devices for elective cosmetic procedures. These regulations shall not apply to laser or intense pulse light devices approved by the Federal Food and Drug Administration for over-the-counter use by a health care practitioner or by an unlicensed person on him or herself. For the record, Dr. Levine stated that the date was October 26, 2012; the hearing began at approximately 11:00 a.m.

Dr. Levine informed the Board that written comment was received from the California Medical Association (CMA) in support of the proposed regulations and an individual who does not agree with the wording of immediately available by email or telephone. This individual suggests the patient be seen by the spa physician within hours and the same day.

Mr. Heppler read a letter into the record from Kathleen McCallum of the California Aesthetic nurses Association. She wished to provide oral testimony but, had to leave due to time constraints. Ms. McCallum's letter wished to convey her Association's endorsement of the definition created by the Committee regarding physician availability.

Yvonne Choong, CMA provided oral testimony that her organization supports these regulations and they believe that the language adequately specifies a level of physician supervision that protects patients undergoing these procedures.

John Valencia, American Society for Dermatological Surgery provided oral testimony.to commend the Board for their work on this regulation, as it represents a significant advance that has not previously existed.

Harrison Robbins, M.D. provided oral testimony that provided background information about the work that the Committee provided to accomplish this regulation. Dr. Robbins expressed some concern with the wording of a paragraph that he felt was somewhat deficient or insufficient. He also requested confirmation about the provider being contactable by electronic or telephonic means without delay and the wording of interruptible. Dr. Robbins requested to know if that meant the provider is able to be interrupted to do this or did that mean during the time he or she is supervising they are non-interruptible.

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Dr. Levine confirmed that it means that the provider is able to be interrupted during the procedure.

Teresa Anderson, California Academy of Physician Assistants provided oral testimony that their organization is in support of this and regulation and thanked the Board for their consideration.

Dr. Levine closed the hearing and asked for comments and questions from the Board.

Ms. Schipske wished to commend the Committee and staff for completing this first round that will definitely send a message to the Legislature.

Dr. Salomonson inquired if the settings where the procedures are being performed would need to have this regulation posted there and if it would include information on how to contact the Board.

Mr. Heppler stated that if in fact the last part of the regulation is invoked and there is a physician providing the assistance and direction to the procedure, that would trigger the practice of medicine requirement and logically that notice requirement would then follow.

Ms. Schipske made a motion to adopt the language as written, and direct the Executive Officer to complete the rulemaking process; s/Bishop; motion carried.

Agenda Item 13 Revised Emergency Contraception (EC) Protocol

Dr. Levine informed the Board that due to the action of the Board of Pharmacy, this agenda item did not need to be discussed.

Agenda Item 14 Update on Joint Forum to Promote Safe and Appropriate Controlled Substance Prescribing and Dispensing

Ms. Whitney announced that the Board of Pharmacy and the Medical Board have selected February 21 – 22, 2013 for the summit. The San Francisco Conference Center has been secured as the location. It has been verified that this will be available for Continuing Medical Education (CME) credit for both dispensers and prescribers. The primary speakers are still being confirmed and once this is done, work will begin to get the word out to a broader group of interested parties.

Ms. Schipske inquired if there is a way that a topic could be added to the forum about the promotion of safe and appropriate controlled substance prescribing, dispensing, and disposal. Disposal is becoming a very big problem particularly because providers do not tell patients the method of properly disposing unused medications.

Agenda Item 15 Special Faculty Permit Review Committee Update

Ms. Yaroslavsky reported that the Special Faculty Permit Review Committee met on September 16, 2012 to discuss possible changes to the Business and Professions Code Section 2168 and California Code of Regulations Section 1315.01-03. The Committee did not have any changes at this time but, recommended medical school officials should provide resources for special faculty permit holders who desire additional training as needed.

The Committee was also presented with proposed dates for upcoming 2012/2013 meetings. The next scheduled meeting date is December 20, 2012.

Ms. Yaroslavsky made a recommendation that staff take a look at cancelling meetings when there

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are no applicants to be discussed as a procedure going forward.

Agenda Item 16 Physician Assistant Committee Update
Mr. Schunke reported that there are several regulations that the Physician Assistant Committee (PAC) has asked to be shared with the Board.

Mr. Schunke reminded the Board that at their May meeting, the members considered a regulatory change dealing with the personal presence of a supervising physician. The Board is responsible for regulations regarding scope of practice issues for physician assistants and regulations dealing with their scope come through the Board. When the members reviewed the draft language at the May meeting, the Board requested that the PAC review and revise the proposed language to address specific concerns expressed by the Board and resubmit the revised language at a future Board meeting. The PAC has been working on this and will be discussing this at their upcoming meeting next week. Once this is finalized, they will return and present this to the Board.

There is another regulation proposal which would expand the type of licensed healthcare providers who may act as preceptors to include physicians and surgeons, PAs, registered nurses who have been certified in advanced practice, certified nurse midwives, licensed clinical social workers, and several others. This regulation has been finalized and submitted to DCA for review and approval. Once this is approved, it will be submitted to the Office of Administrative Law.

The next regulation reviewed was for sponsored free healthcare events. The Board has proposed and adopted regulations that allow physicians licensed in other states to come to California and offer their services for a limited period of time at specific free healthcare events for uninsured and underinsured individuals. The PAC is now moving forward with their own regulatory package similar to what has been adopted by the Board.

The PAC is drafting uniform standards for substance abusing licensees under SB 1441.

Mr. Schunke also mentioned that there was a significant bill dealing with the sunset of the PAC and stated that it would be covered by Ms. Simoes during the legislative update.

The PAC is continuing to promote workforce development and will be reviewing their strategic plan.

At the conclusion of the report, Dr. GnanaDev asked a question regarding supervision of PAs that are participating in a special rotation residency program. Because of the Delegated Services Agreement (DSA) requirement when these PA residents rotate through areas where they can be supervised by other physicians, would this also include unlicensed residents?

Mr. Schunke and Mr. Heppler discussed that they would like to research this item and report back at the next meeting.

Agenda Item 17 Update on Licensing Outreach/Education Program
Mr. Schunke reported that he had attended his largest outreach event at Loma Linda where there were 175 unlicensed residents. He summarized that this year he had gone on 20 outreach trips and attended 45 - 50 outreach events including licensing fairs, meetings with GME staff, and providing presentations to medical students.

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There is a statistic in the Board's annual report that states that the licensing program received 6,600 applications. Mr. Schunke estimated that he had met with 2,200 – 2,300 unlicensed residents during the year. That would equate to 1/3 of the applicant population that would have had an initial meeting or gone through the application process and have their questions answered during these outreach events.

The Governor's executive order that restricts all non-essential travel is still in effect. Fortunately, both DCA and the State and Consumer Services Agency have recognized that the licensing outreach program is mission critical to the Board's mandate. Mr. Schunke will soon prepare a memorandum for Ms. Whitney's signature to request approval of outreach travel for the 2013 calendar year.

Mr. Schunke has been able to make presentations to medical students at UCSD, Loma Linda, and earlier in the month to 225 students at UC Irvine. It was also reported that he traveled to Visalia to Kaweah Delta Hospital. This hospital was recently accredited to start postgraduate training programs in 2013 and Mr. Schunke had the opportunity to meet with staff members and hospital administrators to educate them on what the Board does and the application forms that are required.

Mr. Serrano Sewell stated that he could understand the important benefit of face to face interaction and that should be a priority but, is there any thoughts of an online interactive training being implemented.

Mr. Schunke responded that there are different opportunities that continue to be explored and there has already been several orientations that have been completed using Skype and telephonic meetings. There is also an idea of making available a pop up that expands or explains a question in greater detail when applicants are competing the online application.

Public comment was received for this agenda item.

Hilma Balaian, Kaiser Permanente wished to thank the Board for continuing the outreach program. She also thanked Mr. Schunke for his diligence in helping residents. Ms. Balaian shared that when her organization announces their licensing fair, the newer generation is much more responsive to things that they can see on their phones and computers. She suggested that perhaps the Board could prepare a five minute video that the outreach program could post on the Web site and send to interested residents.

Agenda Item 18 Licensing Committee Update

Dr. Salomonson reported that the Licensing Committee had the previous afternoon. Mr. Worden provided them with a status on staffing and the business process reengineering that was triggered by the previous backlog. The time that it is now taking to evaluate a new application has remained within the parameters. Mr. Worden informed the Committee that both international and U.S./Canadian applicants were at the same timeline. Dr. Salomonson remarked that this impressive because international evaluations can be more challenging.

Mr. Worden also provided the Committee with an update on the Board's Web site regarding the physician and surgeon application and also the policy and procedure manual that are both being redesigned.

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Dr. Salomonson also stated that Mr. Worden discussed a number of items that are in the Strategic Plan and advised them of the components that were relevant to licensing.

There was also an extensive presentation on physician supervision requirements for the allied healthcare professionals. Dr. Salomonson communicated that this served as a good reminder of what a broad number of allied healthcare providers that the Board is responsible for.

The Committee also heard from Ms. Simoes and Mr. Worden on the implementation of SB 122. This bill provides an alternative pathway for California licensure to those individuals who have received some or part of their medical education at an unrecognized or disapproved medical school. Mr. Worden provided a plan on how staff will be able to adjust to the new assessment for requirements on this alternative pathway to licensure.

Dr. Salomonson reported that a question had been raised about the restriction of requirements that all post graduate residency training must be completed in the United States. It was suggested that the Committee reacquaint themselves in looking at international postgraduate education and this will be an agenda item at a future meeting.

Public comment was received for this agenda item.

Hilma Balaian, Kaiser Permanente, suggested that the Board provide some sort of primary source verification for Postgraduate Training Authorization Letters (PTAL).

Dr. Levine requested that Mr. Worden address this when he is providing the Licensing Chief's report.

Agenda Item 19 Update on Federation of State Medical Boards

Ms. Whitney informed the members that the Federation has endorsed House Measure HR 6352. This would add 15,000 new residency slots over the next five years to help address the physician shortage. Ms. Simoes is tracking this bill along with the Federation.

The Federation is sponsoring a board attorney workshop that will be held in November. The Board did make a request for out of state travel for Mr. Heppler but, this was not approved based upon travel restriction.

A tri-regulatory symposium for medical, nursing, and pharmacy was held in Washington, D.C. Ms. Chang, a former Board member and serving on the Federation board attended and will provide a summary of this meeting later in November.

The Federation has sent a notice and is seeking resolutions by February 15, 2013 for their annual meeting. Ms. Whitney encouraged the members that they discuss any ideas with her so they can be developed and presented at the Board meeting on February 1, 2013.

The Federation is seeking nominations for elective office. Ms. Whitney has not heard from any Board members who wish to run for office at this time. Ms. Chang may run for the office of Treasurer. If she does decide to do this, she would need a letter from the Board supporting her nomination.

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Ms. Yaroslavsky made a motion to prepare a letter on Ms. Chang's behalf to support her nomination for Treasurer of the Federation of State Medical Boards; s/GnanaDev; motion carried.

A. Approval of Recommendations for FSMB Committees

Ms. Whitney continued that two Board members have stated their interest in being appointed to committees following the April 2013 annual meeting of the Federation. Dr. Levine is interested in being appointed to the Ethics and Professional Committee and Dr. GnanaDev is interested in being appointed to the Finance Committee.

Ms. Schipske made a motion to prepare a letter of support for nominations and recommending the appointments of Dr. Levine to the Ethics and Professional Committee and Dr. GnanaDev to the Finance Committee; s/Yaroslavsky; motion carried.

B. International Association of Medical Regulatory Authorities (IAMRA)

Ms. Whitney stated that the Board is member of the International Association of Medical Regulatory Authorities (IAMRA). This authority currently has 74 members representing 37 different countries. It held its annual international conference in Canada earlier in the month. The theme of the meeting was medical regulation in the real world. Approximately 200 people attended. Once Ms. Whitney receives the summary of what took place at the meeting, she will share that with the members.

Dr. Salomonson provided an update on her work with the Federation. She attended a specific panel for the USMLE Step 2, clinical skills standards setting. This is an important step that tests the applicants communication skills in terms of their ability to take a medical history. This is currently the sole time that the applicant is assessed for their fluency in English. There is no longer a separate English exam and part of standard setting was to listen to hundreds of speech samples to determine what is adequate.

Dr. Salomonson also continues to work with the Step 3 Committee. This step is the final step prior to licensure and Dr. Salomonson's contribution is to remind the other committee members that some students do not plan to take on more postgraduate training and this test could be the last exam they take until the maintenance of licensure.

Ms. Yaroslavsky reminded the members that she currently is on the Federation's Education Committee. Her Committee is charged with some of the content for the annual meeting and she has communicated issues of concern, interest, and opportunities to them and encouraged the members to apprise her or Ms. Whitney with any that they may have.

Ms. Schipske requested that one area of concern that needs to be addressed in more detail is the issue of collaborative practice. As this Board talks more about physician supervision and scope of practice as a real focal issue, this could be something that most other boards are also dealing with.

Dr. Salomonson did want to clarify one point on her work with the USMLE, all travel is reimbursed by the USMLE and Board funds are not used for this.

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Agenda Item 20 Update on Health Professions Education Foundation
Ms. Yaroslavsky reported that the Health Professions Education Foundation had met for their quarterly meeting in Sacramento in August. They are currently in the process of taking a look at engaging in another strategic plan process and redirecting opportunities to further explore program funding sources as well as challenges to the existing programs.

Thanks to additional funds made available by the federal government, the foundation was able to place 30 additional physicians in underserved areas around the state. Ms. Yaroslavsky concluded by affirming that the foundation is doing a very good job in putting health professionals in communities and could do even better with more funding.

Agenda Item 21 Legislation/Regulations
Ms. Simoes reported on legislative outreach pursuant to Strategic Plan Goal 4, Objective 4.1, stating she contacted 12 legislative district and capitol offices to let them know about the quarterly Board meeting, to extend an invitation, and to provide information about the meeting. Ms. Simoes stated that the Legislature is currently not in session, but will reconvene on December 3, 2012.

A. 2012 Legislation Status and Implementation Plans
Ms. Simoes informed the Board of the implementation plans for the bills signed into law by the Governor. She began by discussing the Board sponsored bills.

The first bill discussed was **AB 1533** (Mitchell). This authorizes 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 for a typical assignment lasting 16 weeks, and not exceeding 24 weeks, as part of an approved and supervised clinical clerkship/rotation at UCLA health care facilities, or with other approved UCLA affiliates. All 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 or expansion of the pilot program. This bill would sunset the pilot program on January 1, 2019 and would require the report to be submitted on or before January 1, 2018.

The Board's implementation plan for this bill is to include a summary in the Board's upcoming newsletter; to notify and train Board staff on the new allowances in this bill; to maintain communication with UC on the status and success of the pilot portion of the UCLA IMG Program; and to schedule update presentations, as appropriate, at future Board meetings.
The next bill reviewed was **SB 1575** (Sen. B&P Comm.). This bill is the vehicle by which omnibus legislation has been carried by the Senate Business, Professions and Economic Development Committee. This omnibus language allows the Board to send renewal notices via email; clarifies that Board has enforcement jurisdiction over all licensees, including licensees with a non-practice license status; established a retired license status for licensed midwives; along with other technical changes.

The implementation for this bill is to include a summary in the Board's upcoming newsletter; to notify and train Board staff; once BreEZe is implemented, to provide physicians the option to receive renewal notices via email and ensure that physicians who have opted in to receive communication from the Board via email are contacted on an annual basis to confirm their email

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address are current; to notify the Midwifery Council and Licensed Midwives of the new retired license status; to notify the Attorney General's (AG's) Office of the clarification in statute regarding the Board's clear enforcement jurisdiction over all licensees; and to update the Board's Web site, as necessary.

Ms. Simoes then moved on to 2012 Legislation, with the bills that have been signed into law.

AB 589 (Perea), Chapter 339. This creates the Steven M. Thomson Medical School Scholarship Program (STMSSP)within the Health Professions Education Foundation (HPEF). STMSSP participants must commit to three years full-time professional practice in direct patient care, and can receive a scholarship of $105,000 per participant. The Board supported this bill because it is consistent with the mission of the Board in promoting access to care.

The Board's implementation plan for this bill is to include a summary in the Board's upcoming newsletter.

AB 1548 (Carter), Chapter 140. This prohibits outpatient cosmetic surgery centers from violating the prohibition of the corporate practice of medicine and elevates the penalties of violating the corporate practice of medicine prohibition.

The implementation plan for this bill is to include a summary in the Board's upcoming newsletter; to notify and train enforcement staff; to notify the AG's office, and to update the Web site, as necessary.

AB 1621 (Halderman), Chapter 76. This exempts 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.

The implementation plan for this bill is to include a summary in the Board's upcoming newsletter; to notify and train staff; and to update the Web site.

AB 1896 (Chesbro), Chapter 119. This aligns state law with the federal Patient Protection and Affordable Care Act (PPACA) and exempts all health care practitioners, including physicians, employed by a tribal health program, from obtaining California licensure in another state.

The implementation plan for this bill is to include a summary in the Board's upcoming newsletter; to notify and train staff; and to update the Web site, as necessary.

AB 2570 (Hill), Chapter 561. This prohibits individuals that are licensed by a board, bureau, or program under or within the Department of Consumer Affairs (DCA) from including a "gag clause" provision in a civil settlement agreement.

The implementation plan for this bill is to include a summary in the Board's upcoming newsletter.

SB 122 (Price), Chapter 789. This allows individuals who have attended and/or graduated from and unrecognized or disapproved school to be eligible for licensure in California if they have continuously practiced in another state for 10 years, if they went to an unrecognized school or 20 years, if they went to a disapproved school.

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The implementation plan for this bill is to include a summary in the Board's upcoming newsletter; to notify and train Board staff on the law and internal processes and procedures; to update the licensing application and directions; to post information on the Board's Web site regarding the new law and update applicant information on the Board's Web site; to require applications to go to the Application Review Committee (ARC) to determine eligibility, staff will work with ARC members on this process; once application issues are determined, staff will work on identifying the need for regulations. The need for regulations will most likely be brought to the Board at the April 2013 Board meeting. The plan also includes sending notification to those applicants that the Licensing Program is aware of so them may apply.

SB 1095 (Rubio), Chapter 454. This expands 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 implementation plan for this bill is to include a summary in the Board's upcoming newsletter; to notify and train Board staff, and to update the Web site and add a link to the Board of Pharmacy's Web site.

SB 1236 (Price), Chapter 332. This is the sunset bill for the Physician Assistant Committee (PAC) and renames them to the Physician Assistant Board (PAB), and makes it its own Board, not a committee of the Medical Board of California (Board). This bill was amended to include the sunset date extension of the Vertical Enforcement and Prosecution (VEP) model, from January 1, 2013 to January 1, 2014.

The implementation plan for this bill is to include a summary in the Board's upcoming newsletter; to notify and train Board staff; to continue to work with PAC (now PAB), to maintain the cooperative working relationship; to notify the AG's office of the VEP sunset date extension; and to address VEP in the Board's Sunset Report.

SB 1274 (Wolk), Chapter 793. This allows 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.

Ms. Simoes brought to the Board's attention several bills of interest on the Tracker list.

AB 1588 (Atkins) and **AB 1904** (Block). Both of these bills are military related. **AB 1588** requires boards under DCA to waive professional license fees, continuing education (CE) requirements, and other renewal requirements as determined by the licensing board, for any licensee or registrant called to active duty. **AB 1904** requires a board under DCA to issue an expedited license to the spouse or domestic partner of a military member on active duty.

SB 1099 is related to regulations and revises the dates that a regulation is effective.

SB 1172 prohibits a mental health provider, including psychiatrists from engaging in sexual orientation change efforts with a patient under 18 years of age, regardless of the willingness of a patient, patient's parent, or other person to authorize such efforts.

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B. 2013 Proposed Legislation

Ms. Simoes advised the members that any proposed legislation for 2013 will be handled through the sunset review process. New issues were discussed at yesterday's meeting and final new issues will be available in the Board's sunset review report to the Legislature.

C. Status of Regulatory Action

Ms. Simoes directed the members to the chart in the Board packet to review the status of all regulatory proposals that are in process. This included the two proposals that hearings were held for earlier that day.

Agenda Item 22 Board Member Communications with Interested Parties

Dr. Levine reported that she had one inquiry from a chief of a department of medicine who asked that she intervene in a licensing issue. She immediately forwarded this request to Mr. Worden and Ms. Whitney and if this issue should come before her panel, she will recuse herself from any involvement in making a decision on this matter.

Dr. GnanaDev disclosed that he was appointed to the board of the American Medical Political Action Committee (AMPAC). He also reported that he had attended the annual meeting of the California Medical Association.

Ms. Schipske disclosed that she recently had a voicemail left for her from a physician that wanted to voice concern about the application for a physician in her practice. She immediately forwarded this message to Ms. Whitney.

Dr. Salomonson disclosed that she had also received a message with a request for assistance on a licensing issue that she forwarded to Mr. Worden.

Agenda Item 23 President's Report

Dr. Levine reported that she has been getting acclimated to better understand her responsibilities of the role of Board President. She spent a very productive day at the Sacramento office meeting with the executive team and individuals that work at headquarters. She had the opportunity to visit the field office in Pleasant Hill to meet with investigators and medical consultants that work out of that office.

Dr. Levine also was able to attend the executive director roundtable with Ms. Whitney and this greatly helped to understand the executive order regarding the use of student assistants and retired annuitants. It also provided an opportunity to provide a case for the critical nature of the Board's need to ensure that the work that these individuals perform continues. Dr. Levine also met with the director of DCA, Denise Brown to introduce herself. Ms. Brown was extraordinarily complementary about the work that the Board does and the progress that has been made.

Dr. Levine has been invited to participate in two national meetings related to medical education in the 21st century. These are both policy level meetings. One was sponsored by the National Health Policy Forum and was held in Washington, D.C. The other was held at Stanford University. They are both involving a national representation of leaders that is thinking about the challenges of the 21st century technological changes, scientific changes, changes in communication, and what needs to be done to prepare medical students for the future. This is still in the strategic thinking stages and Dr. Levine will continue to updated the Board of the outcome of these sessions.

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Dr. Levine has been involved for some time with the American Board of Internal Medicine Stakeholder Roundtable on Professionalism. They recently had a meeting in Philadelphia that looked at issues of professionalism and when the report is finalized, she will bring the proceedings to the Board. This relates to her own interest on the Federation's committee on Ethics and Professionalism. Much of what has been identified in terms of enforcement is really failures of professionalism.

Agenda Item 24 Executive Director's Report

Ms. Whitney began by informing the members that normally there is a presentation at the meeting from the Board of Pharmacy. They are currently meeting on the same two days of this meeting. Ms. Whitney continued by stating that they are talking about two main issues at their meeting. In addition to the emergency protocol that they adopted, they are discussing compounding pharmacies and electronic pedigree requirements for prescription medication. As these are topics of importance for physicians, upcoming information will be included in the upcoming newsletter.

The Department will hold its quarterly executive officers meeting in mid-November. This meeting is following the one that Dr. Levine attended with Ms. Whitney. The topics include performance based budgeting. DCA has been identified as one of the pilot departments that will undergo this and as Ms. Whitney knows more, she will update the members at an upcoming meeting.

A. Update on Staffing and Administration

Ms. Kirchmeyer provided a staffing comparison from the last meeting to this meeting. At the last meeting it was reported that there were 27 vacancies and the vacancy rate was 10%. The Board currently has 18 vacant positions for a vacancy rate of 6.6%. This is great news and improves the work of the Board. There are also five individuals either in background pending a start date or pending verification of eligibility. There are actually only 13 positions that are vacant and this would bring the vacancy rate to 5%. Ms. Kirchmeyer took a moment to thank staff for their hard work in getting these positions filled. Work continues to interview and hire seasonal employees and intermitten employees to replace the loss of student assistants and retire annuitant positions.

The Board staff is still under the personal leave program and employees must take one day off per month and a 5% reduction in pay.

B. Budget Overview

Ms. Kirchmeyer directed the attention to the budget and pointed out that the Board's fund condition at the end of fiscal year 2011/2012 showed a reserve of 5.2 months. The Board only has one augmentation request moving forward and that is for the BreEZe system. Based upon the projections, it appears that the Board will be very close to the mandated level of two to months reserve at the end of this year, and within the mandated level in the next fiscal year.

Ms. Kirchmeyer confirmed that at this time it is not prudent to consider any fee reductions, as previously recommended by the Bureau of State Audits. Staff will continue to monitor this to determine the need.

Ms. Kirchmeyer continued by discussing the Board's actual expenditures. One item that was pointed out showed an overage in the budget of 16,203%. Staff is working on this and it was identified that several contracts were placed on this line item in error and it will be corrected.

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A chart showing a cost comparison for the last five fiscal years was reviewed. This chart is in response to the strategic plan objective 5.3 and staff will continue to monitor this spending and report to the Board.

Ms. Kirchmeyer concluded by sharing with the members that the Board received a thank you letter from the Twin Rivers Unified School District for the generous donation of laptops and printers. The Board received new printers and laptops and was able to survey out the outdated equipment and donate this to a school district.

C. Approval of 2013 Board Meeting Dates and Locations

Ms. Whitney discussed that the Executive Committee did commit to the January 31 – February 1, 2013 Board meeting date in the San Francisco Bay Area. This will safeguard the ability for staff to secure contracts for meeting space and sleeping rooms.

Up for discussion was the April 25 -26, 2013 meeting location. Ms. Whitney also clarified the consequences of conducting a meeting on July 18 – 19, 2013 or on August 1 – 2, 2013. Due to the July 4th holiday, this would warrant a late delivery of the Board meeting materials to the members. The August date could also pose a problem due to the expiration of the 60 day grace period for three of the current Board appointees. If there are not new appointments made to the Board, this could result in the loss of a quorum.

Dr. Salomonson made a motion to hold the April 25 – 26, 2013 meeting in the Los Angeles area; s/Diego; motion carried with Dr. GnanaDev and Ms. Yaroslavsky abstaining.

Ms. Yaroslavsky made a motion to hold the meeting in the Sacramento area on July 18 – 19, 2013; s/Diego; motion carried.

Mr. Serrano Sewell made a motion to hold the October 24 – 25, 2013 in the Ontario area; s/Yaroslavsky; motion carried with Dr. Bishop abstaining.

Agenda Item 25 Enforcement Chief's Report

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

Ms. Threadgill requested approval for 11 orders restoring license to clear status following completion of probation.

Dr. Levine made a motion to approve the orders; s/Yaroslavsky; motion carried.

B. Expert Utilization Report

Ms. Threadgill reported that the number of active experts is 953. This number has slightly increased from the 944 that was reported at the last meeting.

The Enforcement Program is currently coordinating the second presentation of the revised Expert Reviewer Training which will be held on February 9, 2013 at UC Irvine. Ms. Threadgill and Ms. Sweet hope that another training will be provided in June at the UCSD, La Jolla location.

The Program continues to work with the ALJs to provide training by video conferencing to all OAH offices. Training topics have included pain management, electronic medical records, changing the face of medicine, and new robotics versus the old style surgery.

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C. Enforcement Program Update

Ms. Threadgill continued with the Enforcement Program update by reporting that the vacancy rate for investigators is at 9%. When this factor includes candidates that are in background and not yet hired, the vacancy rate is only 3%. The vacancy rate for supervisors remains at 19% and the overall Enforcement vacancy rate is 11%. The Program recently hired seven new investigators who are attending a post special investigator basic course. This 16 week course is required for all investigators at some point during their first year of employment. Once the 16 week post training course is completed, the Board will conduct an in house mini academy that is specific training for Board investigators.

D. Program Statistics

Ms. Threadgill indicated that a question often arises regarding the percentage of cases that are stipulated versus the cases that go to hearing. There numbers were recently calculated and it was found that in fiscal year 2010/2011, 74.6 cases stipulated to a decision; 18.7% of the cases went to hearing and were decided by an administrative law judge and 6.7% resulted in a default decision. In fiscal year 2011/2012, the percentages were 76.9 of cases stipulated, 15.9% went to hearing and 7.2% resulted in a default decision.

Ms. Threadgill then discussed a chart that reflected the progress toward meeting the Enforcement Program goal to reduce the complaint processing time. The complaint unit has done an outstanding job of reducing the average time to 67 days with 48% of the complaints below 50 days. This represents a 16 day reduction in time when compared to 83 days at the end of fiscal year 2011/2012. The goal in the strategic plan is to reduce the time and have 50% of the complaints below 50 days.

Ms. Threadgill stated that there has been progress made in reducing the time to acquire medical records. However, there has not been as much success with the reduction of time to complete subject physician interviews.

Ms. Threadgill continued that at the previous day's meeting, public comment was received on the draft Sunset report to the Legislature. Concern had been expressed that the enforcement program has not attributed the great successes it has achieved relating to case again, production and prosecutorial results to the Vertical Enforcement (VE) program. Ms. Threadgill contended that in no way was there any intent to be overly critical of VE, but part of any healthy organization is to identify and recognize opportunities for improvement and change. The Enforcement Program believes VE has been beneficial for certain types of cases. In the case of Interim Suspension Orders, the early involvement of Deputies in a case has proved invaluable. However, it is disconcerting to hear the 203% increase in criminal referrals being accredited to VE when the VE enforcement manual expressly prohibits deputies from being involved in criminal cases.

The senior staff continues to meet every quarter with HQE senior staff to resolve problems and identify areas of improvement.

Ms. Threadgill concluded that the Program feels that they could bring the case aging down further if some components of VE were modified so that attorney involvement, which is appropriate in some, but not all cases, was limited to the cases where it proves truly beneficial. Ms. Threadgill did not want to imply that there are not positive components to VE and the Program's collaboration with HQE. However, with her being intimately involved with the operations of the Program, she

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believes it would be disingenuous to report to the Legislature that something is working perfectly when there is clearly room for improvement.

Agenda Item 26 Vertical Enforcement Program Report

Prior to Mr. Ramirez's report, several of the members requested information regarding the length of time it takes for a subpoena to be activated. Mr. Ramirez explained that one of the major issues is scheduling. The length of time it takes to schedule a subpoena enforcement in any superior court whether it is Los Angeles, San Diego, or Sacramento, is always going to be a problem.

Mr. Ramirez further explained that most superior courts do not have experience enforcing subpoenas. Instead of going to a dedicated department for a writ or ex parte matters, they are sent to another courtroom where there is not experience in these particular cases. It is believed that if the appropriate entities could assign these matters to one department, it would surely speed up the process of enforcement from the judicial side.

A. Status on Statistics

Mr. Ramirez reported that they have continued to provide quarterly and monthly statistics to Board staff. In the near future, they are going to be submitting a request for statistics from the Board with regards to the statistics set from the basis of the Sunset Report. They wish to make sure that when it comes time to evaluate the VEP program, they have the same statistics and are operating from the same basis in doing a side by side comparison.

At the same time, Mr. Ramirez did want to state that the Attorney General's office did not agree with all the statements that are contained in the Sunset Report in regards to enforcement. They will review the statistics that amplify these concerns and report back to the Board at a later date.

B. HQE Organization and Staffing

Mr. Ramirez reported that there had been a vacancy in the San Diego office due to the transfer of a deputy to the Office of Administrative Law. At this time they have been able to extend an offer for employment to a former HQE attorney, Marty Hagen and he is expected to start November 1, 2012.

Agenda Item 27 Licensing Chief's Report

A. Staffing

Mr. Worden reported that there are currently only three vacancies in Licensing. This is the lowest number of vacancies since he has been the Chief of Licensing. They are currently on the process of interviewing seasonal clerks to help replace the student assistants and in the process of developing a plan to replace the retired annuitants with permanent intermittent employees. The retired annuitants were approved to continue while this is in process.

B. Program Statistics

Mr. Worden reported that in the first quarter of fiscal year 2012/2013, the consumer information unit had answered 26,022 calls. They received 1,708 physician and surgeon applications. 1,556 applications were reviewed and 1,447 licenses were issued. The Board processed 93 application at the SR2 level.

The Strategic Plan goal has been met this quarter and remains below the 45 day level. The statistics that were sent to the members on October 13, 2012, stated that U.S. and IMG application review dates were at 30 days for initial review. Mr. Worden reported that last year it was 43 days for U.S.

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applications and 35 days for the IMGs.

C. Status of International Medical School Program
Mr. Worden continued that are currently 102 international schools in the pending status. There are seven self-assessment reports pending and 30 international medical schools were recognized pursuant to CCR 1314(a) (1). At this time, there has not been approval of any of the 82 schools that have self-assessment reports pending.

D. Status of Free Health Care Event Program
The regulations are complete for the free health care events sponsored program. The Board has not yet received any applications.

Public comment was received for this agenda item.

Hilma Balaian, Kaiser Permanente echoed her previous comment about a primary source verification of PTAL.

Agenda Item 28 Midwifery Advisory Council Update
Carrie Sparrevohn and Dianne Dobbs provided an update for the members.

Ms. Sparrevohn reported that the Midwifery Advisory Council (MAC) met on August 30, 2012. The MAC meeting included a lengthy discussion regarding proposed regulations surrounding the issue of physician supervision.

Ms. Sparrevohn continued that a task force had met regarding students and assistants. There continues to be a debate about what a student can and cannot do, and what constitutes an assistant. Some of the issues that were explored will need clarification in statute in order to provide students with guidelines for actions that they can take in relation to patient care.

Also discussed was the role of a midwife who has completed training, applied for licensure but, not yet licensed. Can this person continue to work under a licensed midwife as an assistant while waiting to be licensed?

Another item that requires review is the apprenticeship model. When the original midwifery practice act was signed into law in 1993, the intent was to allow for the continued route of entry through apprenticeship with the entrance of licensure coming through the challenge method. Currently, supervising midwives seem to be reluctant to have an apprentice who is not enrolled in some kind of formal school. Ms. Sparrevohn commented that if the apprenticeship model is going to be done away with completely, then regulations will need to be put into place in terms of the educational component.

One other issued that the MAC discussed was the licensed midwife annual report and its ongoing inability to adequately reflect the outcome of home births in California.

Ms. Schipske suggested that the Board receive a written list of the regulations that the MAC would like to have put into place. She encouraged the MAC to also identify a legislative sponsor.

Public comment was received for this agenda item.

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Gerri Ryan, Nizhoni Institute of Midwifery commented that she would like to go on the record as supporting dual entry into midwifery. Ms. Ryan supports the education model as well so that students are well versed and understand when it is appropriate to be in a hospital.

Ms. Yaroslavsky made a motion to accept the following upcoming MAC meeting agenda items; an update on the student task force; a presentation on the data collection tool; a report from staff on moving forward with the regulatory and statutory changes to the licensed midwifery annual report; an update from legal on the responsibility of the MAC members and compliance with the open meeting act; and a discussion of Business and Professions Code Section 2514(a) on who can supervise a midwifery student; s/Schipske. Motion carried.

Agenda Item 29 Agenda Items for January 31 – February 1, 2013 Meeting in the San Francisco Area

Dr. Levine requested a presentation from Donate Life on the possibility of sponsorship of a special license plate.

An update was requested on how the Board has implemented uniform standards per the requirements of SB 1441.

There should be a discussion of what it would take for teleconferencing of Board meetings and the creation of the opportunity for comment from those remotely.

An update should be provided on the PA residency program standards.

There should be an agenda item that provides an update on Breeze.

Agenda Item 30 Adjournment

There being no further business, Ms. Yaroslavsky made a motion to adjourn; s/GnanaDev; motion carried.

The meeting was adjourned at 2:00 p.m.

The full meeting can be viewed at:
http://www.youtube.com/watch?v=Okyw[illegible]KfPjQ&feature=BFa&list=PL6Up7Y6dOLoqwSGAmnhWAQjC6RYPIu[illegible]

http://www.youtube.com/watch?v=R_xR91ZKYAw&feature=BFa&list=PL6Up7Y6dOLoqwSGAmnhWAQjC6RYPIu74v

Sharon Levine, M.D., President

Silvia Diego, M.D., Secretary

Linda K. Whitney, Executive Director

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February 21 & 22, 2013
Safe & Appropriate
Controlled Substance
Prescribing & Dispensing

SAVE THE DATE

- Learn about the problems caused by prescription drug abuse and how physicians, pharmacists, law enforcement, prosecutors, regulators, lawmakers and others are working to find solutions.
- **Up to 10 hours of continuing education credit will be granted to California licensed physicians.**
- **Participation is entirely free! (Registration is required.)**
- Hear speakers from the White House, Drug Enforcement Administration, State and local prosecutors, law enforcement, practicing physicians and pharmacists, California's prescription monitoring program, and regulators.
- E-mail the Medical Board at webmaster@mbc.ca.gov to indicate your interest and to receive updates and a registration form when it becomes available.
- Reserve your spot as soon as possible; participation is limited to 500.

Physicians are key to creating solutions to end prescription drug abuse!
Please join us on February 21 & 22 in San Francisco!

MEDICAL BOARD
OF CALIFORNIA

BE AWARE AND TAKE CARE:
Talk to your pharmacist!
CALIFORNIA STATE BOARD OF PHARMACY

PLEASE JOIN US FOR EDUCATION AND CME!

In an effort to educate practitioners and dispensers and prevent prescription drug abuse, the California Medical and Pharmacy Boards' are hosting a "Joint Forum to Promote Appropriate Prescribing and Dispensing".

- Learn about the problems caused by prescription drug abuse and how physicians, pharmacists, law enforcement, prosecutors, regulators, lawmakers, and others are working to find solutions.
- Hear speakers from the White House, Drug Enforcement Administration, State and local prosecutors, law enforcement, practicing physicians and pharmacists, California's prescription drug monitoring program, and regulators.
- Receive up to 10 hours of continuing medical education (CME) credit (four hours for attending the first day, six hours for attending the second).
- Attendance is entirely free, but registration is required.
- Visit the Medical Board's Web site for details to register: http://www2.mbc.ca.gov/EventRegistration/
- Reserve your spot as soon as possible; participation is limited to 500.

Specific details are as follows:

What:	Medical and Pharmacy Boards' "Joint Forum to Promote Appropriate Prescribing and Dispensing"
When:	February 21, 2013 (1:00 p.m. – 5:30 p.m.), and February 22, 2013 (8:00 a.m. – 5:00 p.m.)
Where:	South San Francisco Conference Center
CME:	Up to 10 hours CME credits granted
FEE:	**Free!**

Physicians are key to creating solutions to end prescription drug abuse!

Please join us on February 21 & 22!

If you cannot reach the URL by clicking on a link, please copy and paste it directly into your browser.
Attention: *Please do NOT reply to this e-mail. If you have any questions or require further assistance, please contact the Board at webmaster@mbc.ca.gov.*

Medical and Pharmacy Boards' Joint Forum to Promote Appropriate Prescribing and Dispensing

Preventing Prescription Drug Abuse

February 21 & 22, 2013

South San Francisco Conference Center
255 South Airport Boulevard
South San Francisco, CA 94080
(650)-877-8787

Thursday, February 21, 2013

1:00 p.m. **Welcome and Introductions**
Sharon Levine, M.D., President, Medical Board of California
Amy Gutierrez, Pharm.D., Member, California Board of Pharmacy
Anna M. Caballero, Secretary, State and Consumer Services Agency

1:15 p.m. **Public Policy Relating to Prescription Drug Abuse – The Roles of the Federal and State Governments**
Michael P. Botticelli, Deputy Director of the White House Office of National Drug Control Policy

2:15 Break

2:30 **Prescription Drug Trafficking/Diversion and Abuse**
Joe Rannazzisi, Deputy Assistant Administrator, Office of Diversion Control, Drug Enforcement Administration

4:30 **A Prosecutor's Perspective**
Laura Meyers, Deputy District Attorney, San Francisco and
Ruth Morentz, Workers' Compensation Investigator, San Francisco

5:30 **First Day Closing Remarks**

Friday, February 22, 2013:

8:00 **A Doctor's Perspective**
Cesar A. Aristeiguieta, M.D., Emergency Medicine

8:30 **A Pharmacist's Perspective**
Judi Nurse, Pharm.D., Supervising Inspector, California Board of Pharmacy

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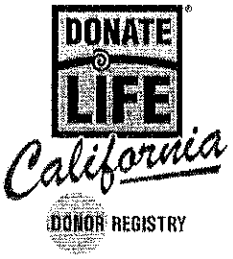
9:00	**Promoting Appropriate Prescribing: How Education and Cooperation of Physicians and Pharmacists Can Address the Problems of Inappropriate Prescribing and Dispensing** Michel Sucher, M.D. David Greenberg, M.D. Darlene Fujimoto, Pharm.D.
10:00	**ER to IR to the ER:** ***from Extended Release to Immediate Release to the Emergency Room, Tracking the Oxycontin to Oxycodone Transition*** Kevin Barnard, Regional Compliance Manager, H.D. Smith
10:15	Break
10:30	**Your patient is already addicted to pain killers, NOW what?** Panel of medical and pharmacy experts Moderator: Ronald Wender, M.D.
12:00-1:00	Lunch (for sale in lobby)
1:00	**CURES: California's Prescription Drug Monitoring Program** Mike Small, Department of Justice Darlene Fujimoto, Pharm.D. Gregory Polston, M.D.*
1:45	**Enforcement and prosecution – what it is, what it could be.** Panel of Experts from Federal, State, and local law enforcement/prosecutors Lynne Dombrowski and Joshua Room, Deputies Attorney General Renee Threadgill, Chief of Enforcement, Medical Board of California Judi Nurse, Pharm.D., Supervising Inspector, Board of Pharmacy Laura Meyers, Deputy District Attorney, San Francisco* Ruth Morentz, Workers' Compensation Investigator, San Francisco Penny R. Korte, Supervising Investigator, Drug Enforcement Administration Moderator: Ronald Wender, M.D.
3:30	Break
3:45	**Expectations vs. Reality: What is the future? Developing operational and legal solutions** Panel of regulators and lawmakers: Sharon Levine, M.D., President, Medical Board of California Amy Gutierrez, Pharm.D., Member, California Board of Pharmacy Linda Whitney, Executive Director, Medical Board of California Virginia Herold, Executive Officer, California Board of Pharmacy Legislators/legislative staff*
5:15	**Closing Remarks and Adjournment**

* not yet confirmed



January 9, 2013

Linda Whitney, Executive Director
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

Dear Director Whitney:

Donate Life California respectfully requests consideration by the Medical Board of California (MBC) to be our official state sponsor as we work to establish a specialized license plate to increase awareness and raise money for organ and tissue donation, education and outreach. We feel strongly this license plate has the potential to save lives here in our state and we promise to do everything possible to mitigate any impact on your staff and resources.

Currently there are 20 other states that have license plates that highlight the need to save lives through organ and tissue donation. In California, the Veterinary Medical Board is the sponsor of a license plate to promote the spay and neuter program to save the lives of abandoned pets. We are asking for your assistance in sponsoring the Donate Life specialty plate since the core mission of the MBC and DLC is to save lives and a sponsoring agency is a requirement for specialty plate campaigns under state law.

As you are aware, the soaring rates for obesity, diabetes and hypertension are fueling a serious gap between the need for kidney transplants and organ availability - especially impacting Latinos, people of color, and those below the federal poverty line. This has led to a critical shortage of life-saving organs in our state with over 21,000 Californians currently on the national transplant waiting list.

With your support of our license plate campaign, this public health crisis will gain statewide attention and highlight the importance of organ and tissue donation with the hope that one third of those in need will no longer die before a suitable match is found as is currently the tragic situation.

With on-going input from the DMV, we are in the midst of finalizing a license plate design (draft attached) and developing a brochure. We also are creating a "turnkey" website and database that will take reservations, order plates, collect fees, and transmit the necessary information to the DMV monthly and when the required number of 7,500 plates is reached.

If you or MBC have any questions, I can be reached at (619) 203-0796 mobile, (619) 563-5133 direct line, or czettel@donatelifecalifornia.org.

Our sincere appreciation for your consideration of this request.

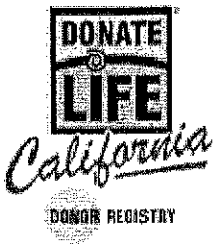
Sincerely,

Charlene Zettel

Charlene Zettel, CEO
Donate Life California

3465 Camino Del Rio South, Suite 410, San Diego, CA 92108 • tel 619-521-1983 • fax 619-521-2833 • www.donatelifecalifornia.org

The Basics About Organ and Tissue Donation



The Basics about Donation

- As of January 4, 2013, 116,796 individuals are on the National Organ Transplant Waiting List. 21,075, or approximately 18% , are residents of California.
- Nationwide, approximately 18 people die each day awaiting life-saving organ transplants, and a new name is added to the national waiting list every 10 minutes.
- One organ donor can save up to eight lives and one tissue donor can improve the lives of up to 50 others.
- In California, consent (first-person or by the family) is given in approximately 80% of cases where patients are pronounced brain dead and are medically suitable to be organ donors.

Needs in Minority Communities

- Nationwide, minorities represent 56% of organ transplant candidates and more than 62% of those awaiting kidney transplants.
- In California, Latinos make up 37% of those waiting for life-saving transplants, Asians/Pacific Islanders 19%, and African Americans another 13%.
- Latinos make up the greatest number of California candidates waiting for a kidney transplant.
- Nationwide, African Americans comprise 12% of the total population, but represent 34% of kidney transplant candidates. This high proportion is due to a higher incidence of diabetes and hypertension.

Milestones

- Donate Life California Organ & Tissue Donor Registry has signed up over 9.7 million Californians in the past five years and set a new national record for first-year signups by an online state registry.
- Donate Life California is now the largest registry in the nation.
- In 2010, the four organ recovery agencies in California coordinated 763 organ donors, with 165 or 22% of them having made their decision in advance through the state donor registry. This resulted in more than 1,000 lives saved through first person consent.
- Since 2006, more than 100,000 lives have been saved or healed through organ and tissue donation as a direct result of the Registry.

Biology

- Organs that may be donated (in order of frequency transplanted) include the kidneys, liver, heart, lungs, pancreas and small intestine.
- Tissues that may be donated include corneas/eyes, heart valves, skin, bone, tendons, cartilage and veins.
- In almost all instances, only patients who experience brain death – a medically, legally and morally accepted determination of death resulting from the complete lack of blood flow to the brain – may donate vital organs. This represents about one percent of all deaths in hospitals annually.

Countering Misconceptions

- All major religions support or permit organ and tissue donation.
- Organs are allocated fairly and equitably based on medical criteria. Priority depends on medical factors such as urgency of need, length of time on the waiting list, blood type, organ size compatibility, and tissue typing (for kidneys). Race, gender, age, income and celebrity status are not considered when determining who receives an organ.
- There is no cost to the donor or his/her family for donation.
- There are no limitations on those who can sign up to be donors, even when past disease or certain chronic conditions may be present. Ultimately, the decision as to whether or not organs or tissue are suitable for transplantation will be made by medical specialists at the time of donation. The message: Don't rule yourself out! Sign up to give life: www.donateLIFEcalifornia.org or www.doneVIDAcalifornia.org.

Background on the Request to the Medical Board of California to be the Official Sponsor for Donate Life California's Specialty License Plate Effort

Who is Donate Life? Why Register to be a Donor?
Donate Life California (DLC) is legislatively tasked with administering the California Organ and Tissue Registry. When people register, they are consenting to be donors. Registration allows their families to honor their wishes not guess at what they would have wanted.

DLC knows this saves lives, which is very important because the need is great in our state. We have more people waiting than donors. Too few donors mean our neighbors are dying waiting.

We have made progress, but we need to make more. Especially since a single donor can save the lives of up to eight people through organ donation and help an additional 50 people with the precious gift of tissue.

Why a Donate Life Specialty Plate
Donate Life plates have proven successful in other states to raise visibility for our important mission and to help generate funds to continue operations and build awareness to increase donor registrations.

Currently only 1 in 3 people who go to the DMV register to be a donor placing us seventh from the bottom in the nation. Many people rule themselves out as donors, which means lives are lost. Needlessly. With funding from the sale of the plates, we hope to be able to expand our education efforts.

Why an MBC Sponsorship Request
Because of our shared commitment and mission to save lives in California. The Medical Board of California also is a respected partner. We appreciate your consideration.

Current Specialty Plate Campaigns Underway
A sponsoring state agency, board or commission is now required for Specialty Plates. Efforts currently underway:

- CA Spay (www.caspayplate): Sponsor: CA Veterinary Medical Board
- CalAg (www.calagplate.com): Sponsor: CA Dept of Food & Agriculture
  It is our understanding they have reached the 7,500 minimum thanks to a generous donation underwriting 5,000 plates. This is the first plate to be approved since legislation increased the approval process.

Sponsor Responsibilities and DLC's Commitment to You
The sponsoring agency is required to be our intermediary with the DMV. It is DLC's commitment to you to mitigate all impact on you by including plate design, design and production of all collaterals and website. DLC also will provide the monthly reports on program updates for your forwarding to the DMV. When we have achieved the minimum number of plates required, we will issue a single check from DLC for your to forward to the DMV.

As a non-profit agency legislatively-mandated to administer the state organ and tissue Registry, we take our mission to save lives very seriously, as do our board members. Each works for one of the four federally-mandated, non-profit recovery organizations serving California.

This level of support on our part has been acknowledged by the DMV. They understand how important it is to have you be our sponsor because of our shared mission to save lives in California.

Update on our progress

- Donate Life license plate design tentatively approved by the DMV
- Brochure copy underway
- Website & order database are being set up by National University (team lead is a heart recipient)
- Interest database has been linked to our Customer Relations program to allow milestone communication
- Fiscal agent identified.

Timeline (We have 12 months to pre-sell 7,500 plates with provision for a 12-month extension)

January – March 2013

Finalize sponsoring agency
Complete design for plate, brochure, website, database
'Soft' Announce & pre-sell volunteers & partners across the state; also the 1,000 people who have supported the license plate by providing us contact information. (Ideally we'd like to be well on our way to 7500 when we announce effort.)

April – National Donate Life Month

Introduce sponsoring agency at Sacramento press conference with Speaker Perez, if possible
Announce plates available for purchase as we celebrate 10 millionth donor registration
Plate 'sales' booths at CA Donate Life Walk in Fullerton (10,000 attendance) and other large events including Fan For Life in San Diego

May – June

Continue to build interest list or start pre-sales when sponsor named.

July

Press conference celebrating the 8thth anniversary of DMV partnership including our License Plate Sponsoring Agency. Continue campaign utilizing strong volunteer and partner base.

Nov

Include message in our annual 'Thanksgiving' awareness efforts

Interim Milestone Communications will include: regional updates on high profile supporters including (hopefully) announcements of corporate fleet supporters., event features on our respective websites, social media campaigns, statewide volunteer calls, etc. Our sponsoring agency will be acknowledged in all efforts!

April 2014 (National Donate Life Month)

Hoping to announce successful completion of the campaign & recognize first plate holder.

Note: Our plate application has a special field to dedicate a plate in honor or memory of an individual (For instance requests have included being able for a recipient to honor their donor). Inevitably we will have wonderful stories as a result of this.

Financial Overview

Sequential Number Annual Plate Cost/Renewal: $49/$38
Personalized Plate Cost /Renewal: $98/78

The cost of the initial plate is covered by first-year purchases. After that, an estimated 60% of proceeds will go to Donate Life CA to help fund operations and increase donor registrations. Revenue estimates to DLC for Year Two on: 7,500 X $38 * 60% = $171,000.

Facts about the Need in our State

The threshold for Donate Life Plates in the other 22 states surveyed average 300, 500 or 1000 plates sold – many in the $25 range. The 7,500 minimum requirement @ $50 is significant but we feel attainable. Why?

- Because nearly 10 million Californians already have signed up to be organ, eye & tissue donors after they are gone
- Because one in five people on the national waiting list live in our state
- Because 22,000 Californians are waiting (80% need a kidney transplant to survive & It is estimated one-third will die waiting before a match can be found)
- Because the lives conservatively of 56,000 people were saved or healed by donors on the CA Registry last year alone!

DLC Commitment to Education

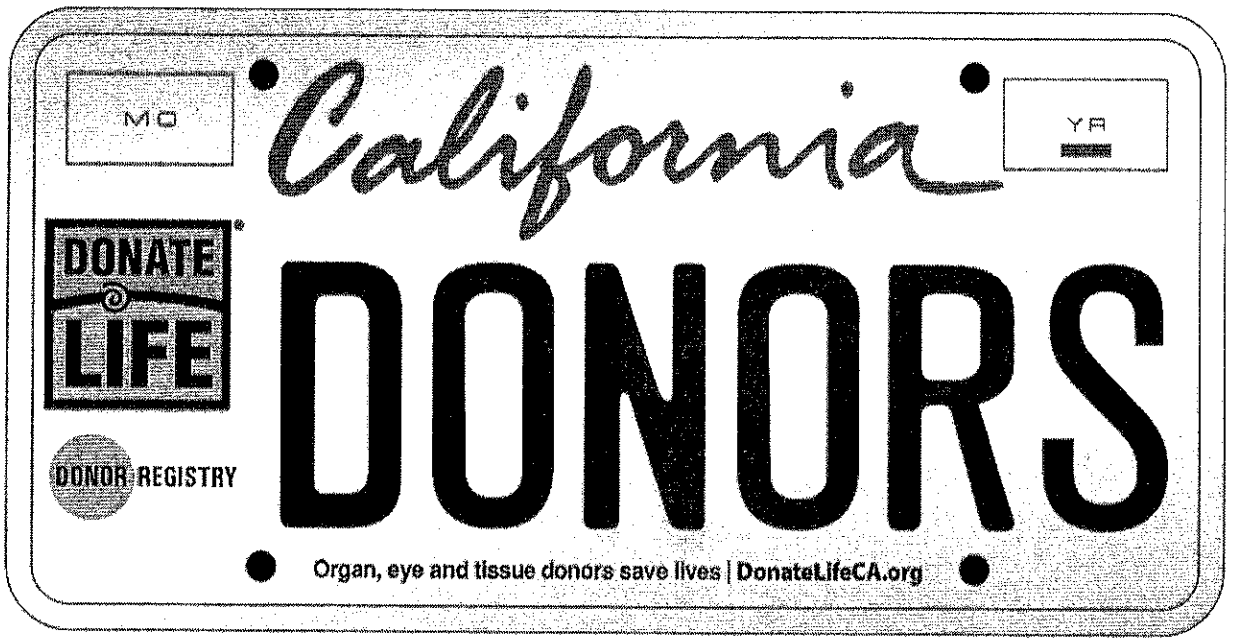
The need for organ transplant in our state is in crisis. Currently only one in three people check yes to be donors because they mistakenly believe they cannot donate. Education is underway to change that critical misunderstanding. We also have experience in successful outreach in the hospitals, with first responders (www.donateLIFEcalifornia.org/firstresponders) and with high school students (www.donateLIFEcalifornia.org/teachers) who will be asked when they apply for their first driver license if they want to register as a donor.

We feel this specialty license plate program will provides us the funding to expand our critically-needed education outreach because too many people needlessly rule themselves out as donors. We're also delighted by the thought of 7,500 little mini-billboards driving around our state reminding people to 1) sign up as a donor and 2) drive carefully!

Appendices

A - Donate Life California specialty license plate design
B - Information sheets provided by the DMV
  B1 - Sponsor information and DLC's Commitment to MBC
  B2 - Specialized License Plate information
  B3 - State Agency Definition per Vehicle Code 5151-5160
C - Legislative history of DLC

Appendix A – Donate Life California specialty license plate design



Appendix B – Information sheets provided by the DMV

DMV Contact: Kathy Mitchell
Registration & Titling Policy
916-657-9842
Kathy.Mitchell@dmv.ca.gov

B1 - Sponsor information for Specialized License Plates (And DLC's Commitment to MBC)

Legislation effective January 1, 2007 (Revised 07/27/2009), requires the Department of Motor Vehicles (DMV) to design, in consultation with a "**State**" agency, and make available for issuance specialized license plates when the required minimum 7,500 application threshold has been met.

Specifications:

- The **state** agency will submit a letter of intent to the department which contains a financial plan and a license plate prototype of a distinctive design (up to four colors) for approval.

  DLC will provide a financial plan to the sponsoring agency and the DMV. A copy of our license plate prototype is attached.

- After plate design approval by the department and the California Highway Patrol, the DMV will authorize the plate prototype to be manufactured.

- The DMV will send the plate sample and approval letter to the **state** agency for plate design approval.

- The **State** agency will be responsible for the design and printing of the application brochure. Prior to print production, the **state** agency will submit a sample application brochure for approval.

DLC will submit a draft brochure and web to the State Agency and DMV. After approval, we will print and distribute the brochure and launch the website. A preliminary statewide Social Media campaign to gauge interest has encouraged us to move forward with this important effort.

- The **state** agency will collect and hold applications and fees until a minimum of 7,500 applications with fees have been received.

  DLC will collect and hold all applications in a secure location until 7,500 applications with fees have been received. We have been advised fees will need to be processed but the issuer will be contacted and refunds provided if we are unable to reach the threshold required.

- The **state** agency will establish an account to deposit individual checks.

  DLC will establish a dedicated account to deposit all individual checks and proceeds from credit card payments.

- The **state** agency will prepare monthly reports for submission to DMV indicating:
  - number of applications collected to date by type (sequential/original ELP/ ELP conversion)
  - fees collected to date by type (sequential/ELP/ ELP conversion)
  - number of all applications and all fees to date.

  DLC will prepare the required monthly reports and send them to the state agency and DMV.

- The **state** agency will submit to the DMV a minimum of 7,500 applications with one check, made payable to DMV, along with a summary of the monthly reports for audit purposes indicating:
  - total number of applications by type (sequential/original ELP/ ELP conversion)
  - total fees collected by type (sequential/ELP/ ELP conversion)
  - total number of applications and fees.

  DLC will submit a single check to the DMV when the 7,500 applications are received along with a summary of the monthly reports for audit purposes. As always, the state agency will be copied.

- The **state** agency will submit an alphabetical listing of all applications submitted by type (sequential/ELP/ ELP conversion). It is highly recommended the **state** agency create an application data base consisting of the following:
  - name/address
  - type of application: sequential/ELP/ ELP conversion
  - dollar amount and check number.

  DLC is finalizing a secure database now with the assistance of National University that will permit us to provide an alphabetical listing of all applications by name, type of application, dollar amount and check number.

- The DMV will review the original ELP applications and reserve those configurations available.

- The DMV will initiate the necessary programming for plate issuance.

- The DMV will process applications and issue plates to applicants approximately nine months from the date of receipt of the applications and fees.

Funding:

- The implementation cost for the specialized license plates is approximately $400,000. The cost is recovered from the sale of the license plates. The first 7,500 applications @ $50 per plate (for sequential) will generate sales revenues of $375,000. Since a certain percentage of the pre-orders will be personalized orders at $98 per set of plates, the implementation cost should be met.

- Once the implementation cost has been met, a deduction will be taken for ongoing administrative costs from every application thereafter.

- The remainder (the majority) of the monies from specialized plates with sequential configurations will be allocated to the Specialized License Plate Fund from every application thereafter. The remainder of the monies from specialized plates with personalized configurations will be allocated partly to the Specialized License Plate Fund and partly to the Environmental License Plate Fund.

B2 - Specialized License Plate information

Due to an injunction filed in the United States District court in the case Women's Resource Network vs Gourley (2004) 305 F. Supp. 2d 1145, the department was prevented from issuing any new Special Interest License Plates pursuant to former Vehicle Code Section 5060. The court determined that Section 5060 was unconstitutional because it created a "public forum" for private speech without establishing neutral criteria upon which to allow the creation of new specialty plates not related to an official governmental purpose. California Legislators have passed a content-neutral bill allows the department to again issue specialty plates. This bill, Chapter 454, Statures of 2006 (Assembly Bill 84), added Article 8.6; Specialized License Plates (Sections 5151 through 5160) to the California Vehicle Code, to allow the issuance of Specialized License Plates sponsored by a "state" agency, which has a design or contains the message that publicizes or promotes a state agency, or the official policy, mission, or work of a state agency. Once your organization has obtained the sponsorship of a "state" agency, the department will be happy to provide your organization with technical assistance for the development of the license plate.

Contained in this package are the following:

1. California Vehicle Code Sections 5151 through 5160, which specifies the design parameters of specialized license plates and the responsibilities of both this department and the sponsoring organizations for implementation of Specialized License Plate Programs.

   Section 5156 sets forth the threshold of 7,500 fee paid applications that a sponsor is required to obtain before the department can implement this program. This threshold was established to ensure that the department's start up costs for such things as programming, plate production and application processing have been covered. The estimated costs for programming alone are $277,000. The complete implementation cost is $400,000.

2. California Vehicle Codes for Environmental License Plates, including fees. Specialized license plate programs that allow personalized configurations are required to include these fees.

3. Specifications Information

4. License plate templates for use in the development of a license plate design.

B3 - State Agency Definition per Vehicle Code 5151-5160

5151. (a) As used in this article, "state agency" means a state office, officer, department, division, bureau, board, or commission, or any other state body or agency.

(b) It is the intent of the Legislature that this article contain the authority for specialized license plates for state agencies.

Added Sec. 3, Ch. 454, Stats. 2006. Effective January 1, 2007.

Application

5152. A person described in Section 5101 may apply for a specialized license plate under this article, in lieu of regular license plates.

Added Sec. 3, Ch. 454, Stats. 2006. Effective January 1, 2007.

Design or Message

5154. Specialized license plates issued under this article shall have a design or contain a message that publicizes or promotes a state agency, or the official policy, mission, or work of a state agency.

Added Sec. 3, Ch. 454, Stats. 2006. Effective January 1, 2007.

Design Criteria

5155. The design criteria for a specialized license plate are as follows:

(a) The license plate for a passenger vehicle, commercial vehicle, or trailer shall provide a space not larger than two inches by three inches to the left of the numerical series and a space not larger than five-eighths of an inch in height below the numerical series for a distinctive design, decal, or descriptive message as authorized by this article. The license plates shall be issued in sequential numerical order or, pursuant to Section 5103, in a combination of numbers or letters.

(b) Specialized license plates authorized under this article may be issued for use on a motorcycle. That license plate shall contain a five-digit configuration issued in sequential numerical order or, pursuant to Section 5103, in a combination of numbers or letters. There shall be a space to the left of the numerical series for a distinctive design or decal and the characters shall contrast sharply with the uniform background color. A motorcycle plate containing a full plate graphic design is not authorized.

(c) Specialized license plates may be issued as environmental license plates, as defined in Section 5103.

Added Sec. 3, Ch. 454, Stats. 2006. Effective January 1, 2007.

Sponsorship and Issuance

5156. (a) (1) A state agency may apply to the department to sponsor a specialized license plate program, and the department shall issue specialized license plates for that program, if the agency complies with all of the requirements of this article.

(2) The department shall not issue specialized license plates to a state agency for a vehicle that is exempt from the payment of registration fees pursuant to Section 9101 or 9103.

(b) Except as provided in subdivision (d), the department shall not establish a specialized license plate program for an agency until the department has received not less than 7,500 applications for that agency's specialized license plates. The agency shall collect and hold applications for the plates. Once the agency has received at least 7,500 applications, it shall submit the applications, along with the necessary fees, to the department. The department shall not issue a specialized license plate until the agency has received and submitted to the department not less than 7,500 applications for that particular specialized license plate within the time period prescribed in this section. Advance payment to the department by the agency representing the department's estimated or actual administrative costs associated with the issuance of a

particular specialized license plate shall not constitute compliance with this requirement. The agency shall have 12 months, following the date of approval of the agency's initial application to sponsor a specialized license plate program, to receive the required number of applications. If, after that 12 months, 7,500 applications have not been received, the agency shall immediately do either of the following:

(1) Refund to all applicants all fees or deposits that have been collected.

(2) Contact the department to indicate the agency's intent to undertake collection of additional applications and fees or deposits for an additional period, not to exceed 12 months, in order to obtain the minimum 7,500 applications. If the agency elects to exercise the option under this subparagraph, it shall contact each applicant who has submitted an application with the appropriate fees or deposits to determine if the applicant wishes a refund of fees or deposits or requests the continuance of the holding of the application and fees or deposits until that time that the agency has received 7,500 applications. The agency shall refund the fees or deposits to an applicant so requesting. The agency shall not collect and hold applications for a period exceeding 24 months following the date of approval of the agency's initial application to sponsor a specialized license plate program.

(c) (1) If the number of outstanding and valid specialized license plates in a particular program, except as provided in subdivision (d), provided for in this article is less than 7,500, the department shall notify the sponsoring agency of that fact and shall inform the agency that if that number is less than 7,500 one year from the date of that notification, the department will no longer issue or replace those specialized license plates.

(2) Those particular specialized license plates that were issued prior to the discontinuation provided by paragraph (1) may continue to be used and attached to the vehicle for which they were issued and may be renewed, retained, or transferred pursuant to this code.

(d) (1) The Department of Veterans Affairs may sponsor a Gold Star Family specialized license plate program and the department may establish this specialized license plate program in the absence of 7,500 paid applications as provided in subdivision (d) of Section 5157.

(2) The Department of Veterans Affairs shall, upon receiving proof of eligibility from an applicant, authorize the department to issue Gold Star Family specialized license plates for a vehicle owned by an eligible family member of a member of the Armed Forces of the United States who was killed in the line of duty while on active duty during wartime service, or during an international terrorist attack that has been recognized by the United States Secretary of Defense as an attack against the United States or a foreign nation friendly to the United States, or during military operations while serving outside the United States, including commonwealths, territories, and possessions of the United States, or as part of a peacekeeping force, which includes personnel assigned to a force engaged in a peacekeeping operation authorized by the United Nations Security Council. An eligible family member is defined as all of the following:

(A) A person who is otherwise eligible under this article to register a motor vehicle.

(B) A person who shows proof from the United States Department of Veterans Affairs or the Department of Defense that the member who was in the Armed Forces of the United States was killed in the line of duty while on active duty in the military.

(C) A person who bears, and shows proof satisfactory to the Department of Veterans Affairs of, one of the following relationships to the member of the Armed Forces killed in the line of duty while serving on active duty:

(i) Widow.

(ii) Widower.

(iii) Biological parent.

(iv) Adoptive parent.

(v) Stepparent.

(vi) Foster parent in loco parentis.

(vii) Biological child.

(viii) Adoptive child.

(ix) Stepchild.

(x) Sibling.

(xi) Half-sibling.

(xii) Grandparent.

(xiii) Grandchild.

(3) Upon the death of a person issued a Gold Star Family specialized license plate, the license plate shall be transferred to the surviving spouse, if he or she requests, or shall be returned to the department within 60 days after the death of the plateholder or upon the expiration of the vehicle registration, whichever occurs first.

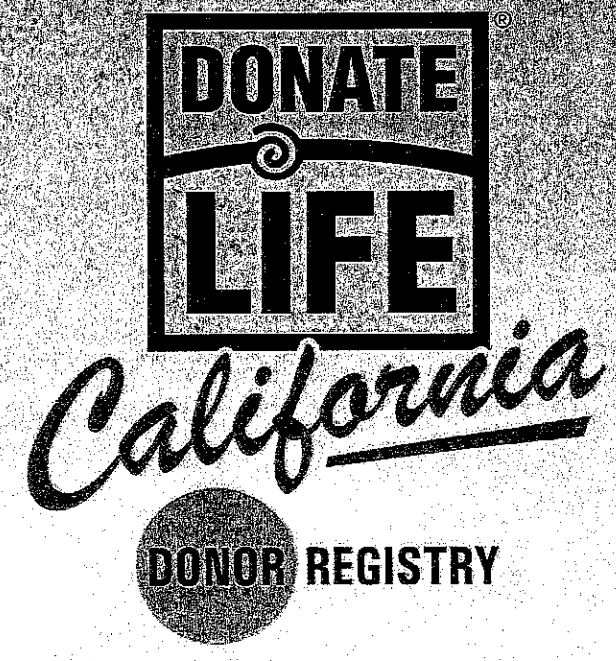
Added Sec. 3, Ch. 454, Stats. 2006. Effective January 1, 2007.
Amended Sec. 2, Ch. 309, Stats. 2008. Effective January 1, 2009.

Appendix C - Legislative history of DLC

For more than 30 years, the State of California and California DMV have played an essential role in saving and healing the lives of California residents through their support of organ and tissue donation. The following is a summary of legislative action that has propelled the Department of Motor Vehicles involvement.

CH. 325, Stats. 1975 **January 1, 1976** ***Introduced the "Pink Dot"***	DMV began its participation in the organ donor program. The law required that with every driver license and identification card issued after July 1, 1976, the department would provide a sticker to affix to the back of the license or identification card, by which an individual may indicate his or her willingness and intent to make an anatomical gift. The card carrier (to which the DL/ID is attached when mailed) was designed to provide a "stick-on" pink dot that could be affixed to the DL/ID, a detachable card to be completed and signed indicating the person's desire to be an organ donor. The formats of the DL/ID were modified to include a circle designating where the pink dot should be affixed.
SB 2012, Watson **(CH. 583, Stats. 92)** **January 1, 1992**	Required DMV to present an organ donor form, and explain its use, to each applicant for an identification card or driver license, or renewal of such a license, at the time of application.
AB 2092, Mazzoni **(1995/96, died))**	Would have required the department to make organ donor information available to the public in each office where applications for driver licenses are received; basically required DMV to promote organ donation. The bill was amended to remove DMV provisions.
AB 1227, Mazzoni **(1995/96, died)**	Would have required DMV to provide for electro magnetically encoded donor information on driver licenses and identification cards, establish a procedure to ensure prompt changes of the anatomical gift information, and to adopt regulations that would ensure that the technology to read the encoded

	information is available only to specified agencies and individuals involved in the administration of anatomical gift laws. These provisions were subsequently amended out of the bill.
SB 771, Speier (1999,died)	Intent was to mark the DL/ID card and create a statewide Organ and Tissue Donor Registry. Died in the Assembly Appropriations Committee.
SB 1403, Polanco, Chapter 887 of 1998 January 1, 1999	Required DMV to modify the donor card to include more donor information and the donor's signature. SB 1403, Polanco (CH. 887 Stats. 1998) required the department to design the driver licenses and identification cards in order that a sticker may be affixed to the licenses and cards; required the sticker be affixed with a substance that is resistant to any unintentional removal, require the department to modify the form issued to all driver license and identification card holders which is used to designate an anatomical gift; and required the Director of the DMV to determine the date when the department's inventory of the form has been depleted and make written notification, as specified.
SB 108, Speier January 1, 2002 **Created a State Donor Registry** **(never implemented)**	This bill intended to increase the number of persons who would identify themselves as potential organ donors through the establishment of a "primary" organ and tissue donor registry. A "primary" registry means that the individual who registers to donate has completed a legally binding document that only the individual can rescind. That is, the individual's family cannot override the decision to donate. The California Health and Human Services Agency was mandated to create the registry, funded by donations. The bill eliminated the department's responsibility of providing a donor form/card used to allow a licensee or identification card holder to indicate his or her willingness and intent to make an anatomical gift. Instead, it required the Department of Motor Vehicles to provide educational material and a standardized form to be completed by any individual desiring to enroll in the Organ and Tissue Donor Registry with instructions for mailing the form to the California Health and Human Services Agency. This bill was enacted in 2002; however, the provisions were never implemented. The California Health and Human Services Agency failed to establish a registry, citing that donations were not sufficient to cover the costs. However, the California Health and Human Services Agency did not set up an account to accept donations for this purpose.
SB 112, Speier January 1, 2004 **Established the Organ and Tissue Donor Registrar and a State Donor Registry**	This bill redirected the responsibilities of establishing and maintaining the Organ and Tissue Donor Registry from the Department of Health Services to the California Organ and Tissue Donor Registrar. The bill required the Department of Motor Vehicles, upon issuance of a DL/ID to provide information about organ/tissue donations and about how private donations can be made to the California Organ and Tissue Donor Registrar. The department was required to provide a standard application form to be completed by potential donors to enroll in the Registry, with instructions to send the form to the Registrar. At the request of Donate Life (the non-profit organization established to oversee the registry), DMV did not provide a form to register, but instead provided information about the registry and its web site, which would (in the future) allow for signing up on-line.
SB 689, Speier Effective 1/1/06 Operational 7/1/06 **Allowed applicants to register as donors at DMV**	This bill requires DMV: to offer applicants the ability to register as an organ and tissue donor during the driver license and identification card process, electronically transmit information on individuals who choose to register to the California Organ and Tissue Donor Registrar, and provide applicants the opportunity to donate $2 for the purpose of promoting and supporting the organ and tissue donor program. The provisions of this bill were implemented effective July 1, 2006 for all original applicants for a DL/ID. By September 2006, the process was added to all renewal applications, including renewal by mail, and online renewal.



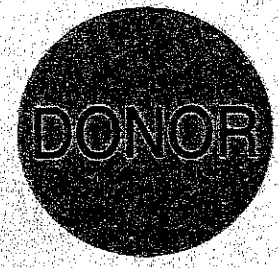
We Need Your Help to Save More Lives in California

Charlene Zettel - *Chief Executive Officer*

Sharon Ross - *Charter Board Member*

Donate Life California: Who We Are

- ✓ Legislatively tasked to administer the State's Organ and Tissue Donor Registry
- ✓ Board comprised of the 4 federally-designated, non-profit organ procurement organizations (the official links between deceased donors in California and people waiting for transplants)
- ✓ DLC is the 'pink dot' on your license



Sierra Donor Services

California Transplant Donor Network

onelegacy

Lifesharing

The Need is Great in Our State - Stats as of 1/9/13

116,796 people are on the national organ waiting list

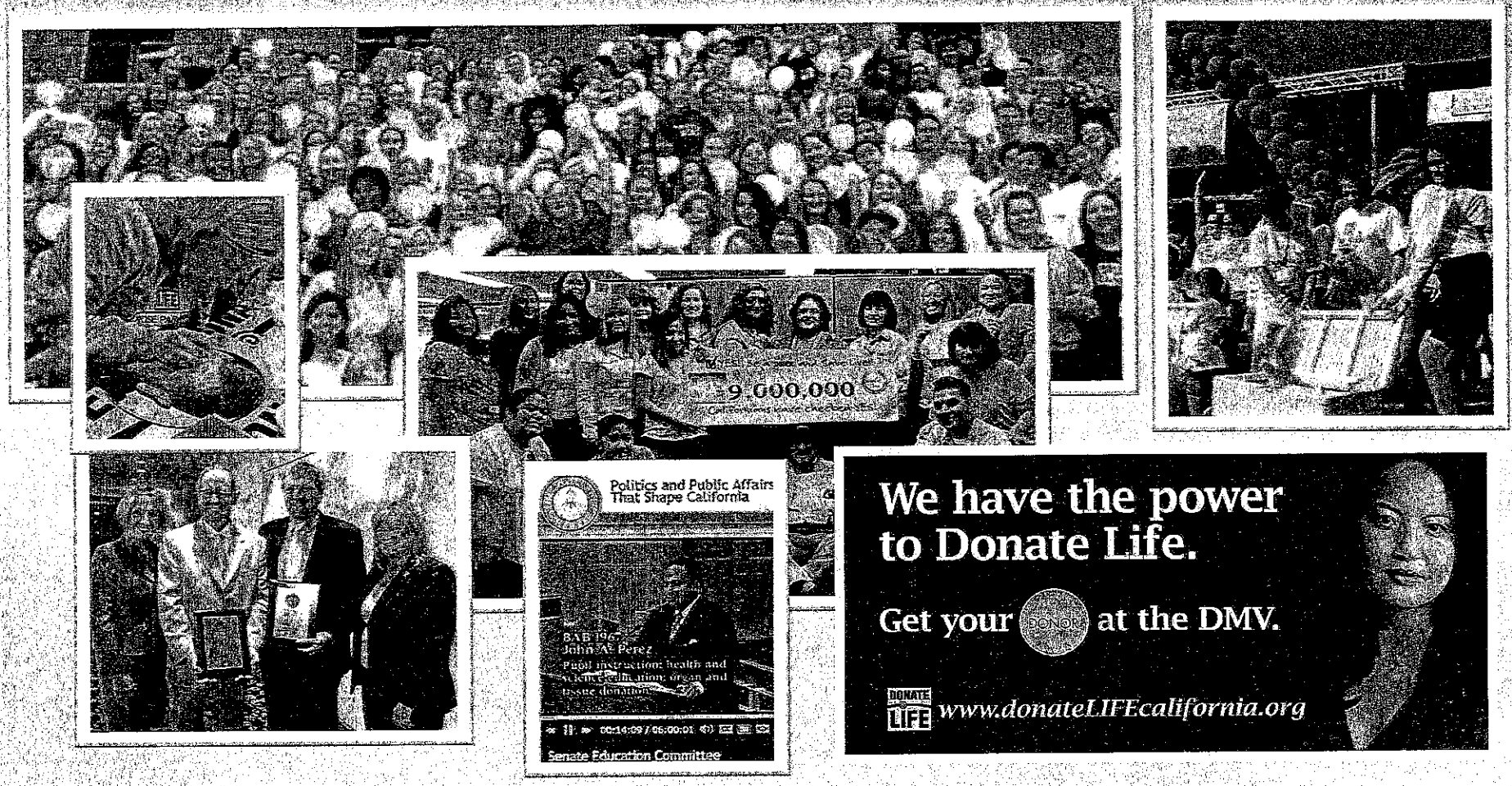
A new name is added every **11** minutes

One in **5** people on the national waiting list lives in California

Currently **21,075** Californians need a transplant to survive

342 are children under 18; **9** are under the age of one

We Do A Lot to Inspire People to Register



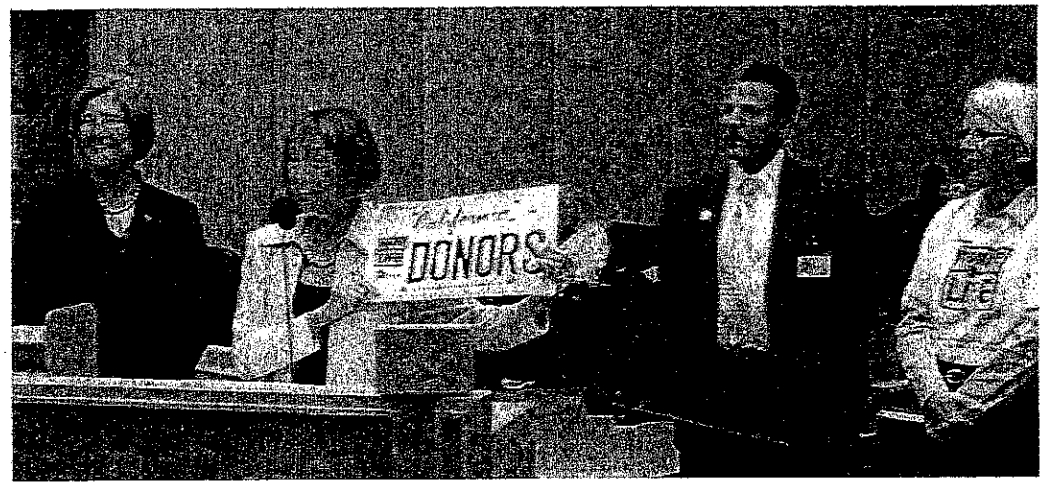
But we need to do more. And we need your help.

Last year we estimate 1,000 Californians died waiting.

An Idea that is Helping In Other States

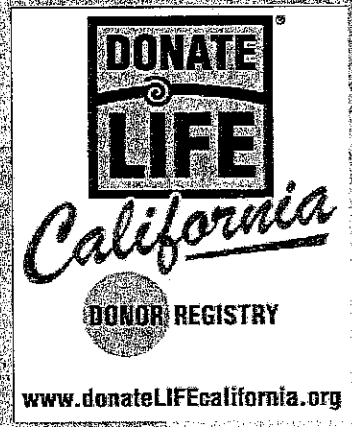
DLC Believes a Donate Life Plate Will Help, too!

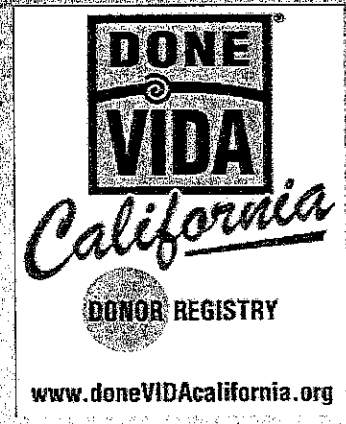
- Specialty plates require a state organization to sponsor the effort
- DLC will handle all reporting and marketing responsibilities
- MBC will incur no expense or liability



Why the Medical Board of California?

A respected partner with a shared commitment and mission to save lives in California.





Charlene Zettel | 619-563-5133 | czettel@donateLIFEcalifornia.org

Sharon Ross | 619-521-1983 | sharon@lifesharing.org

MEDICAL BOARD OF CALIFORNIA
TRACKER – LEGISLATIVE BILL FILE
January 18, 2013

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
SB 62	Price	Coroners: Reporting Requirements: Prescription Drug Use	Introduced	Reco: Support if Amended	
SCR 8	DeSaulnier	Prescription Drug Abuse Awareness Month	Introduced	Reco: Support	

Green – For Discussion

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 62
Author: Price
Bill Date: January 8, 2013, Introduced
Subject: Coroners: Reporting Requirements: Prescription Drug Use
Sponsor: Author

STATUS OF BILL:

This bill has just been introduced.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require a coroner to report deaths that may be the result of prescription drug use to the Medical Board of California (Board), the Osteopathic Medical Board of California (OMBC), the California Board of Podiatric Medicine (BPM), the Physician Assistant Board (PAB), and the Board of Pharmacy (BOP). The initial report must include the name of the decedent, date and place of death, attending physicians, podiatrists, or physician assistants, and all other relevant information available. The initial report shall be followed, within 90 days, by copies of the coroner's report, autopsy protocol, and all other relevant information.

ANALYSIS:

Existing law, Business and Professions Code Section 802.5, requires a coroner to report to the Board (and the OMBC , BPM, and PAB) when he/she receives information based on findings by a pathologist indicating that a death may be the result of a physician's gross negligence or incompetence. This section requires the coroner to make a determination that the death *may* be the result of the physician's gross negligence or incompetence. Requiring coroners to make the determination, could be the reason the Board has seen a decrease in coroners reports; the number of reports received by the Board is at an all-time low. Only four reports were received in FY 2011/12, and only one of the reports indicated a drug related death.

The Board has reason to believe that numerous death have occurred in California that are related to prescription drug overdoses. However, complaints regarding drug-related offenses are often hard for the Board to obtain. In most instances, patients who are receiving prescription drugs in a manner that is not within the standard of practice, are unlikely to make a complaint to the Board. Some complaints regarding overprescribing come from anonymous tips, which usually do not have enough information to allow forwarding to the Board's district office for investigation, as there is no patient to obtain records for or not enough information to

open an investigation. Family members of patients may make a complaint to the Board; however, the Board must have a patient release in order to obtain medical records or seek a subpoena. Sometimes it is difficult to obtain evidence to warrant a subpoena, or the family is not responsive.

The Board included a proposal for required coroner reporting prescription drug related deaths in its Sunset Review Report, as a new issue for the Legislature's consideration. Requiring deaths related to prescription drug use to be reported to the Board would allow the Board to review the documentation to determine if the prescribing physician was treating in a correct or inappropriate manner. This would increase consumer protection and ensure the Board is notified of physicians who might pose a danger to the public, so action can be taken prior to another individual suffering the same outcome. If only one physician was found to be overprescribing, this could save numerous lives.

Senator Price introduced this bill in response to several articles run by the LA Times. These articles included cases of physicians prescribing opioid prescription drugs to multiple patients, which may have resulted in these patients' deaths. The Senator introduced this bill to ensure that the Board has knowledge about these types of cases in the future, so the Board can review these cases, investigate, and take appropriate disciplinary action against physicians prescribing inappropriately.

The current language in this bill still requires the coroner to make a judgment call if the death *may* be the result of prescription drug use, which could lead to a decrease in reporting. The Board may wish to consider requesting an amendment to change "may be" to "is the result of prescription drug use". In addition, requiring coroner reporting of all prescription drug use deaths might be overly broad and interpreted to include deaths that occurred while an individual was taking a non-opioid prescription (i.e., antibiotics). The Board may wish to consider narrowing the type of prescription drug use deaths reported to those related to Schedule II and III prescription drugs.

FISCAL: This bill will likely result in increased workload to the Board. However, the increased workload would be offset by the benefit added to consumer protection. Once the Board has specific numbers, staff will be able work on developing a full fiscal analysis.

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Support if Amended

SENATE BILL No. 62

Introduced by Senator Price

January 8, 2013

An act to amend Section 802.5 of the Business and Professions Code, relating to coroners.

LEGISLATIVE COUNSEL'S DIGEST

SB 62, as introduced, Price. Coroners: reporting requirements: prescription drug use.

Existing law requires a coroner to make a report, as specified, when he or she receives information that indicates that a death may be the result of a physician and surgeon's, podiatrist's, or physician assistant's gross negligence or incompetence.

This bill would expand those provisions to require a coroner to make a report when he or she receives information that indicates a death may be the result of prescription drug use and to require the coroner to additionally file the report with the California State Board of Pharmacy. By increasing the duties of county officers, this bill creates 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, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

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

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

1 SECTION 1. Section 802.5 of the Business and Professions
2 Code is amended to read:
3 802.5. (a) When a coroner receives information that is based
4 on findings that were reached by, or documented and approved by
5 a board-certified or board-eligible pathologist indicating that a
6 death may be the result of a physician and surgeon's, podiatrist's,
7 or physician assistant's gross negligence or incompetence, a report
8 shall be filed with the Medical Board of California, the Osteopathic
9 Medical Board of California, the California Board of Podiatric
10 Medicine, or the Physician Assistant Board. The initial report shall
11 include the name of the decedent, date and place of death, attending
12 physicians ~~or~~, podiatrists, *or physician assistants*, and all other
13 relevant information available. The initial report shall be followed,
14 within 90 days, by copies of the coroner's report, autopsy protocol,
15 and all other relevant information.
16 *(b) When a coroner receives information that is based on*
17 *findings that were reached by, or documented and approved by a*
18 *board-certified or board-eligible pathologist indicating that a*
19 *death may be the result of prescription drug use, a report shall be*
20 *filed with the Medical Board of California, the Osteopathic Medical*
21 *Board of California, the California Board of Podiatric Medicine,*
22 *or the Physician Assistant Board, and shall also be filed with the*
23 *California State Board of Pharmacy. The initial report shall*
24 *include the name of the decedent, date and place of death,*
25 *attending physicians, podiatrists, or physician assistants, and all*
26 *other relevant information available. The initial report shall be*
27 *followed, within 90 days, by copies of the coroner's report, autopsy*
28 *protocol, and all other relevant information.*
29 ~~(b) The~~
30 *(c) A* report required by this section shall be confidential. No
31 coroner, physician and surgeon, or medical examiner, nor any
32 authorized agent, shall be liable for damages in any civil action as
33 a result of his or her acting in compliance with this section. No
34 board-certified or board-eligible pathologist, nor any authorized
35 agent, shall be liable for damages in any civil action as a result of
36 his or her providing information under subdivision (a) *or (b)*.
37 SEC. 2. If the Commission on State Mandates determines that
38 this act contains costs mandated by the state, reimbursement to

1 local agencies and school districts for those costs shall be made
2 pursuant to Part 7 (commencing with Section 17500) of Division
3 4 of Title 2 of the Government Code.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SCR 8
Author: DeSaulnier
Bill Date: January 14, 2013, Introduced
Subject: Prescription Drug Abuse Awareness Month
Sponsor: Author

STATUS OF BILL:

This bill has just been introduced.

DESCRIPTION OF CURRENT LEGISLATION:

This concurrent resolution would proclaim the month of March, each year, as Prescription Drug Abuse Awareness Month and would encourage all citizens to participate in prevention programs and activities and to pledge to "Spread the Word....One Pill Can Kill."

ANALYSIS:

This resolution makes declarations regarding prescription drugs. In 2008, 20,044 deaths were from prescription drug overdoses; in 2009, 1.2 million emergency department visits were related to misuse or abuse of pharmaceuticals; in 2010, 2 million people reported using prescription painkillers non-medically for the first time within the last year; and as many as 70 percent of people who abuse prescription drugs get them from a relative or friend instead of a doctor. This resolution also states that the National Coalition Against Prescription Drug Abuse, in cooperation with local law enforcement agencies and other community organizations, coordinate Prescription Drug Abuse Awareness Month activities. Lastly, this resolution states that community organizations, local government, practitioners, pharmacists, and the general public will demonstrate their commitment to the prevention of prescription medication abuse by participating in activities to highlight local efforts in March.

This bill would proclaim the month of March, each year, to be Prescription Drug Abuse Awareness Month and would encourages all citizens to participate in prevention programs and activities and to pledge to "Spread the Word....One Pill Can Kill."

The epidemic of prescription drug abuse and overdoses is plaguing the nation, as well as California. This bill would help to increase awareness of the prescription drug abuse problem in California and would encourage participation in prescription medication abuse prevention programs. Staff suggests the Board take a support position on this resolution, as it would help to further the Board's mission of consumer protection.

FISCAL: None to the Board.

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Support

Senate Concurrent Resolution No. 8

Introduced by Senator DeSaulnier
(Coauthors: Senators Hancock, Lieu, and Price)

January 14, 2013

Senate Concurrent Resolution No. 8—Relative to Prescription Drug Abuse Awareness Month.

LEGISLATIVE COUNSEL'S DIGEST

SCR 8, as introduced, DeSaulnier. Prescription Drug Abuse Awareness Month

This measure would proclaim the month of March, each year, as Prescription Drug Abuse Awareness Month and encourage all citizens to participate in prevention programs and activities and to pledge to "Spread the Word ... One Pill Can Kill."

Fiscal committee: no.

WHEREAS, In 2008, drug overdoses in the United States caused 36,450 deaths and 20,044 of these were from prescription drug overdoses; and

WHEREAS, Overdose deaths involving opioid pain relievers (OPR) have increased and now exceed deaths involving heroin and cocaine combined; and

WHEREAS, In 2009, 1.2 million emergency department visits were related to misuse or abuse of pharmaceuticals (an increase of 98.4 percent since 2004); and

WHEREAS, Nonmedical use of OPR costs insurance companies up to $72.5 billion annually in health care costs; and

WHEREAS, By 2010, enough prescription painkillers were sold to medicate every American adult with a typical dose of five milligrams of hydrocodone every four hours for one month; and

WHEREAS, In 2010, 2 million people reported using prescription painkillers nonmedically for the first time within the last year—nearly 5,500 a day; and

WHEREAS, As many as 70 percent of people who abuse prescription drugs get them from a relative or friend instead of a doctor; and

WHEREAS, The National Coalition Against Prescription Drug Abuse, in cooperation with law enforcement agencies, community-based organizations, alcohol and other drug service providers, and civic and business leaders, coordinates Prescription Drug Abuse Awareness Month activities to offer our citizens the opportunity to demonstrate their commitment to campaigns and education aimed at raising awareness about the abuse and misuse of prescription drugs, promoting safe storage and disposal of prescription drugs, and using medications only as prescribed; and

WHEREAS, Families, schools, businesses, faith-based communities, law enforcement, medical professionals, county and local governments, health care practitioners, pharmacists, and the general public throughout the state will demonstrate their commitment to the prevention of prescription medication abuse by participating in activities intended to highlight local efforts during the month of March; now, therefore, be it

Resolved by the Senate of the State of California, the Assembly thereof concurring, That the month of March, each year, is hereby be proclaimed to be Prescription Drug Abuse Awareness Month and that all citizens are encouraged to participate in prevention programs and activities and to pledge to "Spread the Word … One Pill Can Kill"; and be it further

Resolved, That the Secretary of the Senate transmit copies of this resolution to the author for appropriate distribution.

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MBC TRACKER II BILLS
1/17/2013

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 5	Ammiano	Homelessness	Introduced	
AB 12	Cooley	Standardized Regulatory Impact Analysis	Introduced	
AB 18	Pan	Individual Health Care Coverage	Introduced	
AB 27	Medina	UC Riverside Medical School: Funding	Asm. Higher Ed.	
AB 58	Wieckowski	Medical Experiments: Human Subjects	Introduced	
ACA 1	Donnelly	Administrative Regulations: Legislative Approval	Introduced	
ACR 1	Medina	UC Riverside School of Medicine	Introduced	
SB 18	Hernandez	Individual Health Care Coverage	Introduced	
SB 20	Hernandez	Health Care Coverage: Basic Health Program	Introduced	
SB 21	Roth	UC Riverside Medical School: Funding	Sen. Education	
SB 44	Yee	State Internet Web sties: online voter registration	Sen. Elections	

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 Final Review *	Date to OAL for Review **	Date to Sec. of State***
Misdemeanor Convictions	At DCA for review and approval	2/03/12	3/09/12	5/04/12	5/04/12	To DCA 1/25/13		
Physician Availability related to the use of lasers	At DCA for review and approval.	7/20/12	8/31/12	10/26/12	10/26/12	To DCA 1/24/13		
Polysom Basic Life Support (to amend 1379.50)	Hearing held 10/26/12; Modified text mailed on 11/14/12; The 15-day comment period ended 12/04/12; Final Regulatory Package is being reviewed by Executive Staff.	7/20/12	8/31/12	10/26/12	10/26/12			

Prepared by Chris Valine
Updated January 25, 2013
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

0758 - Medical Board
Analysis of Fund Condition
(Dollars in Thousands)

FY 2012-13 Governor's Budget	ACTUAL 2011-12	CURRENT YEAR 2012-13	BY 2013-14	BY+1 2014-15	BY+2 2015-16
BEGINNING BALANCE	$ 30,246	$ 24,613	$ 20,835	$ 15,060	$ 8,272
Prior Year Adjustment	$ 752	$ -	$ -	$ -	$ -
Adjusted Beginning Balance	$ 30,998	$ 24,613	$ 20,835	$ 15,060	$ 8,272
REVENUES AND TRANSFERS					
Revenues:					
125600 Other regulatory fees	$ 355	$ 287	$ 288	$ 288	$ 288
125700 Other regulatory licenses and permits	$ 5,946	$ 5,646	$ 5,647	$ 5,647	$ 5,647
125800 Renewal fees	$ 46,269	$ 45,445	$ 45,481	$ 45,481	$ 45,481
125900 Delinquent fees	$ 120	$ 98	$ 98	$ 98	$ 98
142500 Miscellaneous services to the public	$ 31	$ 30	$ 30	$ 30	$ 30
150300 Income from surplus money investments	$ 115	$ 88	$ 60	$ 42	$ 69
160400 Sale of fixed assets	$ 3	$ -	$ -	$ -	$ -
161000 Escheat of unclaimed checks and warrants	$ 16	$ -	$ -	$ -	$ -
161400 Miscellaneous revenues	$ 2	$ 19	$ 19	$ 19	$ 19
164300 Penalty assessments - Probation Monitoring		$ 900	$ 900	$ 900	$ 900
Totals, Revenues	$ 52,857	$ 52,513	$ 52,523	$ 52,505	$ 52,532
Transfers:					
GENERAL FUND LOAN*	$ (9,000)				
TOTALS, REVENUES AND TRANSFERS	$ 43,857	$ 52,513	$ 52,523	$ 52,505	$ 52,532
TOTAL RESOURCES	$ 74,855	$ 77,126	$ 73,358	$ 67,565	$ 60,804
EXPENDITURES					
Disbursements:					
0840 State Controller (State Operations)	$ 58	$ 67		$ -	$ -
8880 FSCU (State Operations)	$ 2	$ 302	$ 259		
FISCAL	$ 126	$			
1110 Program Expenditures (State Operations)	$ 50,056	$ 55,922 **	$ 56,856	$ 57,993	$ 57,980
Anticipated Future Costs					
Antcipated BreEZe Cost			$ 1,183	$ 1,300	$ 1,300
Totals, Disbursements	$ 50,242	$ 56,291	$ 58,298	$ 59,293	$ 59,280
FUND BALANCE					
Reserve for economic uncertainties	$ 24,613	$ 20,835	$ 15,060	$ 8,272	$ 1,524
Months in Reserve	5.2	4.3	3.0	1.7	0.3

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.

* 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. These loans will be repaid when the fund is nearing its minimum mandated level.

** This includes $1.278 million for the BreEZe system. This amount will not be completely expended due to the delay in implementation of the project.

1/14/2013

Medical Board of California

FY 12/13
Budget Expenditure Report
(As of November 30, 2012)
(42% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENSES/ ENCUMB	PERCENT OF BUDGET EXP/ENCUMB	UNENCUMB BALANCE
PERSONAL SERVICES				
Salary & Wages (Staff & Exec Director)	15,268,382	5,934,561	38.9	9,333,821
Board Members	31,500	18,984	60.3	12,516
Phy Fitness Incentive Pay	29,623	11,670	39.4	17,953
Temp Help	1,137,513	523,787	46.0	613,726
Overtime	12,143	12,125	99.9	18
Staff Benefits	7,775,513	2,816,015	36.2	4,959,498
Salary Savings	0			0
TOTALS, PERS SERVICES	24,254,674	9,317,143	38.4	14,937,532
OPERATING EXP & EQUIP				
General Expense	608,071	377,165	62.0	230,906
Fingerprint Reports	333,448	127,876	38.3	205,572
Minor Equipment	132,300	17,871	13.5	114,429
Printing	685,755	90,386	13.2	595,369
Communications	372,190	66,119	17.8	306,071
Postage	282,511	61,370	21.7	221,141
Insurance	41,053	17,245	42.0	23,808
Travel In-State	401,298	50,065	12.5	351,233
Travel Out-of-State	7,000	1,111	15.9	5,889
Training	78,895	13,684	17.3	65,211
Facilities Operation (Rent)	2,702,140	2,175,240	80.5	526,900
Consult/Prof Services	1,606,594	1,484,849	92.4	121,745
Departmental Prorata	4,540,957	2,324,164	51.2	2,216,793
Interagency Services	5,142	0	0.0	5,142
Consolidated Data Center	650,230	228,490	35.1	421,740
Data Processing	129,492	43,094	33.3	86,398
Central Admin Svcs (Statewide Prorata)	2,348,960	1,174,480	50.0	1,174,480
Attorney General Services	13,347,280	4,971,319	37.2	8,375,961
Office of Administrative Hearings	1,525,080	541,150	35.5	983,930
Evidence/Witness	1,893,439	628,577	33.2	1,264,862
Court Reporter Services	225,000	162,659	72.3	62,341
Major Equipment	652,000	0	0.0	652,000
Other Items of Expense	81	32,953	40,682.7	(32,872)
Vehicle Operations	261,925	102,091	39.0	159,834
Court-ordered Payments	0	1,991		(1,991)
Board of Control Claim	0	0		0
TOTALS, OE&E	32,830,841	14,693,949	44.8	18,136,892
TOTALS, EXPENDITURES	57,085,515	24,011,092	42.1	33,074,423
Scheduled Reimbursements	(384,000)	(152,058)	39.6	(231,942)
Distributed Costs	(780,000)	(256,933)	32.9	(523,067)
NET TOTAL, EXPENDITURES	55,921,516	23,602,101	42.2	32,319,414
Unscheduled Reimbursements		(306,017)		
		23,296,084		

Budget Expenditure Report.xls
Date: Jan 11, 2013

MEDICAL BOARD OF CALIFORNIA
ENFORCEMENT PROGRAM
BUDGET REPORT
JULY 1, 2012-NOVEMBER 30, 2012

	FY 12/13 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	9,884,363	3,852,637	current
Staff Benefits	4,545,798	1,662,372	current
TOTAL PERSONAL SERVICES	14,430,161	5,515,009	
OPERATING EXPENSE & EQUIPMENT			
General Expense/Fingerprint Reports	389,307	278,741	1-2
Printing	300,255	55,744	1-2
Communications	222,358	43,669	1-2
Postage	69,500	16,340	1-2
Insurance	38,235	14,840	current
Travel In-State	242,018	27,868	1-2
Travel Out-State	7,000	1,111	1-2
Training	31,000	2,195	1-2
Facililties Operations	2,064,940	1,609,775	current
Consultant/Professional Services	300,000	212,640	1-2
Departmental Services	3,191,838	1,732,126	current
Interagency Services	3,613	0	1-2
Data Processing	18,000	1,795	1-2
Statewide Pro Rata	1,650,379	825,370	current
Attorney General 1/	13,157,280	4,907,512	current
OAH	1,525,080	541,150	1
Evidence/Witness Fees	1,820,939	591,750	1-2
Court Reporter Services	224,750	162,659	1-2
Major Equipment	147,000	0	1-2
Other Items of Expense (Law Enf. Materials/Lab, etc.)	81	30,686	1-2
Vehicle Operations	210,925	86,243	1-2
Minor Equipment	0	1,797	1-2
Court-Ordered Payments	0	1,991	current
TOTAL OPERATING EXPENSES & EQUIPMENT	25,614,498	11,146,002	
DISTRIBUTED COSTS	(744,053)	(247,948)	
TOTAL BUDGET/EXPENDITURES	**39,300,606**	**16,413,063**	
Unscheduled Reimbursements		(30,404)	
		16,382,659	

1/See next page for monthly billing detail

MEDICAL BOARD OF CALIFORNIA
ATTORNEY GENERAL EXPENDITURES - FY 12/13
DOJ AGENCY CODE 003573 - ENFORCEMENT (6303)

		Number of Hours	Rate	Amount
July	Attorney Services	5,386.75	170.00	915,747.50
	Paralegal Services	206.00	120.00	24,720.00
	Auditor/Analyst Services	110.00	99.00	10,890.00
	Cost of Suit			0.00
				951,357.50
August	Attorney Services	6,056.00	170.00	1,029,520.00
	Paralegal Services	215.00	120.00	25,800.00
	Auditor/Analyst Services	79.50	99.00	7,870.50
	Cost of Suit			264.00
				1,063,454.50
September	Attorney Services	5,124.25	170.00	871,122.50
	Paralegal Services	201.50	120.00	24,180.00
	Auditor/Analyst Services	76.00	99.00	7,524.00
	Cost of Suit			726.58
				903,553.08
October	Attorney Services	6,244.75	170.00	1,061,607.50
	Paralegal Services	242.00	120.00	29,040.00
	Auditor/Analyst Services	97.00	99.00	9,603.00
	Cost of Suit			315.00
				1,100,565.50
November	Attorney Services	5,025.25	170.00	854,292.50
	Paralegal Services	169.00	120.00	20,280.00
	Auditor/Analyst	121.50	99.00	12,028.50
	Cost of Suit			1,980.45
				888,581.45
December	Attorney Services	0.00	0.00	0.00
	Paralegal Services	0.00	0.00	0.00
	Auditor/Analyst	0.00	0.00	0.00
	Cost of Suit			
				0.00
			Total July-Dec =	**4,907,512.03**
			FY 12/13 Budget =	**13,157,280.00**

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
BUDGET REPORT
JULY 1, 2012 to NOVEMBER 30, 2012

	FY 12/13 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	2,476,739	1,001,973	current
Staff Benefits	1,216,790	467,332	current
TOTAL PERSONAL SERVICES	3,693,529	1,469,305	
OPERATING EXPENSES & EQUIPMENT			
General Expense	58,184	10,260	1-2
Fingerprint Reports*	333,448	127,236	1-2
Printing	61,000	14,059	1-2
Communications	52,246	6,250	1-2
Postage	125,000	44,791	1-2
Travel In-State	14,758	245	1-2
Training	8,500	199	1-2
Facilities Operation	226,000	202,725	current
Consult/Professional Services	1,225,873	1,260,130	1-2
Departmental Services	519,486	227,232	current
Interagency Services	587	0	current
Data Processing	4,000	4,672	1-2
Statewide Pro Rata	268,016	134,008	current
Attorney General	190,000	63,807	current
Evidence/Witness Fees	7,500	0	1-2
Court Reporter Services	250	0	1-2
Major Equipment	26,000	0	1-2
Minor Equipment	0	0	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	3,120,848	2,095,614	
SCHEDULED REIMBURSEMENTS	(384,000)	(152,058)	
DISTRIBUTED COSTS	(31,130)	(7,783)	
TOTAL BUDGET/EXPENDITURES	**6,399,247**	**3,405,078**	

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

1/11/2013

MEDICAL BOARD OF CALIFORNIA BUDGET OVERVIEW BY BOARD COMPONENT

	EXEC	ENFORCE	OPERATION SAFE MEDICINE	LICENSING	ADMIN SERVICES	INFO SYSTEMS	PROBATION MONITORING	BOARD TOTAL
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*	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
FY 12/13								
$ Budgeted	2,132,008	39,300,606	525,515	6,399,247	1,570,587	3,754,162	2,239,391	55,921,516
$ Spent thru 11/30*	683,433	16,382,659	198,160	3,405,078	777,609	1,262,320	586,825	23,296,084 *
Positions Authorized	8.8	147.0	6.0	53.3	14.0	17.0	25.0	271.1

* net expenditures (includes unscheduled reimbursements)

1/11/2013
Budget Overview by Program.xls

ENFORCEMENT/PROBATION RECEIPTS
MONTHLY PROFILE: JULY 2010 - JUNE 2013

	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	FYTD Total
Invest Cost Recovery	300	350	300	100	50	3,932	40,589	50	10,281	205	0	0	56,157
Criminal Cost Recovery	0	0	150	0	50	250	605	504	1,055	754	14,147	2,558	20,073
Probation Monitoring	42,542	41,848	44,639	105,369	96,368	109,993	343,253	222,925	83,025	97,287	59,217	34,113	1,280,578
Exam	1,639	777	2,481	627	1,692	2,552	977	1,106	6,495	1,831	6,024	2,224	28,424
Cite/Fine	200	4,350	800	10,650	3,250	6,400	8,650	7,002	3,450	7,825	3,075	3,800	59,452
MONTHLY TOTAL	44,681	47,325	48,370	116,745	101,409	123,127	394,074	231,587	104,307	107,903	82,462	42,695	1,444,684
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	1,444,684	

	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	FYTD Total
Invest Cost Recovery	250	300	650	2,349	750	700							4,999
Criminal Cost Recovery	1,409	705	619	5,136	964	10,914							19,747
Probation Monitoring	38,879	47,871	26,432	65,999	45,648	146,950							371,779
Exam	1,848	3,456	6,563	2,666	5,212	975							20,720
Cite/Fine	2,800	1,900	5,100	6,268	11,086	12,300							39,454
MONTHLY TOTAL	45,186	54,232	39,364	82,418	63,660	171,839	0	0	0	0	0	0	456,699
FYTD TOTAL	45,186	99,418	138,782	221,200	284,860	456,699	456,699	456,699	456,699	456,699	456,699	456,699	

excel:enfreceiptsmonthlyprofile.xls.revised 1/9/2013

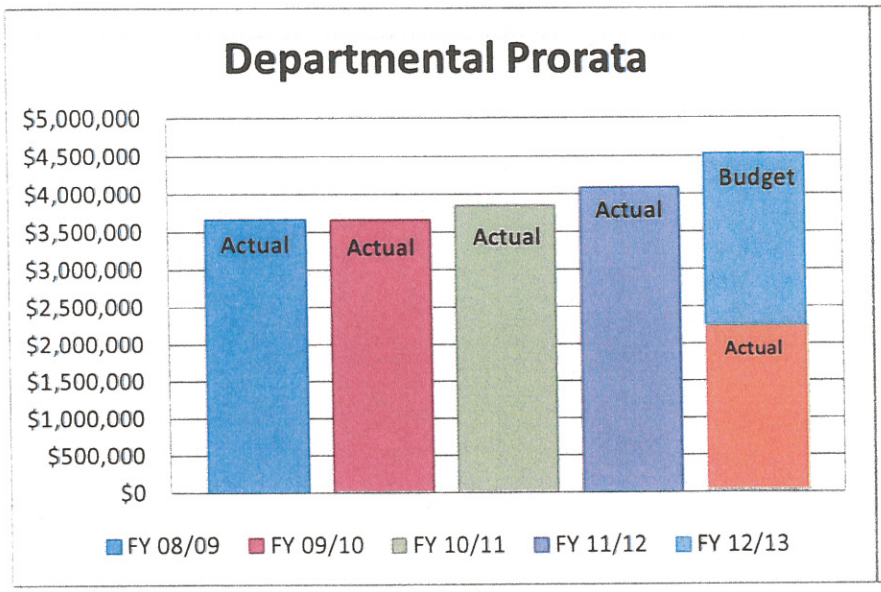
Board Members' Expenditures - Per Diem/Travel
July 1, 2012 - June 30, 2013

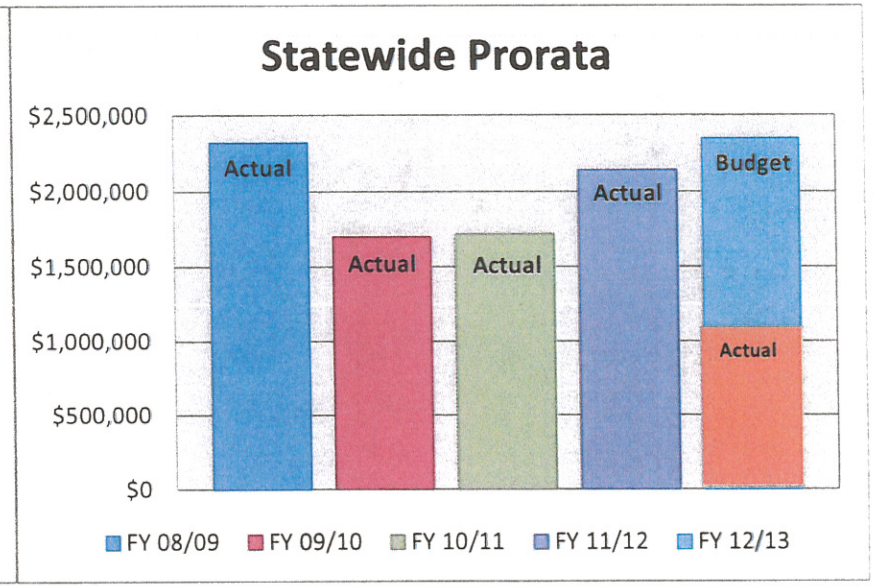
NAMES	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APRIL	MAY	JUNE	YTD
DR. BISHOP - Per diem	$ 1,100.00	$ 400.00	$ 600.00	$ 600.00	$ 600.00								$ 3,300.00
Travel	$ 904.66		$ 517.90	$ 88.64									$ 1,511.20
	$ 2,004.66	$ 400.00	$ 1,117.90	$ 688.64	$ 600.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 4,811.20**
DR. CARREON - Per diem	$ 1,700.00												$ 1,700.00
Travel													$ -
	$ 1,700.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 1,700.00**
MS. CHANG - Per diem													$ -
Travel													$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
DR. DIEGO - Per diem	$ 1,300.00	$ 800.00	$ 600.00	$ 1,800.00	$ 1,400.00	$ 1,100.00							$ 7,000.00
Travel	$ 244.80	$ 94.35		$ 848.07									$ 1,187.22
	$ 1,544.80	$ 894.35	$ 600.00	$ 2,648.07	$ 1,400.00	$ 1,100.00	$ -	$ -	$ -	$ -	$ -	$ -	**$ 8,187.22**
DR. DURUISSEAU - Per diem	$ 1,100.00												$ 1,100.00
Travel	$ 126.56												$ 126.56
	$ 1,226.56	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 1,226.56**
DR. LEVINE - Per diem													$ -
Travel	$ 413.90		$ 285.72	$ 359.62									$ 1,059.24
	$ 413.90	$ -	$ 285.72	$ 359.62	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 1,059.24**
DR. GNANADEV - Per diem	$ 1,200.00	$ 900.00	$ 700.00										$ 2,800.00
Travel													$ -
	$ 1,200.00	$ 900.00	$ 700.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 2,800.00**
DR. LOW - Per diem													$ -
Travel													$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
DR. SALOMONSON - Per diem	$ 400.00		$ 200.00	$ 500.00									$ 1,100.00
Travel	$ 742.92		$ 462.73	$ 515.94									$ 1,721.59
	$ 1,142.92	$ -	$ 662.73	$ 1,015.94	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 2,821.59**
MS.SCHIPSKE - Per diem	$ 1,200.00	$ 400.00	$ 600.00	$ 1,300.00	$ 700.00	$ 900.00							$ 5,100.00
Travel	$ 523.85			$ 535.66									$ 1,059.51
	$ 1,723.85	$ 400.00	$ 600.00	$ 1,835.66	$ 700.00	$ 900.00	$ -	$ -	$ -	$ -	$ -	$ -	**$ 6,159.51**
MS. PINES - Per diem			$ 1,100.00	$ 1,700.00	$ 1,600.00	$ 1,700.00							$ 6,100.00
Travel			$ 171.68	$ 373.44	$ 446.49								$ 991.61
	$ -	$ -	$ 1,271.68	$ 2,073.44	$ 2,046.49	$ 1,700.00	$ -	$ -	$ -	$ -	$ -	$ -	$ 7,091.61
MR. SERRANO SWELL- Per diem			$ 600.00	$ 600.00									$ 1,200.00
			$ 257.30	$ 774.36									$ 1,031.66
	$ -	$ -	$ 857.30	$ 1,374.36	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,231.66
MS. YAROSLAVSKY - Per diem						$ 1,200.00							$ 1,200.00
Travel	$ 688.35	$ 883.88	$ 454.51	$ 581.44									$ 2,608.18
	$ 688.35	$ 883.88	$ 454.51	$ 581.44	$ -	$ 1,200.00	$ -	$ -	$ -	$ -	$ -	$ -	**$ 3,808.18**

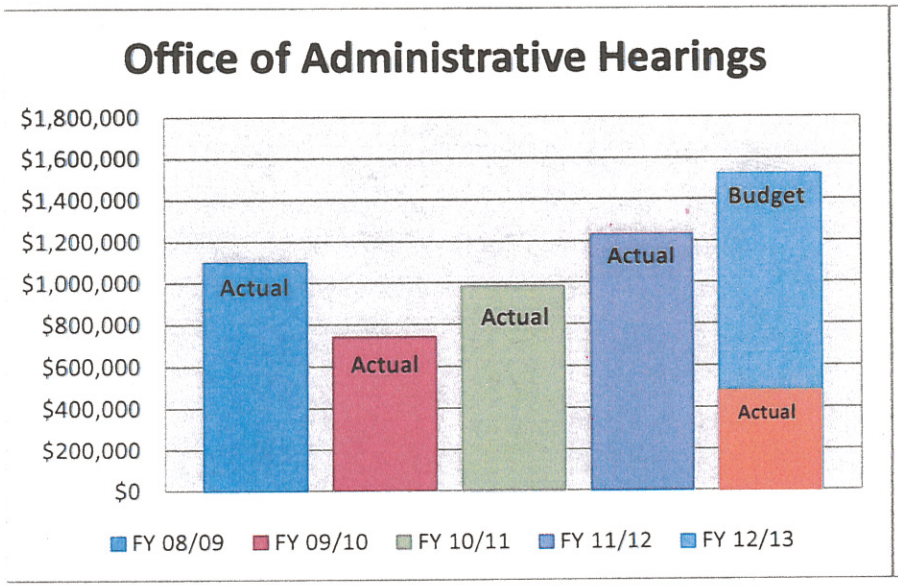
As of: 1/17/2013

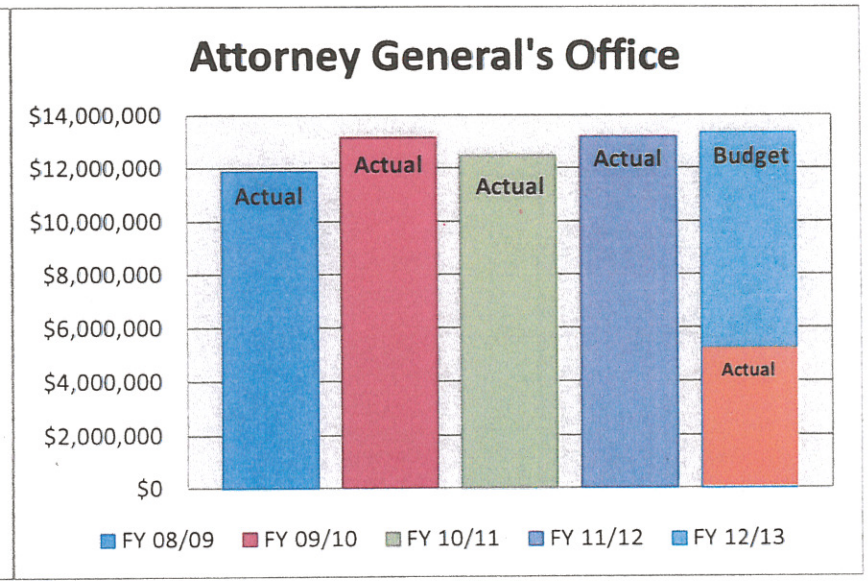
TOTAL PER DIEM	$30,600.00
TOTAL TRAVEL	$ 11,296.77
TOTAL	**$ 41,896.77**

Strategic Plan Objective 5.3
External Agencies' Spending









Project Overview

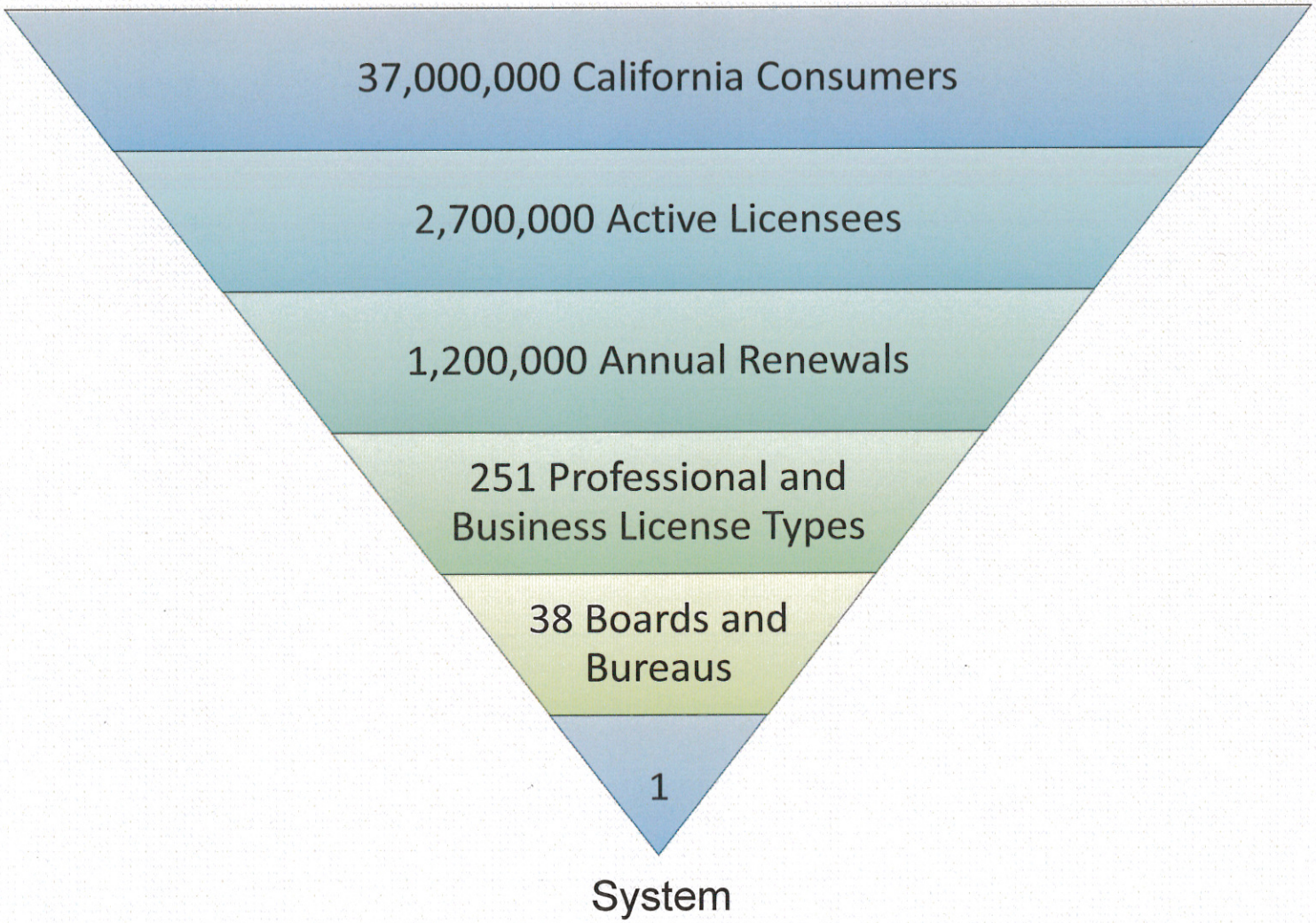
Medical Board of California

February 1, 2013

Background

- Approved in November 2009 to address legacy system deficiencies
- Integrated Licensing & Enforcement solution
- Completely replaces legacy licensing and enforcement systems (3 legacy & 90 workaround databases)
- Consolidates separate project efforts
  (CRIMS, iLicensing, etc.)

Project Landscape



Enforcement Improvements

- Automated complaint intake process
- Prioritization of enforcement cases
- Efficient allocation of enforcement resources
- System alerts to ensure timely case follow-up
- 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
- Alerts staff to ensure timely follow-up

Significant Activities

Completed

- Contract executed – September 22, 2011
- Configuration Interviews – Spring 2012
- Detailed System Design – June 2012
- Standardization Efforts – Summer 2012
- Vendor System Testing – November 2012
- User Acceptance Test preparation – November 2012

Significant Activities

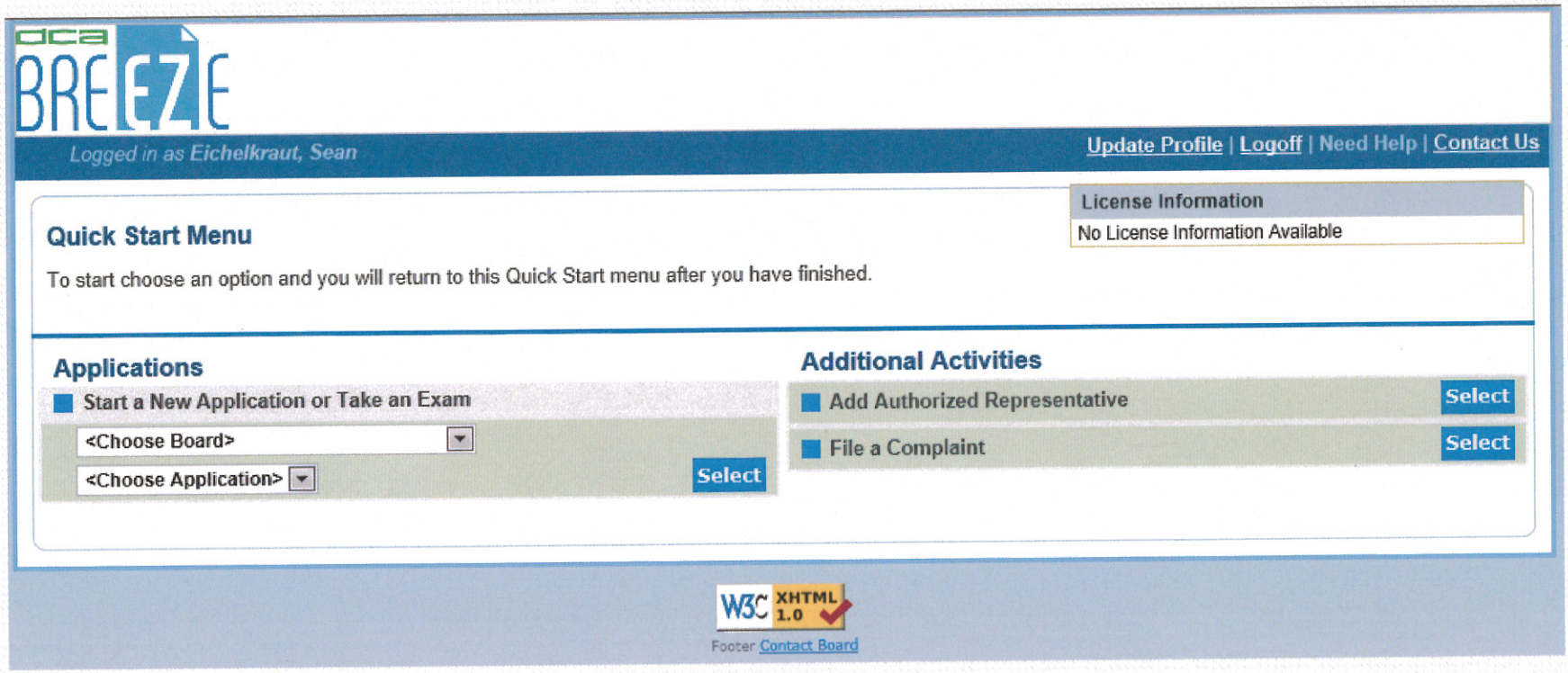
In Progress

- On-going Configuration Refinement
- User Acceptance Testing
- Data Conversion Validation & on-going clean-up
- Internal User Training
- Cutover Preparation

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	February 2013
Converted Data Accepted for Production Use	NA	July 2012	February 2013
Release 1 Go-Live	July 2012	September 2012	February 2013
Release 2 Go-Live	March 2013	TBD	Fall 2013
Release 3 Go-Live	September 2013	TBD	Winter 2014
Full System Acceptance	**October 2013**	**October 2013**	**Spring 2014**

External User Home Page



Introduction Page

dca BREEZE

Logged in as Eichelkraut, Sean

Update Profile | Logoff | Need Help | Contact Us

- Introduction
- Transaction Suitability Questions
- Name and Personal/Organization Details
- Contact Details
- Physician Survey
- Online L1A Personal Information
- Online L1A Examination Information
- L1A Examination Information
- Online L1B Medical Education
- 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

dca BREEZE

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Update Profile | Logoff | Need Help | Contact Us

- Introduction
- Transaction Suitability Questions
- Name and Personal/Organization Details
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- Physician Survey
- Online L1A Personal Information
- Online L1A Examination Information
- L1A Examination Information
- Online L1B Medical Education
- Online L1B Postgraduate Training
- PG Training Info
- Online L1C Postgraduate Training
- Online L1C Medical License Information
- Online L1C ABMS Certification
- Online L1D DEA Certification Part 1
- 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
#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

Physician Survey

Logged in as Eichelkraut, Sean

Update Profile | Logoff | Need Help | Contact Us

- Introduction
- Transaction Suitability Questions
- Name and Personal/Organization Details
- Contact Details
- Physician Survey
- Online L1A Personal Information
- Online L1A Examination Information
- L1A Examination Information
- Online L1B Medical Education
- 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

Logged in as Eichelkraut, Sean

Update Profile | Logoff | Need Help | Contact Us

- Introduction
- Transaction Suitability Questions
- Name and Personal/Organization Details
- Contact Details
- **Physician Survey**
- Online L1A Personal Information
- Online L1A Examination Information
- L1A Examination Information
- Online L1B Medical Education
- Online L1B Postgraduate Training
- PG Training Info
- Online L1C Postgraduate Training
- Online L1C Medical License Information
- Online L1C ABMS Certification
- Online L1D DEA Certification Part 1
- 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	
◉	☑	Aerospace Medicine
○	☐	Allergy and Immunology
○	☐	Anesthesiology
○	☐	Cardiology
○	☐	Colon and Rectal Surgery
○	☐	Complementary and Alternative Medicine
○	☐	Cosmetic Surgery
○	☐	Critical Care
○	☐	Dermatology
○	☐	Emergency Medicine
○	☐	Endocrinology
○	☐	Epilepsy
○	☐	Facial, Plastic and Reconstructive Surgery
○	☐	Family Medicine
○	☐	Gastroenterology
○	☐	General Practice
○	☐	General Surgery
○	☐	Geriatric Medicine
○	☐	Hematology
○	☐	Infectious Disease
○	☐	Internal Medicine
○	☐	Medical Genetics
○	☐	Neonatal-Perinatal Medicine
○	☐	Nephrology
○	☐	Neurodevelopmental Disabilities
○	☐	Neurological Surgery
○	☐	Neurology
○	☐	Neurology with Special Qualification in Child Neurology
○	☐	Nuclear Medicine
○	☐	Obstetrics and Gynecology
○	☐	Occupational Medicine
○	☐	Oncology
○	☐	Ophthamology
○	☐	Orthopedic Surgery
○	☐	Otolaryngology
○	☐	Pain Medicine
○	☐	Pathology
○	☐	Pediatrics
○	☐	Physical Medicine and Rehabilitation
○	☐	Plastic Surgery
○	☐	Psychiatry
○	☐	Psychosomatic Medicine
○	☐	Public Health and General Preventive Medicine
○	☐	Pulmonary
○	☐	Radiation Oncology
○	☐	Radiologic Physics
○	☐	Radiology
○	☐	Rheumatology
○	☐	Sleep Medicine
○	☐	Spine Surgery
○	☐	Sports Medicine
○	☐	Surgical Oncology
○	☐	Thoracic Surgery
○	☐	Urology
○	☐	Vascular Surgery
○	☐	Other ☐ Not Listed

Previous Next Cancel

L1A Exam Questions

dca BREEZE

Logged in as Eichelkraut, Sean

Update Profile | Logoff | Need Help | Contact Us

- Introduction
- Transaction Suitability Questions
- Name and Personal/Organization Details
- Contact Details
- Physician Survey
- Online L1A Personal Information
- **Online L1A Examination Information**
- L1A Examination Information
- Online L1B Medical Education
- Online L1B Postgraduate Training
- PG Training Info
- Online L1C Postgraduate

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 Details

Logged in as Eichelkraut, Sean

Update Profile | Logoff | Need Help | Contact Us

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 Applicatio

<Choose Board>

<Choose Application>

View Application Stat

Medical Board of Califor

Select

Select

Submission Date	06/27/2012
Application Name	PTAL Initial Application
Status	Open
Deficiencies	1. The birthdate is required for calculation of the license expiry date but has not been provided. 2. Insufficient money received 3. Missing Fingerprint Response 4. FBI Fingerprint Not Clear Status 5. DOJ Fingerprint Not Clear Status 6. This transaction deals with application / license modifiers and none has been specified. 7. SSN or FEIN is missing
Notes	

Done

On-line Complaints

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

Respondent Details

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:

Phone Number: **201 410 4588**

E-mail:

* City: **SACRAMENTO**

* State: **California**

Zip code: **95814**

Country: **United States**

County: **SACRAMENTO**

Phone Extension:

Previous Next Cancel

Enforcement Voting

CA.GOV CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

Logged in as Spy, Steve

Update Profile | Logoff | Need Help | Contact Us

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

CA.GOV CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

Logged in as ***Anderson, Anthony***

Update Profile | Logoff | Need Help | Contact Us

Voting Summary Screen

Text 1

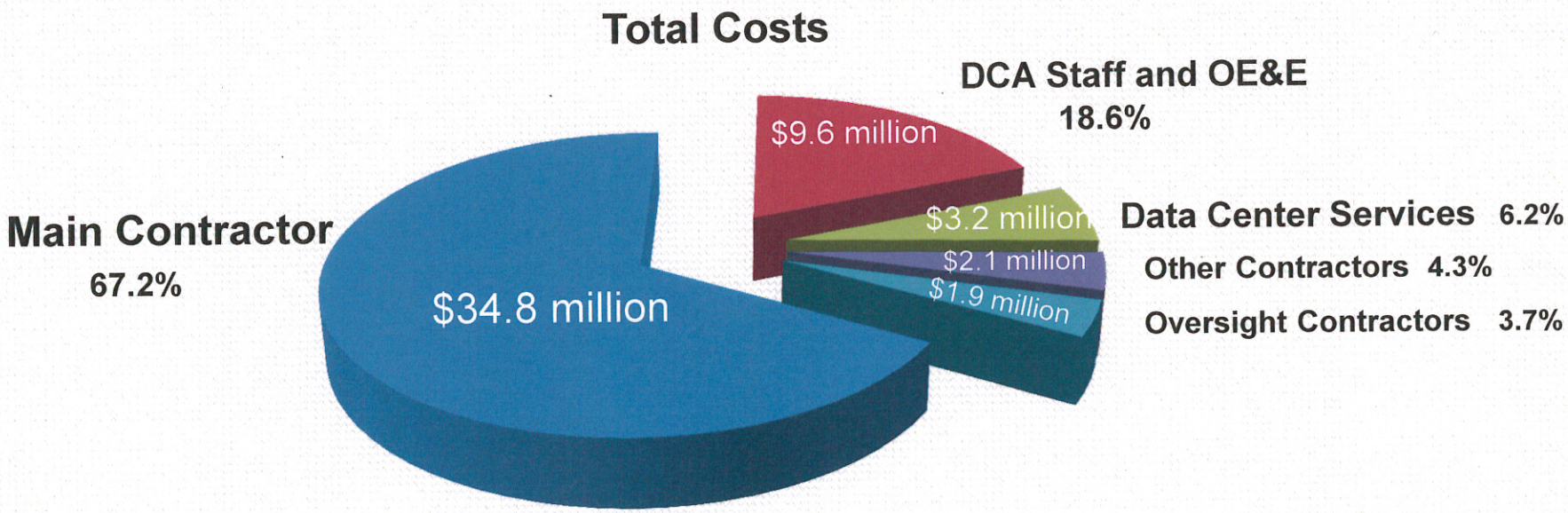
Case #	Respondent	Vote Date	Vote Result	Vote Notes	Actions	
20120001	HAGMAN, NICKLAS	02/02/2012	Accepted	Note Contents	Edit	Attach
20120003	THOMAS, KERRY	01/02/2012	Rejected	Notes Notes Notes	Edit	Attach
					Edit	Attach

Text 2

Return

Costs

Total One-Time Costs	$ 51.6 million
Costs Planned to date	$ 13.6 million
Actual Cost to date	$ 10.7 million



Avoiding Risk

BreEZe Deployed → Then 5-year payment begins

Performance-based Payment Model

Board Involvement

- License Configuration interviews to review processes
- Enforcement Configuration Interviews
- Workflow and Security Interviews
- Online System Configuration Interviews
- Conference Room Pilots
- Data Verification
- User Acceptance Testing

Organizational Change Management

- Change Coaches for each Board to discuss concerns/issues and provide assistance where needed
- Town Halls held with Board staff to discuss BreEZe impacts
- Change 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 – Early Spring 2013

- **Medical Board of California**
- Board of Registered Nursing
- Board of Barbering & Cosmetology
- Board of Behavioral Sciences
- Board of Psychology
- Physician Assistant Board
- Osteopathic Medical Board of California
- Board of Podiatric Medicine
- Respiratory Care Board
- Naturopathic Medicine Committee

dca BREEZE

Questions?

Thank you.

WORKLOAD REPORT
as of December 31, 2012

CONSUMER INFORMATION UNIT FY 12/13					
	FY 12/13	Q1	Q2	Q3	Q4
Total Calls Answered	**46,600**	26,022	20,578		
Calls Requesting Call Back	**5,366**	2,850	2,516		
Calls Abandoned	**5,238**	3,071	2,167		
Address Changes Completed	**3,419**	2,046	1,373		

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

PHYSICIAN & SURGEON DATA FY 12/13					
	FY 11/12	Q1	Q2	Q3	Q4
Applications Received	**3,437**	1,722	1,715		
Initial Reviews Completed	**3,347**	1,556	1,791		
Total Pending	**N/A**	3,907	4,244		
Reviewed	**N/A**	3,365	3,770		
Not Reviewed	**N/A**	542	474		
(SR2s Pending)	**N/A**	93	88		
Licenses Issued	**2,711**	1,447	1,264		
Renewals Issued	**31,112**	16,282	14,830		

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

SPECIALTY BOARD APPLICATIONS FY 12/13					
	FY 12/13	Q1	Q2	Q3	Q4
Applications Received	**0**	0	0		
Applications Pending	**N/A**	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

WORKLOAD REPORT
as of December 31, 2012

SR 2 - CATEGORIES FY 12/13					
	FY 12/13	Q1	Q2	Q3	Q4
Alcohol/Drugs	**14**	5	9		
PG/Medical Knowledge	**44**	25	19		
Convictions	**20**	15	5		
Other	**30**	11	19		

SR 2 - CATEGORIES FY 11/12					
	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

INTERNATIONAL MEDICAL SCHOOL APPLICATIONS FY 12/13					
	FY 12/13	Q1	Q2	Q3	Q4
Schools Pending Recognition at Beginning of Quarter	**N/A**	101	98		
Pending Self-Assessment Reports (included above)	**N/A**	7	9		
New Self-Assessment Reports Received	**2**	0	2		
New Unrecognized Schools Received	**51**	27	24		
School Recognized Pursuant to CCR 1314(a)(1)	**63**	30	33		
School Recognized Pursuant to CCR 1314(a)(2)	**0**	0	0		
TOTAL Schools Pending Recognition at End of Quarter	**N/A**	98	94		

INTERNATIONAL MEDICAL SCHOOL APPLICATIONS FY 11/12					
	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

RESEARCH PSYCHOANALYST FY 12/13					
	FY 12/13	Q1	Q2	Q3	Q4
RP Applications Received	**4**	4	0		
RP Licenses Issued	**3**	2	1		

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

WORKLOAD REPORT
as of December 31, 2012

LICENSED MIDWIVES FY 12/13					
	FY 12/13	Q1	Q2	Q3	Q4
Applications Received	**20**	8	12		
Applications Pending	**N/A**	5	6		
Licenses Issued	**17**	5	12		
Licenses Renewed	**63**	31	32		

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

FICTITIOUS NAME PERMITS FY 12/13					
	FY 12/13	Q1	Q2	Q3	Q4
P&S - FNP Received	**593**	363	230		
P&S - FNP Issued	**627**	284	343		
P&S - FNP Pending	**N/A**	55	116		
P&S - FNP Due Diligence	**645**	544	101		
Podiatric FNP Received	**10**	6	4		
Podiatric FNP Issued	**13**	6	7		
Podiatric FNP Pending	**N/A**	18	8		
Podiatric FNP Due Diligence	**22**	14	8		

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

WORKLOAD REPORT
as of December 31, 2012

OPTICAL REGISTRATIONS FY 12/13					
	FY 12/13	Q1	Q2	Q3	Q4
RDO - Business Registrations Issued	**9**	0	9		
RDO - Pending Applications Business	**N/A**	1	20		
CLS - Out-of-State - Business Registrations Issued	**0**	0	0		
CLS - Pending Out of State Applications -Business	**N/A**	1	1		
Spectacle Lens Registrations Issued	**98**	66	32		
Spectacle Lens - Pending Applications	**N/A**	59	24		
Contact Lens Registrations Issued	**47**	33	14		
Contact Lens - Pending Applications	**N/A**	20	7		
Spectacle Lens Registrations Renewed	**442**	230	212		
Contact Lens Registrations Renewed	**204**	94	110		

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

POLYSOM FY 12/13					
	FY 12/13	Q1	Q2	Q3	Q4
Polysomnographic Trainee Applications Received	**11**	2	9		
Polysomnographic Trainee Registrations Pending	**11**	2	9		
Polysomnographic Trainee Registrations Issued	**6**	0	6		
Polysomnographic Technician Applications Received	**88**	20	68		
Polysomnographic Technician Registrations Pending	**54**	21	33		
Polysomnographic Technician Registrations Issued	**25**	0	25		
Polysomnogrpahic Technologist Applications Received	**495**	168	327		
Polysomnogrpahic Technologist Applications Pending	**338**	208	130		
Polysomnogrpahic Technologist Registrations Issued	**197**	0	197		

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 December 31, 2012

SPECIAL PROGRAMS
FY 12/13

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	11	12			10	14			6	9			2	3			21	10			0	0		
2112	0	1			0	1			0	2			0	0			1	0			0	0		
2113	7	4			8	2			2	3			10	13			20	9			0	0		
2168	0	0			0	0			2	1			3	2			1	0			0	0		
2072	0	0			0	0			0	0			0	0			0	0			0	0		
1327	0	0			0	0			0	0			0	1			0	0			0	0		

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

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

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

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

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

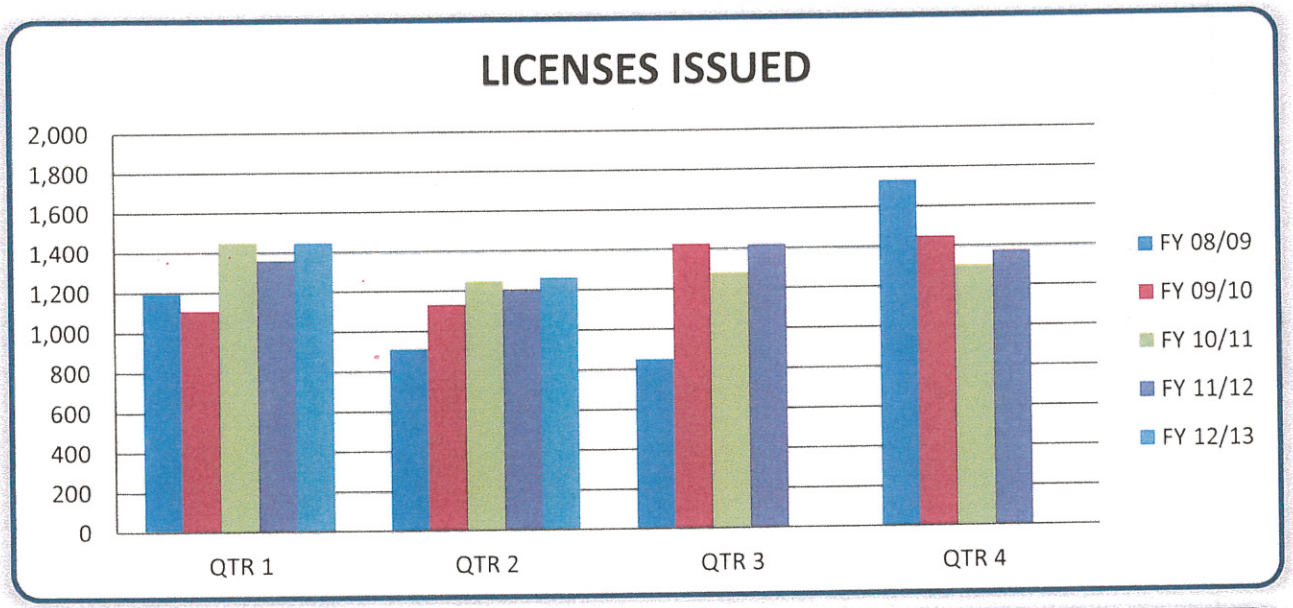
2072 - Special Permit - Correctional Facility

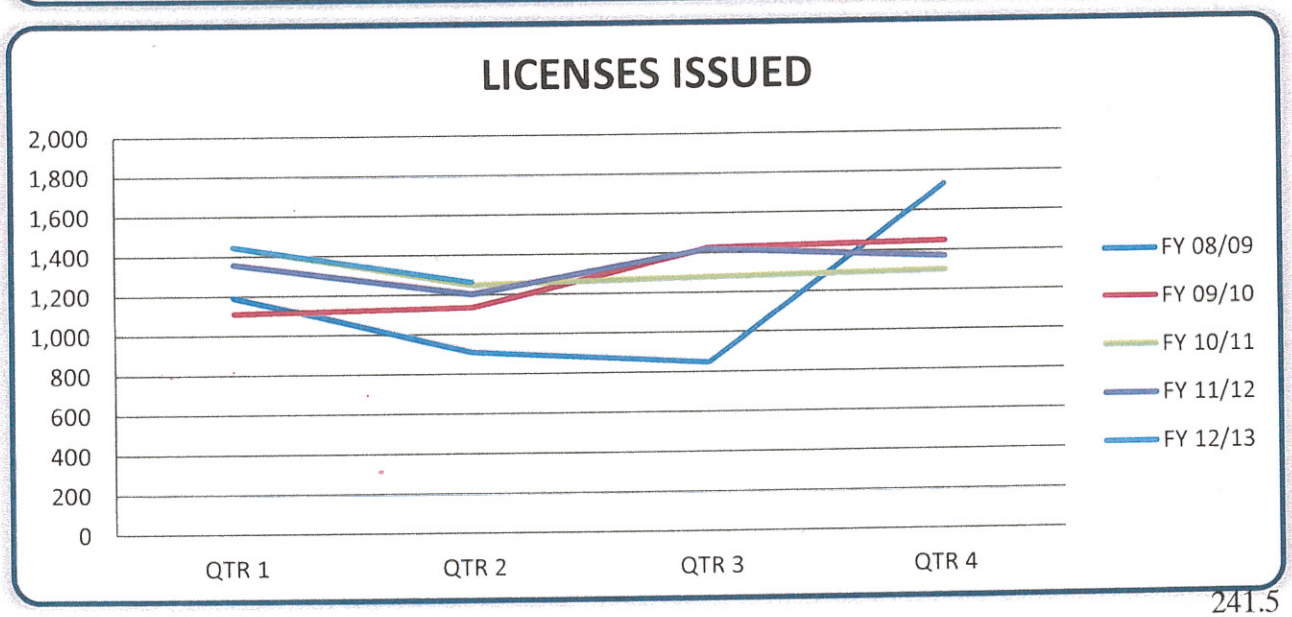
1327 - Medical Student Rotations - Non-ACGME Hospital Rotation

WORKLOAD REPORT
as of December 31, 2012

PHYSICIAN'S AND SURGEON'S LICENSES ISSUED
Five Fiscal Year History

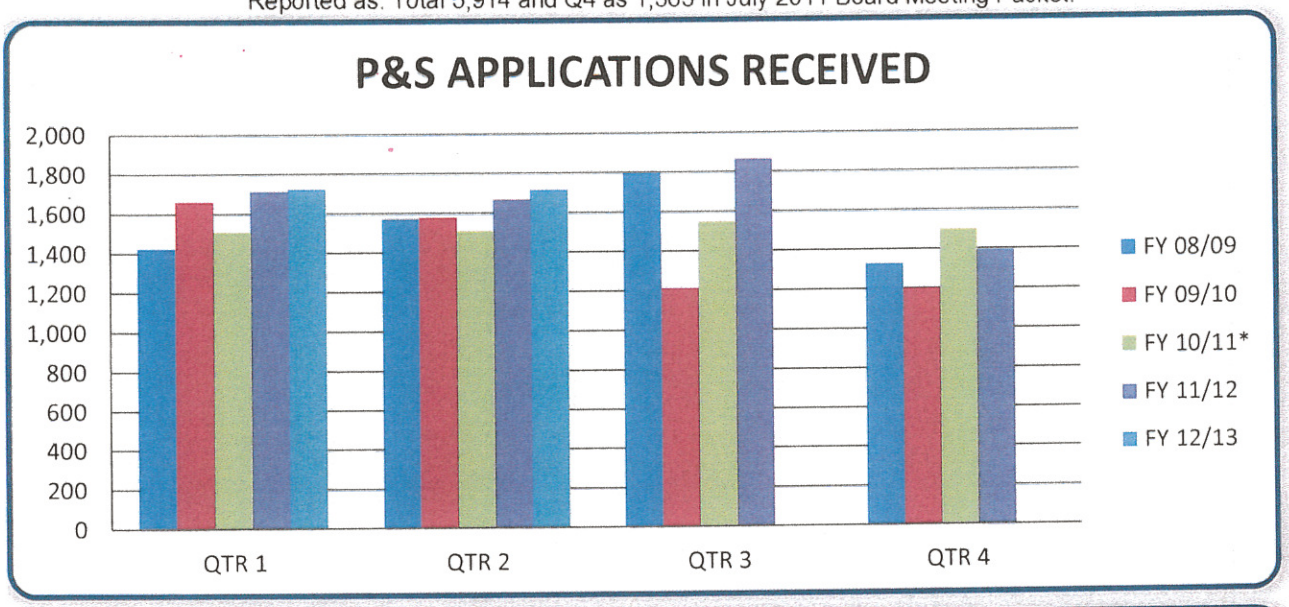
Fiscal Year	QTR 1	QTR 2	QTR 3	QTR 4	TOTAL
FY 12/13	1,447	1,264			***2,711***
FY 11/12	1,358	1,203	1,419	1,371	***5,351***
FY 10/11	1,447	1,248	1,277	1,300	***5,272***
FY 09/10	1,107	1,132	1,424	1,447	***5,110***
FY 08/09	1,192	912	849	1,735	***4,688***

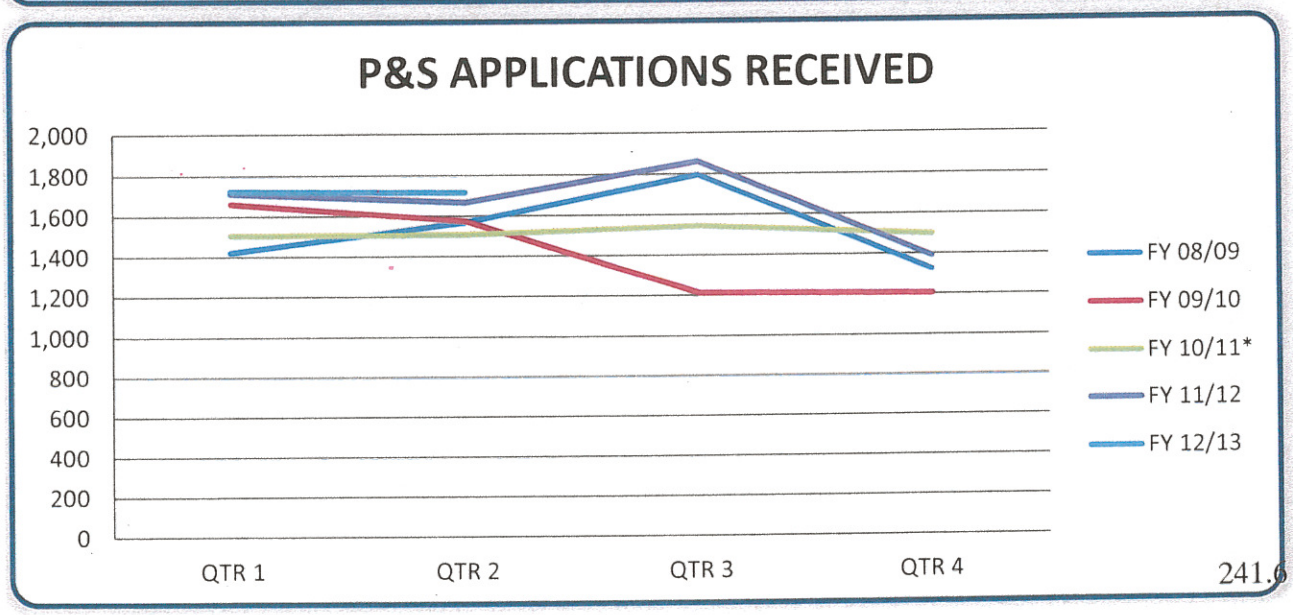




*PHYSICIAN'S AND SURGEON'S LICENSE AND PTAL APPLICATIONS RECEIVED Five Fiscal Year History					
Fiscal Year	QTR 1	QTR 2	QTR 3	QTR 4	TOTAL
FY 12/13	1,722	1,715			***3,437***
FY 11/12	1,711	1,666	1,862	1,390	***6,629***
FY 10/11*	1,503	1,505	1,543	1496	***6,047***
FY 09/10	1,658	1,573	1,211	1,203	***5,645***
FY 08/09	1,420	1,568	1,794	1,325	***6,107***

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





WORKLOAD REPORT
as of December 31, 2012

Fiscal Year - 2012/2013

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

	FY 12/13	Q1	Q2	Q3	Q4
Number of Weeks 45 Day Initial Review Goal Not Met	**0**	0	0		
Number of Weeks Per Quarter / Total Weeks	**26**	13	13		
Highest # of Days Initial Review Goal Exceeded	**N/A**	0	0		

Fiscal Year - 2011/2012

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

	FY 11/12	Q1	Q2	Q3	Q4
Number of Weeks 45 Day Initial Review Goal Not Met	**9**	1	6	2	0
Number of Weeks Per Quarter / Total Weeks	**52**	13	13	13	13
Highest # of Days Initial Review Goal Exceeded	**N/A**	3	7	5	0

Licensing Chief's Report

WORKLOAD REPORT
as of December 31, 2012

Agenda Item 24B
FISCAL YEAR 2012-2013

PHYSICIAN'S AND SURGEON'S APPLICATIONS RECEIVED AND LICENSES ISSUED

Fiscal Year - 2012/2013

2012 - 2013 -->	Applications Received (License & PTAL)					Percentage				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
US/CAN	975	1,165			2,140	56.62%	67.93%			62.26%
IMG - License	269	270			539	15.62%	15.74%			15.68%
IMG - PTAL	478	280			758	27.76%	16.33%			22.05%
TOTAL	1,722	1,715	0	0	3,437	100.00%	100.00%	0.00%	0.00%	100.00%

2012 - 2013 -->	Licenses & PTAL Issued					Percentage				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
US/CAN	1,037	953			1,990	71.67%	75.40%			73.40%
IMG - License	239	198			437	16.52%	15.66%			16.12%
PTAL - License	171	113			284	11.82%	8.94%			10.48%
TOTAL	1,447	1,264	0	0	2,711	100.00%	100.00%			100.00%
Total PTAL Issued	427	326			753					

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					

REQUESTS FOR NEW SCHOOL CODES
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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	Queensland University (QU) - Australia U.S. Branch Campus	10/29/2010			Pending			1/17/2012	X	Staff completed initial review of Self-Assessment Report. Report delivered to medical consultant on 10/31/12 for review.
Austria	Medical University of Austria (Medizinische Universitat Wien)	10/29/2012	10/29/2012	11/20/2012	Recognized	X	11/27/2012			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Bahrain	Royal College of Surgeons in Ireland - Medical University of Bahrain	10/12/2012	10/12/2012	10/24/2012	Recognized	X	11/13/2012			Chief/Legal Counsel 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	11/27/2012	Recognized	X	11/30/2012			Chief/Legal Counsel verified medical school is eligible 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 6/19/12.
Bangladesh	University of Dhaka, Zainul Haque Sikder Women's Medical College & Hospital	7/13/2010	3/12/2012	10/8/2012	Recognized	X	10/19/2012			Chief/Legal Counsel verified medical school is eligible 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	Faculdade de Ciencias Medicas de Minas Gerais (FCMMG)	8/21/2012	8/27/2012		Pending	?			?	Letter sent on 8/27/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Brazil	Faculdade de Medicina de Itajuba (FMIT)	7/1/2011	9/21/2011 1/13/2012		Pending	?			?	Staff requested additional information from FMIT to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Brazil	Universidade Estacio de Sa (UNESA) Faculdade de Medicina	2/1/2012	3/27/2012 11/6/2012	10/29/2012 11/26/2012	Pending				X	School informed on 12/14/12 they will need to submit Self-Assessment Report since the school is a private, for profit university.
Brazil	Universidade Sao Francisco (USF) Faculdade de Ciencias Medicas	12/1/2011	4/13/2012		Pending	?			?	Letter sent on 4/13/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Bulgaria	Medical University Prof. Dr. Paraskev Stoyanov Varna	6/10/2011	3/22/2012		Pending	?			?	Letter sent on 3/22/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).

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
Chile	Universidad Mayor	12/18/2012			Pending	?			?	Staff needs to send a letter to the school requesting information to determine if the school is eligible for recognition.
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	HuBei University of Medicine	6/29/2012	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).
China	Jilin University, Norman Bethune College of Medicine	7/19/2012	7/25/2012		Pending	?			?	Letter sent on 7/25/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
China	Nanjing University of Chinese Medicine	10/8/2012	10/12/2012	11/18/2012	Recognized	X	11/27/2012			Chief/Legal Counsel verified medical school is eligible 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	Shanxi Medical University	11/27/2012			Pending	?			?	Staff needs to send a letter to the school requesting information to determine if the school is eligible for recognition.
China	Shanxi Medical University	11/27/2012			Pending	?			?	Staff needs to send a letter to the school requesting information to determine if the school is eligible for recognition.
China	West China School of Medicine, Sichuan University	8/31/2012	9/10/2012 10/10/2012		Recognized	X	10/19/2012			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
China	Wuhan University School of Medicine (formerly Hubei Medical University)	7/6/2011	7/18/2012	11/21/2012	Recognized	X	11/27/2012			Chief/Legal Counsel 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	?			?	Letter sent on 4/9/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Colombia	Universidad de los Andes Facultad de Medicina		7/25/2012	8/23/2012	Recognized	X	10/4/2012			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Czech Republic	Charles University 2nd Faculty of Medicine	12/17/2012			Pending			12/17/2012	X	Staff needs to review Self-Assessment Report

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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
Dominican Republic	Pontificia Universidad Catolica Madre y Maestra Facultad de Ciencias de la Salud	8/1/2012	8/1/2012		Pending	?			?	Letter sent on 8/1/12 to the medical school requesting information to determine eligibility 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 3/12/2012 based on medical consultant's review of self-assessment report.
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	X	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).
El Salvadore	Universidad Evengelica de El Salvadore, Faculty of Medicine	6/6/2012	6/19/2012 10/3/12	9/6/2012 11/15/2012	Recognized	X	11/27/2012			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
France	Université de Paul Sabatier, UFR des Sciences Médicales de Purpan	7/23/2012	7/25/2012	12/13/2012	Recognized	X	1/10/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Georgia	Tbilisi Medical Institute 'Vita'	6/22/2011	4/11/2012 10/10/2012	9/10/2012 11/15/2012	Pending				X	School informed on 11/15/12 they will need to submit Self-Assessment Report since the school is a private, for profit university.
Germany	Universität Duisburg-Essen Medizinische Fakultät (University of Duisburg-Essen Faculty of Medicine)	10/31/2012	11/8/2012		Pending	?			?	Letter sent on 11/8/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1)
Germany	Univeritaet Leipzig Faculty of Medicine	9/6/2012	9/12/2012		Pending	?			?	Letter sent on 9/12/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Ghana	Kwame Nkrumah University of Science & Technololgy	11/5/2012	11/8/2012		Pending	?			?	Letter sent on 11/8/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Ghana	University for Development Studies School of Medicine and Health Sciences	7/1/2012	7/18/2012	10/11/2012	Recognized	X	10/19/2012			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Haiti	Université Notre Dame d'Haiti Faculté de Médicine	9/06/2012	9/12/2012 10/10/2012	10/2/2012	Pending	?			?	Initial review completed by staff. Unofficial response received from school - Requested school to resubmit formal response on 10/10/12.
India	Gujarat University, Kerasal Medical College & Research Institute	10/11/2012	11/8/2012		Pending	?			?	Letter sent on 11/8/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).

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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	Himachal Pradesh University, Indira Gandhi Medical College, Shimla	9/26/2012	10/12/2012		Recognized	X	10/30/2012			Chief/Legal Counsel 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 Tamil Nadu Dr. MGR Medical University, Madurai Medical College	4/12/2012	4/13/2012	9/13/2012	Recognized	X	10/4/2012			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
India	Maharashtra University of Health Sciences, Armed Foces Medical College	9/7/2012	9/10/2012	10/23/2012	Recognized	X	10/30/2012			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
India	Maharashtra University of Health Sciences, Dr. Vaishampayan Memorial Government Medical College	10/9/2012	10/10/2012	10/22/2012	Recognized	X	10/30/2012			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
India	Maharashtra University of Health Sciences, JMF's A.C.P.M. Medical College	8/28/2012	9/12/2012		Pending	?			?	Letter sent on 9/12/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Maharashtra University of Health Sciences, Rajarshi Chhatrapati Shau Maharaj Government Medical College Kolhapur	8/9/2012	8/9/2012		Pending	?			?	Letter sent on 8/9/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Maharashtra University of Health Sciences, Shri Bhausahab Hire Government Medical College	5/1/2012	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	Mahatma Gandhi University, Malankara Orthodox Syrian Church Medical College	2/24/2011	3/16/2012		Pending	?			?	Letter sent on 3/16/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	NTR University of Health Sciences, Alluri Sitarama Raju Academy of Medical Sciences	8/13/2012	8/27/2012	10/15/2012	Recognized	X	10/19/2012			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
India	NTR University of Health Sciences, Prathima Institute of Medical Sciences	7/26/2012	8/2/2012	8/28/2012	Recognized	X	10/4/2012			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
India	NTR University of Health Sciences, Rangaraya Medical College, Kakinada	11/5/2012	11/8/2012		Pending	?			?	Letter sent on 11/8/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Pondicherry University, Vinayaka Mission's Medical College Vinayaka Mission's University, Vinayaka Mission's Medical College	8/31/2011	4/11/2012	9/24/2012	Recognized	X	10/4/2012			Chief/Legal Counsel 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	Rajasthan University of Health Sciences, Mahatma Gandhi Medical College and Hospital, Jaipur / Mahatma Gandhi University of Medical Sciences & Technology, Mahatma Gandhi Medical College & Hospital	3/16/2012	3/19/2012	10/5/2012	Recognized	X	10/19/2012			Chief/Legal Counsel verified medical school is eligible 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 / Father Muller Medical College	6/17/2011	3/13/2012 6/4/2012 8/8/2012	11/19/2012	Recognized	X	1/10/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
India	Rani Durgavati Vishwavidyalaya University (formerly Jabalpur University), Netaji Chandra Bose Medical College	11/26/2012	11/27/2012		Pending	?			?	Letter sent on 11/27/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Shivaji University, Dr. D. Y. Patil Education Society's Medical College / D.Y. Patil Deemed University, D. Y. Patil Medical College / Maharashtra University of Health Sciences, Nashik, D.Y. Patil Medical College	9/8/2011	3/9/2012 resent 7/26/2012 9/7/2012	8/24/2012	Recognized	X	10/4/2012			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
India	Tamil Nadu Dr. M.G.R. Medical University, K.A.P. Vishwanathan Government Medical College	6/2/2011	3/15/2012		Pending	?			?	Letter sent on 3/15/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Tamil Nadu Dr. M.G.R. University, Stanley Medical College	8/28/2012	9/12/2012		Pending	?			?	Letter sent on 9/12/12 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	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	Islamic Azad University, Ardabil Branch Faculty of Medicine	8/20/2012	8/27/2012		Pending	?			?	Letter sent on 8/27/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Iran	Khorasan University of Medical Sciences (Mashhad University of Medical Sciences)	11/27/2012			Pending	?			?	Staff needs to send a letter to the school requesting information to determine if the school is eligible for recognition.

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REQUESTS FOR NEW SCHOOL CODES
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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
Iran	Tabriz University of Medical Sciences Faculty of Medicine	6/4/2012	6/19/2012	10/11/2012	Recognized	X	10/19/2012			Chief/Legal Counsel verified medical school is eligible 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).
Ireland	University of Dublin, Trinity College Dublin School of Medicine	9/17/2012	10/12/2012		Pending	?			?	Letter sent on 10/12/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Italy	Universita degli Studi Insubria Varese-Como Facolta di Medicina e Chirurgia	11/21/2012	11/27/2012		Pending	?			?	Letter sent on 11/27/12 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	Kansai Medical University	6/23/2010	3/22/2012 9/7/2012	8/23/2012	Pending	?			?	Initial review completed by staff. Additional information requested from school on 9/7/12 and 1/17/13.
Japan	Kawasaki Medical School	8/9/2012	8/9/2012		Pending	?			?	Letter sent on 8/9/12 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 7/13/2012	7/6/2012	Pending	?			?	Additional information requested from school on 7/13/12.
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 7/12/2012	6/28/2012	Pending	?			?	Formal response requested from school on 7/12/12.
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).

REQUESTS FOR NEW SCHOOL CODES
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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	Manipal University, Melaka-Manipal Medical College	6/10/2011	4/11/2012		Pending	?			?	Letter sent on 4/11/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Mauritius	University of Mauritius, SSR Medical College	11/9/2011	4/11/2012 6/28/2012 8/9/2012	6/26/2012 8/6/2012	Recognized	X	10/4/2012			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Mexico	Benemerita Universidad Autonoma de Puebla Escuela de Medicina	10/1/2012	10/11/2012	12/12/12	Pending	?			?	School's attorney has indicated that they are not able to release the requested information.
Morocco	Université Sidi Mohammed Ben Abdellah Fez, Faculty of Medicine and Pharmacy	9/10/2012	9/12/2012		Pending	?			?	Letter sent on 9/12/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Nepal	Universal College of Medical Sciences, Paklihawa Campus	7/15/2011	10/29/2012		Pending			7/15/2011	X	Staff completed initial review of Self-Assessment Report. Additional information requested from school on 10/29/2012.
Neves	Medical University of the Americas	3/19/2012			Pending			3/19/2012	X	Staff needs to review Self-Assessment Report
Nigeria	Ambrose Alli University College of Medicine	8/28/2012	8/28/2012		Pending	?			?	Letter sent on 8/28/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Pakistan	Baqai Medical University, Baqai Medical College	6/15/2011	3/30/2012 10/4/2012	9/25/2012 10/10/2012	Recognized	X	10/19/2012			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Pakistan	Foundation University Medical College	5/29/2012			Pending	?		5/29/2012	?	Legal Counsel will request additional information from school to determine if it can be categorized as a CCR 1314.1(a)(1) school.
Pakistan	Peoples University of Medical and Health Sciences for Women	10/24/2012	11/8/2012		Pending	?			?	Letter sent on 11/8/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Pakistan	University of Health Sciences, Lahore, F.M.H. College of Medicine and Dentistry	7/19/2012	7/25/2012 9/7/2012	8/27/2012	Recognized	X	10/4/2012			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Pakistan	University of Health Sciences Lahore, Nishtar Medical College and Hospital (NMCH)	9/1/2010	5/17/2011 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	11/15/2012	Recognized	X	11/15/2012			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).

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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	University of the Punjab, Fatima Jinnah Medical College for Women	6/26/2012	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).
Peru	Universidad Nacional Mayor de San Marcos Facultad de Medicina	7/26/2012	8/2/2012		Pending	?			?	Letter sent on 8/2/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Peru	Universidad Peruana Cayetano Heredia Facultad de Medicina Alberto Hurtado	11/15/2012	11/27/2012		Pending	?			?	Letter sent on 11/27/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Peru	Universidad Ricardo Palma Facultad de Medicina Humana	9/4/2012	9/12/2012	10/01/2012 10/12/2012	Recognized	X	10/19/2012			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Philippines	Silliman University Medical School	11/28/2012			Pending			11/28/2012	X	Staff needs to review Self-Assessment Report
Poland	Medical University of Warsaw English Language Program	11/14/2010	6/30/2010 3/12/2012	11/18/2010 7/26/2012	Pending			11/14/2010	X	Review complete. Board will hear consultant's report and vote on recognition at Jan/Feb 2013 Quarterly Board Meeting
Poland	WroclawMedical University Faculty of Medicine	6/21/2012	6/26/2012	9/17/2012	Recognized	X	10/4/2012			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Russia	Far Eastern State Medical University (Previously known at Khabarovsk State Medical Insitute)	10/15/2012	11/8/2012		Pending	?			?	Letter sent on 11/8/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Russia	North-Western State Medical University I.I. Mechnikov / Saint-Petersburg Medical Academy of Postgraduate Studies	7/25/2012	7/25/2012		Recognized	X	10/30/2012			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Russia	Ural State Medical Academy / Sverdlovsk State Medical Institute	10/2/2012	10/12/2012		Pending	?			?	Letter sent on 10/12/12 to the medical school requesting information to determine eligibility 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).
Russia	Yaroslavl State Medical Academy	5/10/2011	4/11/2012	11/27/2012	Recognized	X	11/27/2012			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Saudi Arabia	University of Dammam College of Medicine	12/14/2012			Pending	?			?	Staff needs to send a letter to the school requesting information to determine if the school is eligible for recognition.
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).

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
Serbia	University of Nis Faculty of Medicine	11/26/2012	11/27/2012		Pending	?			?	Letter sent on 11/27/12 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		Recognized	X	11/21/2012			Chief/Legal Counsel 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 8/9/2012 10/10/2012	7/31/2012 10/30/2012	Recognized	X	11/8/2012			Chief/Legal Counsel 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.
Spain	Universidad Miguel Hernández Facultad de Medicina	9/12/2012	9/12/2012 Resent on 12/7/2012		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).
Sudan	International University of Africa Faculty of Medicine & Health Sciences	11/19/2012	11/27/2012		Pending	?			?	Letter sent on11/27/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Syria	Al-Baath University Faculty of Medicine	3/10/2011	4/12/2012		Pending	?			?	Letter sent on 4/12/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Turkey	Gulhane Askeri 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).
Ukraine	Crimean State Medical University named after S.I. Georgievsky	11/8/2012	11/8/2012		Pending	?			?	Letter sent on 11/8/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Ukraine	Lugansk State Medical University	8/6/2012	8/7/2012	12/27/2012	Pending	?			?	Letter sent on 8/7/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Ukraine	M. Gorky Donetsk National Medical University	7/8/2011	4/9/2012		Pending	?			?	Letter sent on 4/9/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).

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	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).
United Kingdom	University of London, University College London School of Medicine	10/1/2012	10/10/2012	11/13/2012	Recognized	X	1/10/2013			Chief/Legal Counsel verified medical school is eligible 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 Luis Razetti	3/22/2012	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).
Zimbabwe	University of Zimbabwe College of Health Sciences, Godfrey Huggins School of Medicine	8/28/2012	8/28/2012		Pending	?			?	Letter sent on 8/28/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	January 22, 2013
ATTENTION:	Medical Board of California
SUBJECT:	Recognition of Medical University of Warsaw– English Language Program
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing

RECOMMENDED ACTION:

The Medical Board of California (Board) should recognize the medical education from the Medical University of Warsaw's English Language Program as substantially compliant with requirements of sections 2089 and 2089.5 of the Business and Professions Code and section 1314.1 of title 16 of the California Code of Regulations. This recognition would be retroactive to the start of the English Language Program in 1993, and recognition would be granted without a site visit of the medical school.

BACKGROUND AND ANALYSIS:

The Board already recognizes the Medical University of Warsaw (MUW) pursuant to Section 1314.1 (a)(1) of Title 16, California Code of Regulations. MUW is a well established medical school in Poland with the primary mission of training citizens of Poland to practice medicine in Poland. MUW has an overall 200 hundred year history of providing medical school education. In 1949 after World War II the medical school was reopened as the Medical Academy of Warsaw and is now known as the Medical University of Warsaw. In 1993, MUW started an English language program at its Second Faculty of Medicine. It is designed for students that speak English with the goal of these graduates practicing medicine in European countries. MUW then added students from the U.S., Canada and students from other countries who are fluent in English. MUW's English language program meets the criteria for the Board's review pursuant to Section 1314.1 (a)(2) of Title 16, California Code of Regulations.

In April 2010, MUW officials submitted a Self Assessment Report to commence the Board's review process of their medical school. After staff's initial review of the Self-Assessment Report, the Board requested Licensing Medical Consultant Joseph Silva, M.D., M.S.C.P., review the school's application. Staff and Dr. Silva requested additional information from MUW, and the medical school officials provided the requested information. The additional information was then reviewed by Dr. Silva.

Staff requests that Board members review Dr. Silva's report and determine whether to recognize the medical education provided to students by MUW's English language program. Dr. Silva recommends that recognition be granted, that it be retroactive, and that no site visit be required.

Alternatively, if the Board requires further information regarding the school's educational resources before a decision is reached; staff will request MUW officials to submit the information for review during a future meeting. If the Board determines site inspections are necessary prior to making a determination, staff will prepare the necessary documents.

FISCAL CONSIDERATIONS:

In accordance with Business and Professions Code Section 2089.5, the costs of conducting a site inspection are borne by the medical school applying for the Board's recognition. These costs include all team members' air and ground travel costs within the guidelines allowed by the State, the consultant's daily per diem expense, and the consultant's travel expenses to and from any Board meetings where the team presents its report. Subsection (e) of Section 1314.1 of the regulations requires the medical school to reimburse the Board for the team's estimated travel expenses in advance of the site visit.

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

September 17, 2012

To: Curt Worden
Chief of Licensing
Medical Board of California

From: Joseph Silva, MD, MACP
Medical Consultant

Subject: Evaluation of Medical University of Warsaw (MUW) English Language Program/ Self-Assessment Report; Application for Recognition in California

BACKGROUND

The Medical Board of California (Board) requested a review of the materials provided by Medical University of Warsaw's English Language Program (MUW-ELP), located in Warsaw, Poland, to determine if MUW-ELP complies with Business and Professions Code Sections 2089 and 2089.5 and Title 16, Section 1314.1 of the California Code of Regulations. The following is my critique of the information I was provided including:

1. MUW-ELP Self-Assessment Report (SAR) and supporting documentation.
2. MUW-ELP 's responses to the Board's requests for additional information.

MISSION AND OBJECTIVES

MUW-ELP initially indicated that it did not have any official system or rules that would allow it to track the progress of its English program graduates in obtaining residency training outside Poland, but noted that it was in the process of preparing a specific regulation that will allow it to collect this data in the future. Beginning in the 2012/2013 academic year, MUW-ELP will introduce a survey for its English program graduates to evaluate their vocational preparation and career paths, similar to the questionnaire used to gather information from graduates of the Polish language program since 2010. MUW-ELP provided a draft of the survey.

The Board requested a description of any other evaluative tools that are used to determine if the school's missions are being achieved. MUW-ELP provided information on their Student Survey tool, peer review visits, student progress evaluation and review, and other quality and internal audits that the school employs. In addition, MUW-ELP provided documentation of the last two Accreditation Reviews of MUW by Polish authorities: Polish Accreditation Committee (conducted on 3/22-23/2011) and Accreditation Committee for Polish University Medical Schools (conducted on 3/20-21/2012). In table 5 of the Polish Accreditation Committee's 2011 review (page 31 of "IX Summary of Compliance"), nine areas were rated as "full compliance" (structure of Graduate qualification, study programs and curricula, academic staff, learning outcomes, scientific research, student affairs, legal

culture of the University and the unit, public relations). One area was substantial (teaching facilities) and one area was partial (internal Quality Assurance Program). The substantial rating could be improved if MUW develops a University teaching hospital. The Accreditation Committee for Polish University Medical School's 2012 review further amplifies teaching successes and failures. It is interesting to note on page 38 of this report that 49 students failed examines in the prior year and 493 passed.

MUW-ELP indicated that they are revising their QM system based on "Standards and Quality Guidelines for Quality Assurance in European Higher Education Area."

Warsaw teaching hospitals are all certified via ISO 9001 standards.

MUW-ELP noted that the achievement of their mission and objectives is confirmed by MUW's high position in Polish higher education institution rankings (2nd position in the field of medical studies with the highest maximum score in the area of employers' preferences) in a magazine similar to US News and Report.

In the initial SAR, MUW-ELP indicated that rules were being prepared to allow MUW-ELP to obtain information about USMLE results from their graduates. As of June 2011, MUW-ELP now has information on the USMLE results of its students and graduates for all three steps.

Conclusion: Overall MUW has satisfactorily addressed the Board's questions with regard to its missions and objectives and its tracking of student performance.

FACILITIES

In response to the Board's request for the names of the hospitals and their locations where students in the English language program have been approved to complete clinical rotations outside of Poland, MUW listed over 70 hospitals used for clinical training. The Board asked for additional information to assure that each site complies with B&P Section 2089.5, including affiliation agreements between MUW and each clinical training location. The 70 hospitals listed do not have formal training affiliates with MUW. These are used only for limited rotations at hospitals outside the MUW sphere. These rotations are screened for credit once a student completes a rotation. Quality and grade determined is made by an administrative officer at MUW. Each student's curriculum is considered individually and credit given only after a review. MUW points out that in academic year 2008/2009 – there were no such clinical rotations. Subsequent rotations have been primarily at the Loyola Health System which is recognized as a valid medical school in the US which provides first rate training.

Conclusion: Explanations offered for Facilities leads me to conclude they comply with our standards for training at clinical facilities.

CLINICAL OVERSIGHT

Subsection (b)(4) of Section 1314.1 now requires the institution to have a system of central oversight to assure that the faculty define the types of patients and clinical conditions that the students must encounter, the appropriate clinical setting for the educational experiences, and the expected level of student responsibility. Further, the system shall ensure that the faculty monitor and verify student experience and modify it as necessary to ensure that the objectives of the clinical education program will be met.

MUW indicated that the medical faculty and staff are responsible for the preparation of students to their contact with patients. The Board requested clarification of how student experiences are verified. In response, MUW stated that each Unit of Warsaw verifies student's experiences and, if needed, modifies student's progress through a variety of ways: by exams conducted during and at the end of each course to evaluate the knowledge, skills and competences of students; via Pedagogical Committee meetings held at least twice a year to review assessment criteria and rules, student results, grades, absenteeism, completions rates, etc.; and by other QM bodies (Program Board, Faculty Council, Office for Didactics and Learning Outcomes, etc).

Conclusion: Data submitted by MUW pertinent to this section is that faculty and staff have duties commensurate with insuring compliance with this requirement.

ADMISSION AND PROMOTION STANDARDS

Subsection (b)(8) of Section 1314.1 now requires the institution to document that its admitted students generally meet entrance requirements equivalent to those utilized by U.S. and Canadian medical schools, including an appropriate background check of all applicants admitted to the institution. MUW has indicated that in Poland, institutions of higher education are not permitted by law to inquire prospective students about their criminal convictions or history of disciplinary problems. It is my understanding that the Medical University of Silesia conducts background checks and may be able to provide information on this practice. MUW appears willing to confirm background checks but may need guidance.

EVALUATION OF PROGRAM EFFECTIVENESS

Subsection (b)(14) of Section 1314.1 now requires that an institution collect and use a variety of outcome data to demonstrate the extent to which it is meeting its educational program objectives. The Board requested information on what outcome data the school collects to assess whether students in the English program are meeting the school's educational program objectives and how the school uses that outcome data. As previously noted, MUW undergoes regular evaluation of their instruction, faculty, instructional methods, facilities, etc. by Polish authorities. MUW

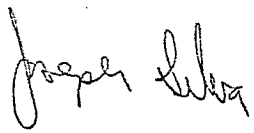
provided the Board with both the Polish Accreditation Committee Report (March 2011) and the Accreditation Committee for Polish University Medical Schools Report (March 2012).

Additional responses from MUW indicate they are currently analyzing an appropriate "materials base for providing instruction" (see Attachments 5 and 6). These current evaluations place them on compliance with CA law as to training. The medical school also highlights that they are developing new formal procedures for curriculum design, review, evaluation and improvement. This is a trend occurring world-wide in many medical schools.

CONCLUSION

In conclusion, I believe MUW is in compliance with our new and existing regulations and questions framed. The criminal check background is the only area not imposed. I recommend action for approval by the California Medical Board with a discussion of criminal checks (which could be left to subsequent hiring agencies, primarily hospitals in the US or other countries).

Sincerely,



Joseph Silva, MD, MACP

Professor of Internal Medicine, UC Davis

Dean Emeritus

University of California, Davis

Davis, CA 95616

Medical Board of California – Licensing Consultant

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	January 16, 2013
ATTENTION:	Board Members
SUBJECT:	Midwifery Advisory Council Update
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing

RECOMMENDED ACTION:

Based upon the Midwifery Advisory Council's request, the Board should consider amending Business and Professions Code (B&P) section 2516 to use the Midwives Alliance of North America prospective data collection and amending B&P section 2514 to allow a Certified Nurse-Midwife (CNM) to supervise a midwifery student.

BACKGROUND AND ANALYSIS:

The Midwifery Advisory Council (MAC) meeting was held on December 6, 2012, in Sacramento.

The MAC was updated with the Board's decision to proceed with legislative changes in the Sunset Review Report regarding the physician supervision requirement and the use of drugs and devices as allowed in the practice of midwifery, instead of proceeding with the proposed regulatory amendments to the California Code of Regulations, Title 16, Division 13, Sections 1379.23 and 1379.24. MAC was advised the Board made this decision to proceed with legislative changes as the proposed regulatory amendments did not adequately address the needs of the licensed midwives and physicians and surgeons, nor did it adequately address consumer protection.

MAC reviewed the proposal to change the current retrospective method of collecting data for the required annual reporting of licensed midwifery statistics to the Office of Statewide Health Planning and Development (OSHPD). The reporting system that the MAC evaluated is from the Midwives Alliance of North America (MANA). MANA is a private organization and the MANA data reporting system is a prospective data collection system. To use the MANA system the Board would incur costs for startup and yearly maintenance. MANA provided an informal estimate to the MAC Chair, Carrie Sparrevohn, L.M., of $25,000.00 for the initial setup costs and approximately $15,000.00 a year in maintenance. This change would require a statutory change to B&P section 2516 and contracting in compliance with State law. Currently, MANA does not provide statistics by county and has different timelines for reporting the data than currently required in statute.

The MAC also identified that a CNM is not included in B&P section 2514 as being authorized to supervise a midwifery student. However, B&P section 2513 does authorize a CNM to verify a midwifery student's clinical experience training. The MAC supports amending B&P section 2514 to include CNMs as health care providers authorized to supervise midwifery students.

Note: The Board of Registered Nursing is the licensing authority for CNMs.

LICENSED MIDWIFE DATA COLLECTION PROPOSAL

SUMMARY

Current Method

- Individual midwife data compiled and reported annually, at the end of the reporting period, to Office of Statewide Health Planning and Development (OSHPD), known generally as 'retrospective data collection'
- OSHPD reports aggregate data to MBC
- MBC includes data in annual report to the Legislature

Difficulties and shortcomings of current method

- Reporting form created by a group unfamiliar with data collection
- No method for assuring data is accurate and complete
- Reporting form is difficult to use by respondents and difficult to interpret by the scientific community
- Obvious errors cannot be verified or corrected
- Data collected is unique to CA and not comparable to other states

PROPOSED CHANGE

Utilization of the MANA Statistics Project (Midwives Alliance of North America)

- National Standard – Research registry of birth information collected since 2004
- Data collection form designed and updated by interdisciplinary team of experts in the field of maternal-child health research
- Software is designed to both aid data entry and flag specific entries for review by a specially trained team
- Currently in use for publication of papers in scientific, peer reviewed, journals
- Allows CA data to be compared with like data on a national level
- Data is entered into data base as it occurs, 'prospectively', creating transparency and accountability
- Currently being used for data collection by a number of other states
- Data collected far exceeds what is currently being collected in quantity, accuracy and transparency

Statute change required

- Current statute is very specific about what data is to be collected and it doesn't match what is being collected nationwide by MANA, necessitating the statute change
- California LMs would be required, by new statute, to participate in and meet the requirements of the MANA Stats Project with summaries of individual midwife data being submitted to OSHPD with reports to MBC and legislature, as above
- Fiscal: modest outlay to fund contributor support during initial uptake of new contributors to the database

Exploration of the Use of the Midwives Alliance of North America Statistics Project for California Licensed Midwife Data Reporting

This report, written by Bruce Ackerman and Jen Brown of the MANA Division of Research (DOR) and Carrie Sparrevohn, Chair of the Midwifery Advisory Council (MAC), continues a discussion of the need for more accurate, transparent, and accountable data collection between California licensed midwives and the Medical Board of California (MBC) via the Office of Statewide Health Planning and Development (OSHPD) and ultimately the State of California via an annual report delivered to the legislature by the MBC. The MAC has been exploring alternatives to the current data collection system, mandated by B&P section 2516, (Appendix E), for some time and has become aware of the Midwives Alliance of North America Statistics Project (hereafter cited as MANA Stats). The MANA Stats project will be described in detail below but constitutes a recommended approach, using nationally accepted best practices, to improving the collection of data related to out of hospital births attended by California licensed midwives (LMs) and the reporting of that data, annually, to the Medical Board of California.

Background

Current California LM reporting process as dictated by Business and Professions code Section 2516

California's licensed midwives are currently required to report annually, to OSHPD, aspects of their practice and client load related to out of hospital births that are prescribed by B&P section 2516 (a). (See Appendix E for current language). The form currently used for this process was developed by the MAC in conjunction with OSHPD and has been in use since the 2008 reporting year. (For a copy of the current form see Appendix F)

There have been several issues/concerns associated with the current process. First, data is submitted for each of the midwife's clients *after* the end of the reporting year, in a *retrospective* manner. This begs the question of both transparency and possible accuracy as there is no way to confirm complete data. When using data to create statistics (as this data is intended to be used) data collected in a *prospective* manner is deemed, by the scientific community, to be superior. Currently the state does not have this ability, although the MANA Stats Project does. Secondly, the current data collection tool is difficult for midwives to use correctly which has led to the reporting of inaccurate data. There is no mechanism (or funding) to evaluate suspected errors or even identify inconsistencies that may be reporting errors. As a result, the aggregate reports forwarded to the Medical Board and made public are allowed to stand without correction as submitted and therefore may be an inaccurate or mis-representation of actual data.

A national standard of data collection exists in the MANA Stats Project. In order for California statistics to be compared with like data, on a national level, California must collect LM data in a similar manner to what is now being collected nationally. The unique method, currently used in California, was developed before the MANA Stats Project was the viable option it now is. Currently, the Legislature, OSHPD, the MBC, or any other entity or researcher would be unable to compare and contrast the practices of California LMs with other similar practitioners nationwide, making it more difficult to address issues of best practices on a regulatory or legislative level to ensure the safety of California's birthing families.

Introduction to the Midwives Alliance of North America Statistics Project (MANA Stats)

MANA Statistics Project (MANA Stats) is a research registry of birth information operated by the Midwives Alliance of North America since 2004. At present approximately 123 California midwives voluntarily participate in MANA Stats. Nationwide, midwives or midwifery practices from 43 states actively participate. There have also been a number of scientific, peer reviewed, papers published using the data from the MANA stats project over the last five or so years. (Johnson K, Daviss BA. Outcomes of planned home birth with certified professional midwives: large prospective study in North America. BMJ 2005;330;1416; http://www.bmj.com/content/330/7505/1416)
Midwives voluntarily enrolled in MANA Stats enter each individual client into a database as the client enters care, continuing to submit data as it becomes available over the course of the client's care, completing it when care is complete. All data is entered on-line, through a sophisticated web-based data collection tool. This type of data collection is generally termed *prospective data collection,* and is a much more respected form of data collection in the scientific community than *retrospective data collection* which is what California is currently using. With prospective data collection the client is entered into the database at the beginning of care, when the outcome is unknown. There is no ability to then leave that client out of the data set regardless of the birth outcome. If California began participating in a nationally recognized process of data collection, such as the MANA stats, we would ensure California data was collected in the most respected, professional and responsible, scientific way.

The MANA data collection form itself has received a great deal of improvement and validation. The form currently in use is version 4.0, and has been re-designed twice by an interdisciplinary team experienced in the field of maternal-child health research, acquainted with the way midwives practice, and experienced in information systems design and maintenance. Each data form revision has built upon measurement of the prior versions' performance, producing a well-refined, sophisticated yet simple design.

Software aids the midwife in completing the form appropriately without any information either left out or incomplete, thus avoiding many of the inaccuracies seen with the current California reporting instrument. As the midwives submit these completed forms to MANA stats, some will be sent to the Data Review Team, which would review and contact, if necessary, the reporting midwife. This ensures not only accuracy but transparency. (This review process is described in greater detail in Appendix B)

Each contributing midwife is able to view her own personal statistics for a given year via her Annual Summary Report (ASR) on the secure website. The ASR details her caseload for that year and the outcomes of clients in her care for labor and birth. The ASR is designed to report standard statistics used in maternal-child health. (See the Appendices for an overview of the MANA Stats data collection tool, the process for using it and a sample ASR)

MANA Statistics in other States

Oregon, as described below, requires licensed midwives to contribute to the MANA Stats Project. Vermont has similar legislation in effect. Washington is currently in the process of drafting a similar requirement, and Arizona, Colorado, New Hampshire, Texas and New Mexico are considering such rules.

Oregon reporting process:

An example of how this is being used in other states

Oregon licensed midwives (as stated above) are required by statute to participate in the MANA Stats Project, ensuring accurate data for their annual reports. The Oregon Health Licensing Agency (OHLA) looked to the MANA stats project, proactively, as the means to accomplish this for their licensees. The reporting midwife now prints a copy of her ASR, which is sent with her license renewal application, to the OHLA. This process is in its first year and all parties are working through the start-up kinks, but it shows promise for several reasons:

- Due to the well-developed processes by which the MANA Stats Project ensures accurate and consistent data collection, the reports submitted are as complete as possible and categorize outcomes in ways accepted within the research community, making them comparable with existing benchmarking.
- As Oregon midwives all participate in MANA Stats, a research cohort is created which could allow further study of licensed midwifery practice in the state, and which contributes to the national MANA Stats database.
- The Oregon process requires no state-specific software, but leverages the existing MANA Stats web system maintained by the Midwives Alliance.

What would be required for California Licensed Midwives to utilize the MANA Stats reporting tool to collect state data?

The intent of this report is to explore the implications of changing from the current reporting methodology in California to leveraging the strengths of the MANA Stats Project. First and foremost, the existing statute would need to be amended to require California LMs to participate in and meet the requirements of the MANA Stats Project as their sole reporting requirement. LMs would be required to submit a copy of the Annual Summary Report (ASR) from their MANA Stats account to OSHPD each year. OSHPD would then submit the aggregate data to the MBC, just as they currently do.

The present California statute is quite detailed as to the specific data that must be reported by CA LMs. Such detail has constrained the MAC, OSHPD and the Medical Board, resulting in the present difficult reporting instrument. For the new process to ensure best practices are enabled regarding an ability to gather information that is both relevant and a tool to better refine the practice of midwifery in California, as envisioned here, the statute would have to describe the data in broad terms, or not at all, leaving it up to the MAC and the MBC to, through regulations, bring it in-line with what is currently on the MANA Stats data collection tool. This would allow for incremental changes without returning to the legislature. (See the Appendix D for a complete list of changes to captured data). By changing the statute so that the existing MANA Stats Annual Summary Report would satisfy its requirement and subsequently leaving it to the MBC to keep current with what MANA Stats is collecting, California could adopt the approach of requiring MANA Stats of licensed midwives without requiring custom software design, custom form design, or the maintenance of custom software.

If this approach were taken, the reporting deadline for CA LMs would need to align with the MANA Stats timeline to allow completion of midwives' individual birth forms and completion of MANA's review process. If midwives were to continue to report their outcomes on a calendar year basis (January through December), the deadline for midwives to send their ASR to OSHPD would need to be no earlier than July 15. Alternatively, the existing March reporting deadline could be retained, but with the reporting period being from November through October of the previous year, or some other variation

that would allow adequate time for the complete submission of data by midwives, review by MANA and aggregation by OSHPD. Either of the afore mentioned approaches would be equally workable, but a report of births through December that would be completed by March is not feasible since the MANA stats project is set up to work on a national level and its timeline for data submission and data review is already set for all participating midwives across the country. Adherence to the March deadline for a calendar year report would not allow enough time for completion of the process on MANA's end.

The present California reporting process can be compared with the MANA Stats process as follows.

Present Reporting Process	**Process using MANA Stats**
Midwife provides care for clients	Midwife enters clients in database at onset of care and provides on-going care for those clients
Throughout the year, some but not all midwives voluntarily participate in the MANA Stats project (pre-logging each client and completing the data form on each)	Throughout the year, all California LMs would participate in the MANA Stats project (pre-logging each client and completing the data form on each)
After the reporting year, midwife reviews her charts, tallies the numbers, and completes the on-line reporting form	After the reporting year, when all entries have been reviewed by the MANA Stats project team, the midwife sends her ASR to OSHPD by a method to be determined (mail or electronic)
Deadline for midwives' reporting to OSHPD is March 30 of the following year	Deadline for midwives' sending their complete ASR should be no earlier than July 15 of the following year if reporting for Jan-Dec, OR deadline could remain March 30 for reporting of data on a different timeline, as described above.
OSHPD tallies the reporting forms, and produces an aggregate report for the Medical Board	OSHPD tallies the reporting forms, and produces an aggregate report for the Medical Board
Research data for California Licensed Midwives is not available	Research data for California Licensed Midwives is available through the MANA Division of Research, as a complete cohort.

Details and Caveats

Need for support of new MANA Stats contributors

As Oregon has discovered, if it were decided to require all California LMs to participate in the MANA Stats Project, it is imperative that they be notified of the change early and more than once so that full compliance is reached. Participation in the MANA Stats project requires that the midwife make log entries for all her births as she takes on the clients, completing the data forms in a timely manner. Midwives who are not familiar with the process might assume that they can wait until their California reporting is due to "catch up" with this, but they will not be able to do so. This is a further safeguard to ensure accuracy as well as transparency. The Support team at the MANA Stats Project would be the point group for the data collection, not OSHPD. The MANA stats support team, working through the MAC with the MBC and/or with the California Association of Midwives (CAM) would do outreach and continue, on an on-going basis, to educate LMs on the process, thus ensuring a more total capture of the required data.

When these changes are adopted there would be an expected influx of new enrollees into the MANA Stats Project. It would be essential for the success of this process for there to be funding made available to allow the MANA support team to increase its level of attention to California enrollees, especially in the first year, as they would all benefit from personal contact to assure the data was collected efficiently and accurately. The fiscal portion of this proposal would need to be worked out and decided upon as the process moves forward through the legislature.

Non-Consented births

The MANA Stats process requires that each of the midwife's clients sign a Consent Form (See Appendix H), agreeing to allow their data to be included in the research registry. This is a standard requirement of all research data collection: the subject needs to consent to having their data used in this way. It is rare for a client to decline consent, but it does happen occasionally (less than 1% nationwide). The Oregon Health Licensing Agency created a form for midwives to use for those clients who declined consent during a reporting year. This form could be a basis for creating a similar form for California.

(to see a copy of this consent form: https://www.manastats.org/docs/ConsentForm_Color.pdf AND to look at the Oregon form for non-consenting clients: http://www.oregon.gov/OHLA/DEM/docs/form/DEM_MANA_Declined_Reporting_Form_OHLA.pdf)

Limiting the report to California births

It should be mentioned that some California licensed midwives attend births outside California. It would need to be decided if the current system, of California LMs only reporting on births attended within California, would be continued. If it was decided to limit the ASR for California midwives, to births that occurred in California, this could be done, but would require an addition to the MANA Stats software. That software change would require advance notice, and funding would be needed to pay for programming time. If it were decided to collect data on all of the births attended by a California LM then no change to software would be required.

Allowing for an exception for midwives who do not attend out-of-hospital births

For California LMs who attend no out-of-hospital births within the state in a reporting year, the current system of allowing those LMs to report just that, rather than participate in the MANA stats project, should be continued.

In Conclusion

California should utilize the midwives' Annual Summary Report (ASR) from the MANA Statistics Project for reporting practice data by licensed midwives through OSHPD to the Medical Board. Doing so would leverage an existing and mature process that would result in the most accurate aggregate data being reported to the Medical Board. The use of this process by California, would allow California's data on out of hospital births attended by licensed midwives to be incorporated, in total, in a national data base. The underlying data (that not included in the summary but used to create it) would reside in the MANA Stats research registry, where it could be the basis of research to further understand and improve midwifery practice and outcomes in California. Several other states, as referenced herein, are currently passing or have passed legislation requiring Licensed Midwives to participate in the MANA stats project for data collection in their respective states. This makes it apparent that the use of the same process for all states is the most sustainable path forward.

Appendix A: MANA Stats data collection process

This is a very brief "tour" of the MANA Statistics Project web system, to show how the midwife enters her birth data. For more detail or to ask questions, please contact the MANA Division of research, or take a look at the demonstration site, at http://demo.manastats.org where you can make a sample log entry and explore the data form completely.

The midwife begins by making a log entry for each of her clients as they enter her care. By pre-registering her planned births, it is assured that a data form is completed for every one of them.

Your Workspace
Client Log/ Data Forms
Statistics
Preferences
Contact Us
Sign Out

MANA Statistics Project

Midwives Alliance NORTH AMERICA

Client Log and Data Forms

The Client Log lists all the prospective births logged to date by you or the other midwives in your practice. Clients for which data forms have not yet been submitted are shown below. You can sort the log by birth code, initial visit date, age, EDD, or consent status: just click on the heading by which you want to sort.

To update log information for a client--if you've sent off a consent form or if the EDD is revised--click on the "Update" link to the left of the appropriate entry.

Add a new client to the log

Items in your log: 9

Log Entry	Birth Code	Initial Visit Date	Age	Due Date▲	Client Consent	Consent Form	Data Form
Update	AN-02	6/17/11	34	9/3/11	Yes	received	Add to data form
Update	AN-08	4/11/11	30	9/7/11	Yes	received	Add to data form
Update	AN-05	7/7/11	26	9/18/11	Yes	received	Add to data form
Update	AN-49	2/4/11	21	9/18/11	Yes	received	Start data form
Update	AN-22	5/9/11	36	9/19/11	Yes	received	Add to data form
Update	AN-48	4/8/11		9/23/11	Yes	received	Start data form
Update	AN-43	7/17/11	27	9/29/11	Yes	received	Start data form
Update	AN-51	4/4/11	40	10/2/11	Yes	received	Keep checking
Update	AN-47	8/1/11	32	2/1/12	Yes	received	Add to data form

Web site and data forms ©2004-2011 Midwives Alliance

Signed in as: Anne Midwife

A Consent Form is collected, on paper, from each client, which assures that the client agrees to allow her data to be included in the MANA Stats registry, informing her of the purpose of the registry and of its operation including safeguards taken to protect and de-identify her data. In order for research to be done on human subjects' data, Institutional Review Boards will require that this informed consent process was followed. The great majority of women agree, but occasionally a client will decline consent, and her data form will not be able to be entered by the midwife; in these cases that client's log entry is recorded as non-consenting and the midwife is not able to complete the on-line data form. The Annual Summary Report would include a warning if there were any log entries during the reporting year for which client consent was not obtained.

The midwife completes the MANA Stats data form for those clients who gave consent. This is the third generation of data form since the inception of the web-based data collection system in 2004, and it is considerably refined, streamlined and simplified based on study of the performance of prior versions. The present "Minimal Form" does an excellent job of collecting consistent data to allow the key Maternal/Child Health outcomes to be accurately derived from it, while minimizing the burden on practicing midwives so they can keep current with the data collection process.

Shown below is a portion of the data form within the Labor & Birth page.

Start | Demographic | History | Pregnancy | Labor & Birth | Postpartum | Newborn | Finish

Birth Summary

Was a pharmacological induction of labor attempted?: ○ - ○ Yes ◉ No

Was induction by herbs/castor oil, homeopathy, nipple stimulation, AROM, or membrane-stripping attempted?
○ - ◉ Yes ○ No

Mode of birth: ○ - ◉ spontaneous vaginal ○ forceps ○ vacuum ○ cesarean

State or province where the birth occurred: CA

Place of birth:

○ -
◉ home
○ birth center
○ hospital
○ higher-level hospital after transport from planned hospital
○ en route
○ other

Number of babies: 1

Estimated blood loss (until point at which uterine tone was established): 0.5 cups or 118 cc (milliliters)

Was the baby born before 37 completed weeks? ○ - ○ Yes ◉ No ○ Unknown

Stages of Labor *(You can use 12- or 24-hour time; you must fill out all boxes of the time and date.)*

Time and date active labor began:	12 : 24	AM	1 /	5 /	2012	*(MM/DD/YYYY)*
Time and date continuous pushing began:	4 : 17	AM	1 /	5 /	2012	*(MM/DD/YYYY)*
Time and date of birth:	4 : 42	AM	1 /	5 /	2012	*(MM/DD/YYYY)*
Time and date third stage ended:	5 : 18	AM	1 /	5 /	2012	*(MM/DD/YYYY)*
Rupture of membranes:	4 : 13	PM	1 /	4 /	2012	*(MM/DD/YYYY)*

After completing the data form, the software checks the form for completeness and consistency, and might display flags on questions that were not answered, or for which the answer given could be erroneous or inconsistent. The midwife may correct the form to clear these flags, or if she cannot she may enter an explanation into the flag itself. Thus the software always allows the form to be submitted (even if it lists a 66-pound baby!) but the data is far more complete and accurate for analysis due to this checking process.

Sex: ○ - ○ female ◉ male ○ ambiguous

Birth weight: 66 lb 4 oz or 30050 g

Please double-check this value. If it is mistyped, please correct it. If not, please confirm that it is correct here:

Appendix B: MANA Stats Review Process

After the midwife submits her data forms, some of them will be queued for review by the Data Review Team. The review process accomplishes three goals: it produces data that is transparent and accurate, ready for analysis by researchers; it educates the midwives (who might receive a call from the reviewer to resolve questions about her use of the form); and it allows the DOR to continually monitor where the data form might be improved. Data reviewers follow a detailed protocol, assisted by sophisticated software, to focus their review on exactly the issue(s) that caused the form to be sent to review. All changes made to a data form, throughout its history even before the midwife submits it, are recorded by the software for audit purposes.

Forms are sent to review for many reasons which fall into four basic categories- notes, unanswered questions, possible errors or logical inconsistencies, and deaths.

- ***Notes:*** On the form there are two large text boxes where a midwife may write notes. The temporary box is used for the midwife's notes to herself or to the MANA stats team, and are deleted after review. The other note box stays with the form and allows the midwife to provide additional narrative information to researchers. Forms with notes in these boxes are reviewed because midwives may write a note asking the reviewer to add another midwife to the form, change a birth code, or some other administrative chore. The other purpose of reviewing these forms is to de-identify any information (i.e. remove names) in the notes that will be seen by researchers.
- ***Unanswered questions:*** Forms on which the midwife has left a question unanswered and entered an explanation into the error flag are sent to review. The vast majority of these explanations are some version of "unknown" where the midwife does not have the information, generally after cases of transfer of care. In these cases the reviewer approves the explanations and submits the form as is.
- ***Possible errors or logical inconsistencies:*** Besides explanations for unanswered questions there are also many scenarios which are flagged to prevent errors from typos. For example if the date of birth is more than 28 days before or after the due date, the form is flagged. If it is correct the midwife simply enters something like "correct, preterm" in the explanation and the reviewer would approve the form as is. Forms where the midwife enters a low birth weight, under 2500 grams, are also flagged and reviewed in this manner. The software also follows a sophisticated set of validation protocols to flag a midwife when she has entered data into a form that is inconsistent and therefore a possible error. If the midwife does not correct the form to clear the flag, she must enter an explanation which is then reviewed. Examples of this kind of review are forms where the midwife marks that the planned place of birth at the start of labor was home but the birth took place in the hospital but there is no transport shown in the form, or where there is both a transfer of care in pregnancy and a transport in labor. The reviewer would follow the specific review protocol and most likely contact the midwife to verify the scenario and get the error corrected. For example if a midwife has entered a transfer of care in pregnancy for a breech and also a transport in labor for a breech, the reviewer must contact her to determine when the transfer actually took place. The reviewer would then correct the form according to the midwife's instructions.
- ***Deaths:*** All forms with a death reported will be reviewed using a FIMR-type (Fetal and Infant Mortality Review) interview with the midwife to ensure accurate classification of the death

according to accepted research standards. Death reviewers are experienced reviewers who have undergone additional training. The goals of death review are to ensure accurate classification of each death, provide additional information regarding cause of death, and to allow the midwife to provide a narrative explanation of the situation. Deaths are classified as miscarriages (pregnancy loss before 20 weeks), intrauterine fetal demise (pregnancy loss after 20 weeks but before birth), neonatal death (after birth until 28 days) and infant deaths (after 28 days). An example of a misclassified death would be one where the midwife reports that the baby died during labor but the APGAR was listed as 3 at 5 minutes which indicates the baby was alive at birth. During the death interview the reviewer would determine exactly when the baby died and change the form to reflect the correct type of death. In the above case the correct classification would be a neonatal death. Maternal deaths are also reviewed in this manner and are classified as before, during or after the birth and whether or not they were pregnancy-related.

Appendix C: Sample Annual Summary Report (ASR)

The following two pages show the complete Annual Summary Report as viewed by a typical midwife through her account on the MANA Stats web system.

This report covers all entries to care and all births that took place in the report year. It covers all clients who enter care in the report year and subsequently miscarry or transfer out of care (even if the miscarriage or transfer occurred in the following year).

Clients who enter care in this report year but are still pregnant on 12/31 will not have their birth outcomes represented in this year's report.

The first two statistics in the Caseload section are based on data forms either in progress or submitted. All other statistics are based on completed and submitted data forms only. Fetal losses and deaths are reported as "not yet reviewed" if the Midwives Alliance Data Review Team has not yet completed review of those data forms; they are reported as "confirmed" if the review has been completed.

MANA Stats Annual Summary Report (2010)	
MIDWIFE CASELOAD	
Clients who entered care with midwife in report year	24
Clients who entered care in report year and transferred out in pregnancy (in report year or after)	2
Clients who entered care in report year and died AP (in report year or after)	0 confirmed, pregnancy-related 0 confirmed, not pregnancy-related 0 confirmed, unknown whether pregnancy-related 0 not yet reviewed
Clients who entered care in report year and were in midwife's care for labor/birth in report year	12
Clients who entered care in previous year and were in midwife's care for labor/birth in report year	3
Total number of clients who were in midwife's care for labor/birth in report year	15
Total number of labors/births attended in report year as Midwife 2 or Midwife 3	9
OUTCOMES OF LABOR/BIRTHS AS PRIMARY MIDWIFE	
Clients who went into labor intending to give birth at home/birth center	15
Home/birth-center births as planned	13
Intrapartum transports	2 (0 urgent)
Postpartum maternal transports	0 (0 urgent)
Neonatal transports	1 (0 urgent)
Babies admitted to hospital in first 6 weeks of life (including neonatal transports)	1
NICU admissions in first 6 weeks of life	1

Antepartum fetal demises	0 confirmed, due to congenital anomalies 0 confirmed, not due to congenital anomalies 0 not yet reviewed
Intrapartum fetal demises	0 confirmed, due to congenital anomalies 0 confirmed, not due to congenital anomalies 0 not yet reviewed
Fetal demises at unknown point	0 confirmed, due to congenital anomalies 0 confirmed, not due to congenital anomalies
Neonatal deaths (first 28 days of life)	0 confirmed, due to congenital anomalies 0 confirmed, not due to congenital anomalies 0 not yet reviewed
Infant deaths, post-neonatal, in first 6 weeks of life (between 29 and 42 days of life)	0 confirmed, due to congenital anomalies 0 confirmed, not due to congenital anomalies 0 not yet reviewed
Maternal deaths in labor or first 6 weeks postpartum	0 confirmed, pregnancy-related 0 confirmed, not pregnancy-related 0 confirmed, unknown whether pregnancy-related 0 not yet reviewed
Cesarean sections	1
Vacuum or forceps deliveries	0
3rd or 4th degree lacerations	0
Estimated blood loss of 500 ml or more	1
Meconium (thick/particulate)	0
Babies with 5-minute Apgar under 7	0
VBACs attempted in home/birth center (whether outcome was vaginal or surgical birth)	1
VBACs completed in home/birth center (successful VBACs)	1
VBACs attempted in home/birth center and completed in hospital (successful VBACs)	0
Vaginal breech births completed in home/birth center/hospital	0
Frank	0
Complete	0
Footling	0
Other/unknown	0
Multiple births	0
Births after 42 weeks	0
Births with active labor over 24 hours	0
Births with 2nd stage over 4 hours	1
Births with 3rd stage over 1 hour	1
Breastfeeding as of last postpartum visit	12

Appendix D: List of items currently required by B&P Section 2516 which will not be captured on the ASR

- Births with collaborative care or under physician supervision.
- Outcomes are not listed by county, though the larger data base does include mother's county and zip code of residence and also the state where the birth occurred.
- Breeches are not listed by where the birth is completed. (ASR lists vaginal breeches, but does not specify location as home, birth center or hospital)
- Transfers by antepartum, intrapartum, postpartum and neonatal are captured though not the reason's for such transfers or their outcomes. This information resides in the full data base.
- All multiple births are listed together, twins are not separated out
- Reasons for deaths are not captured on the summary, however the ASR separates out fetal deaths as due to anomalies or not and maternal deaths as pregnancy-related or not and reasons for deaths are maintained in the larger data base.
- Either California could change the deadline for LM reporting from March 30 to July 15, or alternatively the report could be due in March but be for a reporting period other than the calendar year, e.g. for October through September.

Appendix E: B&P Section 2516

2516. (a) Each licensed midwife who assists, or supervises a student midwife in assisting, in childbirth that occurs in an out-of-hospital setting shall annually report to the Office of Statewide Health Planning and Development. The report shall be submitted no later than March 30, with the first report due in March 2008, for the prior calendar year, in a form specified by the board and shall contain all of the following:

(1) The midwife's name and license number.

(2) The calendar year being reported.

(3) The following information with regard to cases in California in which the midwife, or the student midwife supervised by the midwife, assisted during the previous year when the intended place of birth at the onset of care was an out-of-hospital setting:

(A) The total number of clients served as primary caregiver at the onset of care.

(B) The total number of clients served with collaborative care available through, or given by, a licensed physician and surgeon.

(C) The total number of clients served under the supervision of a licensed physician and surgeon.

(D) The number by county of live births attended as primary caregiver.

(E) The number, by county, of cases of fetal demise, infant deaths, and maternal deaths attended as primary caregiver at the discovery of the demise or death.

(F) The number of women whose primary care was transferred to another health care practitioner during the antepartum period, and the reason for each transfer

(G) The number, reason, and outcome for each elective hospital transfer during the intrapartum or postpartum period.

(H) The number, reason, and outcome for each urgent or emergency transport of an expectant mother in the antepartum period.

(I) The number, reason, and outcome for each urgent or emergency transport of an infant or mother during the intrapartum or immediate postpartum period.

(J) The number of planned out-of-hospital births at the onset of labor and the number of births completed in an out-of-hospital setting.

(K) The number of planned out-of-hospital births completed in an out-of-hospital setting that were any of the following:

(i) Twin births.

(ii) Multiple births other than twin births.

(iii) Breech births.

(iv) Vaginal births after the performance of a cesarean section.

(L) A brief description of any complications resulting in the morbidity or mortality of a mother or an infant.

(M) Any other information prescribed by the board in regulations.

(b) The Office of Statewide Health Planning and Development shall maintain the confidentiality of the information submitted pursuant to this section, and shall not permit any law enforcement or regulatory agency to inspect or have copies made of the contents of any reports submitted pursuant to subdivision (a) for any purpose, including, but not limited to, investigations for licensing, certification, or regulatory purposes.

(c) The office shall report to the board, by April 30, those licensees who have met the requirements of subdivision (a) for that year.

(d) The board shall send a written notice of noncompliance to each licensee who fails to meet the reporting requirement of subdivision (a). Failure to comply with subdivision (a) will result in the midwife being unable to renew his or her license without first submitting the requisite data to the Office of Statewide Health Planning and Development for the year for which that data was missing or incomplete. The board shall not take any other action against the licensee for failure to comply with subdivision (a).
(e) The board, in consultation with the office and the Midwifery Advisory Council, shall devise a coding system related to data elements that require coding in order to assist in both effective reporting and the aggregation of data pursuant to subdivision (f). The office shall utilize this coding system in its processing of information collected for purposed of subdivision (f).
(f) The office shall report the aggregate information collected pursuant to this section to the board by July 30 of each year. The board shall include this information in its annual report to the Legislature.
(g) Notwithstanding any other provision of law, a violation of this section shall not be a crime.

Appendix F: Current Licensed Midwife Reporting Form

https://lmar.oshpd.ca.gov

Medical Board of California
Expert Reviewer Program Report

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

January 2, 2013

SPECIALTY	Number of cases reviewed/sent to Experts (Jan-Dec, 2012)	Number of Experts used and how often utilized (Jan-Dec, 2012	Active List Experts 964 ↑
ADDICTION	22	**10 EXPERTS** 7 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 8 CASES* (*INVOLVED COMPANION CASES)	16 ↑
ALLERGY & IMMUNOLOGY (A&I)	1	**1 EXPERT** 1 LIST EXPERT REVIEWED 1 CASE	4
ANESTHESIOLOGY (Anes)	27	**18 EXPERTS** 12 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 3 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 7 CASES* (* INVOLVED COMPANION CASES)	65 ↑
COLON & RECTAL SURGERY (CRS)	1	**1 EXPERT** 1 LIST EXPERT REVIEWED 1 CASE	3
COMPLEMENTARY/ALTERNATIVE MEDICINE	12	**5 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 5 CASES	20 ↑
CORRECTIONAL MEDICINE	1	**1 EXPERT** 1 LIST EXPERT REVIEWED 1 CASE	29 ↑
DERMATOLOGY (D)	8	**5 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 4 CASES	10
EMERGENCY (EM)	16	**10 EXPERTS** 6 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 4 CASES	51 ↑

Medical Board of California
Expert Reviewer Program Report

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

January 2, 2013

SPECIALTY	Number of cases reviewed/sent to Experts (Jan-Dec, 2012)	Number of Experts used and how often utilized (Jan-Dec, 2012	Active List Experts 964 ↑
Medical Oncology (Onc)	6	**4 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES	11
MIDWIFE REVIEWER	3	**2 EXPERTS** 1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	6
NEUROLOGICAL SURGERY (NS)	13	**6 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES 2 LIST EXPERTS REVIEWED 4 CASES	8 ↓
NEUROLOGY (N)	4	**4 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE	27 ↑
NEUROLOGY with Special Qualifications in Child Neurology (N/ChiN)			3
NUCLEAR MEDICINE (NuM)			5
OBSTETRICS & GYNECOLOGY (ObG)	68	**26 EXPERTS** 10 LIST EXPERTS REVIEWED 1 CASE 7 LIST EXPERTS REVIEWED 2 CASES 3 LIST EXPERTS REVIEWED 3 CASES 2 LIST EXPERTS REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 6 CASES* 1 LIST EXPERT REVIEWED 8 CASES* 1 LIST EXPERT REVIEWED 10 CASES* 1 LIST EXPERT REVIEWED 12 CASES* (*DIFFICULT SPECIALTY/LIMITED AVAILABLE EXPERTS)	80 ↑
OPHTHALMOLOGY (Oph)	15	**9 EXPERTS** 7 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 6 CASES	31 ↓

Medical Board of California
Expert Reviewer Program Report

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

January 2, 2013

SPECIALTY	Number of cases reviewed/sent to Experts (Jan-Dec, 2012)	Number of Experts used and how often utilized (Jan-Dec, 2012	Active List Experts 964 ↑
ORTHOPAEDIC SURGERY (OrS)	16	**12 EXPERTS** 9 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES	27
OTOLARYNGOLOGY (Oto)	1	**1 EXPERT** 1 LIST EXPERT REVIEWED 1 CASE	21 ↓
PAIN MEDICINE (PM)	54	**16 EXPERTS** 5 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES 2 LIST EXPERTS REVIEWED 5 CASES 1 LIST EXPERT REVIEWED 6 CASES* 2 LIST EXPERTS REVIEWED 7 CASES 1 LIST EXPERT REVIEWED 9 CASES* (*INVOLVED COMPANION CASES, and WITH LIMITED AVAILABLE EXPERTS,)	21 ↑
PATHOLOGY (Path)	5	**5 EXPERTS** 5 LIST EXPERTS REVIEWED 1 CASE	10 ↑
PEDIATRICS (Ped)	5	**5 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	44
PHYSICAL MEDICINE & REHABILITATION (PMR)	1	**1 EXPERT** 1 LIST EXPERT REVIEWED 1 CASE	10 ↑

Medical Board of California
Expert Reviewer Program Report

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

January 2, 2013

SPECIALTY	Number of cases reviewed/sent to Experts (Jan-Dec, 2012)	Number of Experts used and how often utilized (Jan-Dec, 2012	Active List Experts 964 ↑
PLASTIC SURGERY (PIS)	35	**14 EXPERTS** 7 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES 1 LIST EXPERT REVIEWED 11 CASES* (*INVOLVED COMPANION CASES)	51 ↓
PREVENTIVE MEDICINE (PrM) OCCUPATIONAL MEDICINE	3	**3 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE	9
PSYCHIATRY (Psyc)	134	**61 EXPERTS** 21 LIST EXPERTS REVIEWED 1 CASE 5 OFF LIST EXPERTS REVIEWED 1 CASE* 17 LIST EXPERTS REVIEWED 2 CASES 2 OFF LIST EXPERTS REVIEWED 2 CASES* 3 LIST EXPERTS REVIEWED 3 CASES 1 OFF LIST EXPERT REVIEWED 3 CASES* 6 LIST EXPERTS REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES 1 OFF LIST EXPERT REVIEWED 5 CASES* 1 LIST EXPERT REVIEWED 6 CASES** 1 LIST EXPERT REVIEWED 7 CASES** 1 LIST EXPERT REVIEWED 8 CASES** 1 LIST EXPERT REVIEWED 9 CASES** *INVOLVED PSYCHOLOGISTS USED FOR PROBATION CASES **COMBINATION CASE REVIEWS AND EVALUATIONS, AND INVOLVED COMPANION CASES	86 ↑
RADIOLOGY (Rad)	8	**7 EXPERTS** 5 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES	35 ↑
SLEEP MEDICINE (S)			8

Medical Board of California
Expert Reviewer Program Report

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

January 2, 2013

SPECIALTY	Number of cases reviewed/sent to Experts (Jan-Dec, 2012)	Number of Experts used and how often utilized (Jan-Dec, 2012	Active List Experts 964 ↑
SURGERY (S)	24	**10 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 2 LIST EXPERTS REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES	44 ↓
Pediatric Surgery (PdS)	1	**1 EXPERT** 1 LIST EXPERT REVIEWED 1 CASE	3
Vascular Surgery (VascS)	5	**3 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES	14
THORACIC SURGERY (TS)	5	**6 EXPERTS** 5 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	16 ↑
(MEDICAL) TOXICOLOGY			3
UROLOGY (U)	14	**9 EXPERTS** 6 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES	18

TOTAL CASES SENT (Calendar Year 2012)	627
TOTAL LIST EXPERTS UTILIZED (Calendar Year 2012)	349
TOTAL ACTIVE LIST EXPERTS (as of 1/2/2013)	964

/susan (1/2/13)

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		FY 2012/2013 1st Qtr		FY 2012/2013 2nd Qtr	
	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records
Complaint Processes												
Complaint Received by Board → Analyst Assigned/Initial Review Conducted	10	6761	11	6869	9	7513	12	7699	9	2141	8	1974
Analyst Assigned/Initial Review Conducted → Request Medical Release	25	1216	24	1360	28	1567	42	1557	29	395	28	354
Request Medical Release → Medical Release Returned	29	1044	26	1166	25	1321	27	1281	29	327	29	310
Medical Release Returned → Request Records from Subject/Provider	7	687	7	802	11	888	17	865	14	222	15	192
Request Records from Subject/Provider → Records Received from Subject/Provider	39	1759	38	1879	35	1906	35	2015	34	548	32	469
Records Received from Subject/Provider → Complaint to Medical Consultant	15	1617	16	1865	17	1768	21	1798	23	456	20	377
Complaint to Medical Consultant → Complaint Returned from Medical Consultant	54	1934	54	2120	52	2129	45	2164	39	535	31	467
Complaint Returned from Medical Consultant → Case Closed/Complaint to Investigation	7	1932	4	2114	5	2126	4	2151	5	534	7	464
Investigative Processes												
Complaint to Investigation → Complainant Interview Completed	103	349	102	424	110	490	89	531	95	132	71	132
Complainant Interview Completed → Subpoena Served	173	42	237	43	172	44	202	45	155	18	161	18
Complainant Interview Completed → Medical Records Requested with Release	76	141	88	170	59	194	87	203	69	49	75	60
Subpoena Served → All Records Received	124	120	100	178	88	166	82	146	90	40	60	27
Medical Records Requested with Release → All Records Received	95	372	92	406	85	420	64	416	67	114	43	109
All Records Received → Case to Medical Consultant for Review	78	227	84	318	70	369	59	322	50	79	52	75
Case to Medical Consultant for Review → Subject Interview Attempted	110	374	109	488	77	558	76	532	87	109	73	111
Subject Interview Attempted → Subject Interview Completed	66	712	53	880	53	961	51	1046	57	255	46	244
Subject Interview Completed → Case Sent to Expert Review	97	412	81	511	72	580	57	626	60	147	48	147
Case Sent to Expert Review → Case Back from Expert Review	79	510	72	601	63	658	61	701	78	171	55	172
Case Back from Expert Review → Case Closed or Referred for Action	39	495	31	585	30	656	29	705	35	169	32	174

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		FY 2012/2013 1st Qtr		FY 2012/2013 2nd Qtr	
	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records
Case Referred for Action → Accusation/Petition to Revoke Probation Filed	121	239	113	237	103	219	129	284	146	70	95	84
Accusation/Petition to Revoke Probation Filed → Stipulation Received	330	159	291	173	318	142	329	202	294	46	301	53
Stipulation Received → Mail Vote Sent	6	136	6	132	4	124	5	153	5	35	3	39
Accusation/Petition to Revoke Probation Filed → Date Hearing Closed - Submit to ALJ	416	25	370	30	393	44	318	45	484	15	400	15
Date Hearing Closed - Submit to ALJ → Proposed Decision Received	28	35	98	43	39	58	40	63	67	27	58	22
Proposed Decision Received → Mail Vote Sent	5	54	5	53	6	60	6	72	6	27	4	22
Mail Vote Sent → Case Outcome	131	206	87	208	111	205	82	262	109	72	74	75

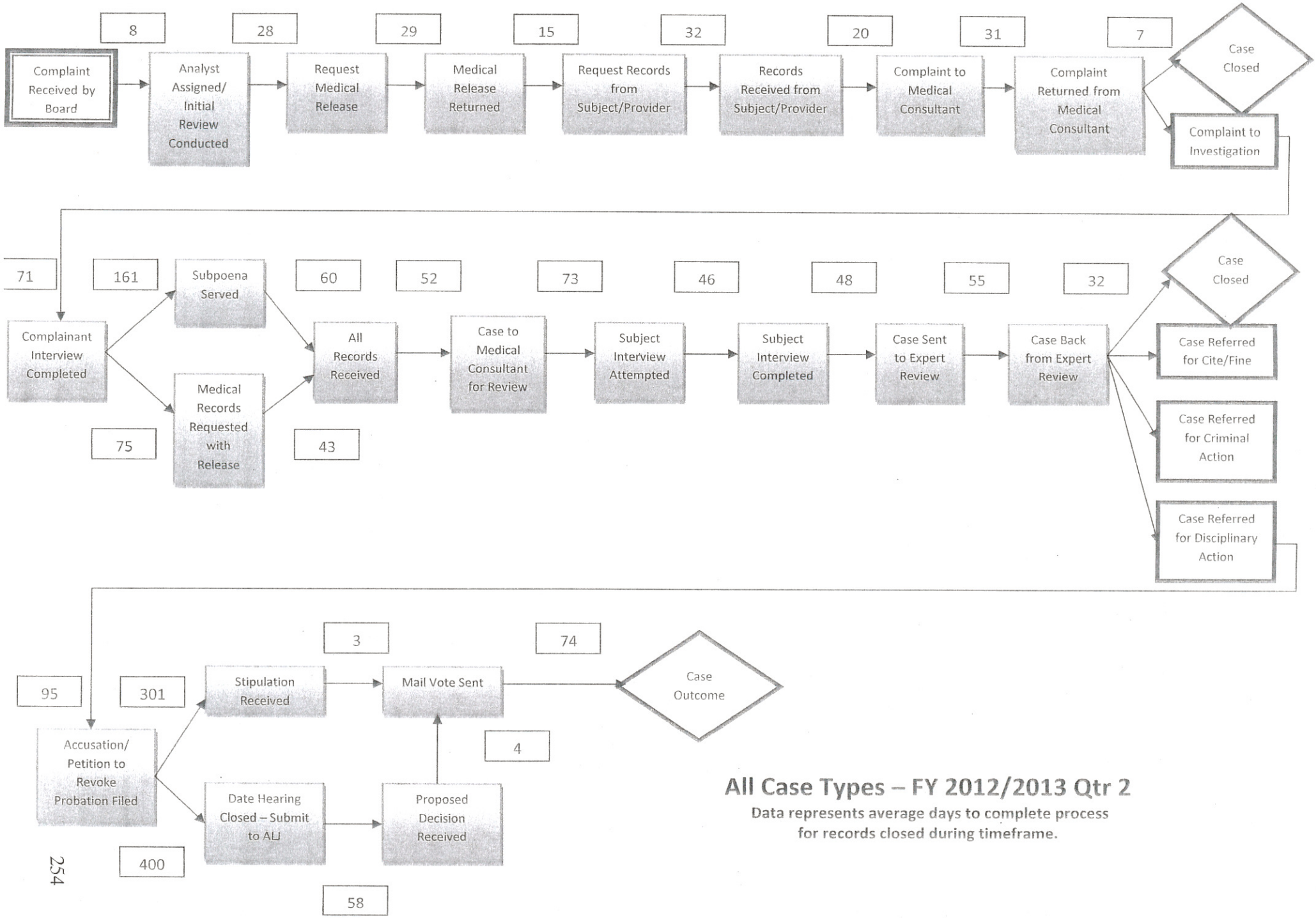
Data represents overall average days from Receipt to Closure for records closed during reported time frames.	FY 2008/2009		FY 2009/2010		FY 2010/2011		FY 2011/2012		FY 2012/2013 1st Qtr		FY 2012/2013 2nt Qtr	
	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records
Complaint Received → Closure in Complaint Unit	84	5278	84	5247	80	5755	91	5687	73	1583	74	1440
Complaint Received → Closure at Field/Referred for Administrative or Criminal Action/Citation Issued	467	1585	464	1747	453	1861	419	2101	396	585	396	558

MEDICAL BOARD OF CALIFORNIA
Enforcement Processing Timeframes
2012 Strategic Plan Objective 5.2

Enforcement Process	2008/2009		2009/2010		2010/2011		2011/2012		2012/2013 Qtr 1		2012/2013 Qtr 2	
	# Cases[1]	AVG[2]	# Cases	AVG	# Cases	AVG	# Cases	AVG	# Cases	AVG	# Cases	AVG
Complaint	6426	75	6563	76	7008	74	7217	83	1980	67	1844	63
% of Complaints Below 50 days (Goal: 50-60%)	**43%**		**41%**		**35%**		**42%**		**48%**		**50%**	
Investigation	1100	349	1290	328	1411	312	1545	264	406	267	394	269
Discipline												
AG Processing to Preparation of an Accusation	240	103	304	106	294	107	333	103	73	83	79	70
Other Stages of the Legal Process (e.g., after charges filed)	228	381	232	368	216	417	280	396	67	440	80	412

[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)**



All Case Types – FY 2012/2013 Qtr 2

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

ENFORCEMENT TIMEFRAMES

FISCAL YEARS	2006 - 2007		2007 - 2008		2008- 2009		2009 - 2010		2010 - 2011		2011 - 2012		2012 - 2013 *	
	AVERAGE	MEDIAN	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	65	51
INVESTIGATION	307	289	324	272	349	309	328	292	312	283	264	225	269	243
TOTAL MBC														
DAYS	361	338	385	321	424	372	404	355	386	360	347	289	334	294
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	0.92	0.81
AG PREP FOR ACC	127	76	121	58	103	63	106	66	107	72	104	78	77	68
OTHER LEGAL	446	350	471	324	381	311	368	312	417	324	396	351	426	353
TOTAL AG														
DAYS	573	426	592	382	484	374	474	378	524	396	500	429	503	421
YEARS	1.57	1.17	1.62	1.05	1.33	1.02	1.30	1.04	1.44	1.08	1.37	1.18	1.38	1.15
TOTAL MBC & AG														
DAYS	934	764	977	703	908	746	878	733	910	756	847	718	837	715
YEARS	2.56	2.09	2.68	1.93	2.49	2.04	2.41	2.01	2.49	2.07	2.32	1.97	2.29	1.96

Years calculated using 365 days per year
Data source: MBC Annual Reports, except 2012-2013

* Data through 12/31/2012

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	FY 12/13 *
Automatic Suspension Order	5	1	5	0	3	7	4	6	3
PC 23 Order	8	4	8	6	15	7	12	12	14
Out of State Suspension Order	15	14	8	11	18	18	21	17	4
Agreement - No Practice/Restriction	2	6	5	2	3	3	2	0	2
Suspension/Cease Practice Issued by Chief	5	5	3	1	2	1	3	4	2
Interim Suspension Order	31	32	22	18	22	22	28	35	17
Temporary Suspension Order	1	0	0	1	0	0	1	0	0
Totals	**67**	**62**	**51**	**39**	**63**	**58**	**71**	**74**	**42**

* Suspensions Issued through 12/31/2012

Medical Board of California

Investigation Prosecution Timeframes*

	2005	2006		2007		2008		2009		2010		2011	2012
	Prior to VE	All	VE	All	VE	All	VE	All	VE	All	VE	All	All
Calendar Day Age from Case Assigned to Case Closed Not Resulting in Prosecution													
Average	271	299	138	330	268	374	358	383	381	333	333	296	263
Median	252	285	134	304	269	335	324	346	346	298	297	273	230
Record Count	827	703	192	648	539	609	588	673	672	664	663	857	794
Calendar Day Age from Request to Suspension Order Granted													
Average	51	44	4	34	38	19	19	52	39	40	40	43	73
Median	17	3	2	22	23	10	10	23	23	1	1	17	24
Record Count	24	21	11	17	13	21	17	17	16	27	27	31	51
Calendar Day Age from Request to Receipt of Medical Records													
Average	58	53	37	59	57	63	58	73	73	64	64	67	46
Median	32	31	26	31	31	28	28	32	32	29	29	30	28
Record Count	475	376	228	264	259	256	252	243	243	257	257	246	236
Calendar Day Age from Request to Physician Interview Completed													
Average	48	51	43	52	50	63	63	52	52	46	46	52	47
Median	36	42	38	37	36	41	42	37	37	34	34	38	35
Record Count	597	453	172	406	371	473	466	696	696	582	582	729	664
Calendar Day Age from Request to Receipt of Expert Opinion													
Average	51	47	35	51	43	50	50	48	48	47	47	58	57
Median	41	35	31	36	35	39	38	36	35	37	37	39	38
Record Count	519	424	82	344	270	374	359	426	424	415	415	599	447
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	495
Median	525	504	120	523	339	541	486	575	569	616	616	533	457
Record Count	187	149	17	198	95	157	131	189	186	200	199	239	231
Calendar Day Age from Accusation Filed to Disciplinary Outcome**													
Average	608	602	85	576	188	561	243	473	339	426	340	425	449
Median	526	466	99	426	182	384	238	351	309	326	304	391	367
Record Count	212	195	3	226	29	203	80	198	145	171	156	190	237

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

Medical Board of California

Citations Issued & Civil Actions Filed by Calendar Year

	2005	2006	2007	2008	2009	2010	2011	2012
***Citations Issued**	80	81	76	109	124	100	98	122
Citations Issued for Failure to Produce Records	0	6	3	3	2	5	6	3
Civil Actions Filed	3	3	1	1	2	1	6	0
Civil Actions Filed for Failure to Produce Records	2	2	1	1	0	0	3	0

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

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January 24, 2013

Board Members
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

Re: Attorney General's Preliminary Response to MBC Sunset Review Report 2012

Dear Members:

This letter report will constitute the preliminary response of the Health Quality Enforcement Section of the Attorney General's Office to the Medical Board of California Sunset Review Report 2012. This report is preliminary in nature because our office has not yet received the supporting data and methodology information we requested from the Board's Executive Director on December 3, 2012. Once we receive the requested statistics or data in the requested format (alphabetized by physician name, etc.), we will be able to fully analyze the data set forth in Section 5 of the Report, ensuring that we are comparing "apples to apples," using the same cases and time periods.[1] We would like to comply with the Board's directive to collaborate with Board's Enforcement Program in reporting data, where possible, using the same beginning and end markers to measure aging and averages for important events.

We want to note at the outset that since the Vertical Enforcement and Prosecution Model (VE/P) model[2] was implemented in January of 2006, the Attorney General's office has continued

[1] On January 2, 2013, a further request was sent to Executive Director Whitney requesting that data collected for the Board's anticipated further review of VE/P include physician names to permit our office, once it requests and receives the data, to properly analyze it and compare it to our ProLaw data. Again, we are endeavoring to report our case management data, where possible, in a manner consistent with the format followed by the Board's Enforcement Program.

[2] "VE/P" refers to the "vertical enforcement and prosecution model" mandated by the Legislature in Government Code section 12529.6, which defines the manner in which allegations of unprofessional conduct by physicians and surgeons are to be investigated and, if warranted by the evidence, prosecuted by the Health Quality Enforcement Section. Government Code section 12529.6, subdivision (b), provides that both an investigator and a deputy attorney general will be assigned to investigation cases and the investigator will, under the direction but not the supervision of the deputy attorney general, obtain the evidence necessary for the Attorney General to advise the Board on legal matters, including whether to file an accusation or dismiss the complaint for lack of evidence.

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AFTER PAGE 258

to work in a collaborative and productive manner with the Board's Chief of Enforcement and her staff to implement the goals of the Vertical Enforcement/Prosecution model enacted by the Legislature. The hard work of investigators and deputy attorneys general over the past seven years is commendable.

As an example of collaboration to ensure the intent of the Legislature[3] is followed, HQE and Enforcement Program managers participated in the creation of a Vertical Enforcement and Prosecution Manual ("Manual"), the most recent edition of which was jointly created in 2011, and issued in early 2012.[4] Among other things, the third edition of the Manual provides for the first time timelines for investigators for moving investigation cases forward.[5] For example, the Manual now sets forth specific timeframes for an investigation to be assigned to an investigator and for the AG's Lead Prosecutor (LP) to be appraised of the case.

The AG's direction of the case commences once the Lead Prosecutor receives an investigation for review from the Supervising Investigator.[6] Throughout our participation, the goal is to collect quality evidence necessary for successful prosecutions. Early involvement of the AG's office helps focus investigative resources on cases that may merit urgent interim relief, such as in the case of impaired physicians, consistent with the Board's responsibilities pursuant to Business and Professions Code section 2220.05, subdivision (a).[7] We will be reporting

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[3] Government Code section 12529.6, subdivision (a), states : "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."

[4] Vertical Enforcement and Prosecution Manual (Third Edition, July 2011). Prior editions of the Manual were published in March and November 2006. A Joint Guidelines handbook was published in April of 2008. The focus of prior editions was to address the roles of our respective offices in the management of investigations at critical junctures of AG direction, such as subject interviews, expert reviewer selection and expert report review. Efforts to improve DAG/investigator teamwork have been pursued since the inception of VE/P. HQE and MBC Enforcement are now in agreement with critical aspects of the program such that our focus now is on investigative timeline efficiency, and an expanded role of the Lead Prosecutor. Throughout this time period, efforts have also been made to lower investigative legal costs, and to promote statewide consistency in how VE/P is applied.

[5] Vertical Enforcement and Prosecution Manual (Third Edition, July 2011), p. 10).

[6] Lead prosecutors review matters for compliance with Business and Profession Code section 2220.08, identify cases ripe for interim relief, and obtain primary deputy attorney general assignments from Supervising Deputy Attorneys General (SDAGs), among other duties. (Vertical Enforcement and Prosecution Manual (Third Edition, July 2011), pp. 6-7.)

[7] Business and Profession Code section 2220.05, subdivision (a), states: "In order to ensure that its resources are maximized for the protection of the public, the Medical Board of California shall prioritize its investigative and prosecutorial resources to ensure that physicians and surgeons representing the greatest threat of harm are identified

(continued...)

statistics regarding this important function of the AG's Office in the response to the Board's Sunset Review Report Supplemental 2013.

This continuing collaborative effort has improved public protection of patients receiving medical services in California, while at the same time protecting physicians from unwarranted or needlessly protracted investigations and prosecutions, thereby addressing two primary concerns of the legislature in creating the VE/P model. VE/P has improved the quality of investigations and prosecutions. There has also been a decrease investigation and prosecution timelines, compared to pre-VE/P, and a higher percentage of serious, disciplinary[8]outcomes for administrative cases. The shorter the timelines for investigation and prosecution, the sooner a physician is either disciplined or exonerated. Quicker and higher quality disciplinary outcomes translate into fewer patients exposed to potential harm and thus better public protection. Expeditious resolution in favor of a physician removes the cloud of suspicion over the physician created by the investigation and gets the physician back into the productive practice of medicine.

The Attorney General in directing investigations and prosecuting cases takes very seriously the statutory mandate that gives public protection the highest priority.[9] Further, the

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(...continued)
and disciplined expeditiously. Cases involving any of the following allegations shall be handled on a priority basis, as follows, with the highest priority being given to cases in the first paragraph:

> "(1)Gross negligence, incompetence, or repeated negligent acts that involve death or serious bodily injury to one or more patients, such that the physician and surgeon represents a danger to the public.
>
> "(2)Drug or alcohol abuse by a physician and surgeon involving death or serious bodily injury to a patient.
>
> "(3)Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances, or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith prior examination of the patient and medical reason therefor. However, in no event shall a physician and surgeon prescribing, furnishing, or administering controlled substances for intractable pain consistent with lawful prescribing, including, but not limited to, Sections 725, 2241.5, and 2241.6 of this code and Sections 11159.2 and 124961 of the Health and Safety Code, be prosecuted for excessive prescribing and prompt review of the applicability of these provisions shall be made in any complaint that may implicate these provisions.
>
> "(4)Sexual misconduct with one or more patients during a course of treatment or an examination.
>
> "(5)Practicing medicine while under the influence of drugs or alcohol."

[8] The AG's office does not consider public letters of reprimand serious discipline, as explained further in footnote 19.

[9] Business and Professions Code section 2229, subdivision (a) ["Protection of the pubic shall be the highest priority of the [Board] in exercising [its] disciplinary authority."] The Attorney General, as the chief law officer of the state (Cal. Const., art. V, § 13) possesses not only extensive statutory powers but also broad powers derived from the

(continued...)

important oversight role assigned to HQE by the Legislature is held in the highest regard by this office. Finally, the high burden of proof[10] demanded in administrative cases against physicians demands involvement at the investigative phase to ensure meritorious cases are pursued. VE/P requires trial deputies to become involved in the investigation phase of a case where many of the evidentiary and legal issues that will be faced in trial are first encountered.

Key statistical measures that support the above assessment have been previously identified.[11] For example, one statistical measure is the average number of days from the date of receipt of the consumer complaint at the Medical Board District Office to the date the investigation is closed, either for insufficiency of evidence, or because the case has been accepted for prosecution. This basically measures how long it takes the Medical Board's Enforcement Program to complete investigations. The Board's table at page 99 of the Sunset Report shows significant improvement in this measurement. Information has been requested from the Executive Director of the Board so that we can further analyze these statistics. We note that with respect to the date for "case accepted for prosecution," there have been differences in how the Board tracks transmittals. In the past year, however, there has been much progress in this area. The Board's District Offices have been cooperating with Lead Prosecutors and Supervising Deputy Attorneys General in reconciling the date of closure or transmittal of a case.[12]

Further, the Medical Board and the AG's Office are striving to become more closely aligned in the measurement of significant events. For example, the AG's Office has measured the aging of investigations from the date the investigation is stamped received at the first District Office which receives the complaint. However, as reflected in the Sunset Report at page 99, the Medical Board measures aging from the date an investigation is assigned to an investigator. Given that the Manual now requires immediate assignment to an investigator and notice to the LP within 24 hours on all urgent cases and ten days from receipt at the District Office of all other cases, we look forward to further improvements in this measurement. We welcomed the institution in July of 2009 of the "Aged Case Council" where Enforcement Program staff examines investigations which are not meeting the goal of completing investigations in 180 days as set forth in Business and Professions Code section 2319. Pursuant to the Board's request,

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(...continued)
common law relative to the protection of the public interest. (*D'Amico v. Board of Medical Examiners et al.* (1974) 11 Cal.3d 1, 11.) The AG has independent responsibilities to uniformly and adequately enforce the law.

[10] *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853 [standard of proof to be applied at the administrative level is clear and convincing proof to a reasonable certainty.]

[11] See the October 4, 2010, Attorney General Report to the Board, p. 17 (Section 12, Attachment R to the Board's 2012 Sunset Review Report, p. 54).

[12] The date is determined by the date the Primary DAG (or Lead Prosecutor) signs the Report of Investigation, indicating closure or acceptance for prosecution.

Enforcement Program staff and HQE management meet on a quarterly basis to discuss improving case investigations and other issues. Added to these efforts are the monthly and quarterly case data productions by HQE and the AG's Case Management Section ("CMS") reporting on topics such as unfiled cases and the aging of administrative matters.

Another key statistical measure is the average number of days from the date the case is accepted by HQE for prosecution to the date the accusation is sent to the Medical Board for filing—measuring how long statewide it takes HQE to prepare proposed accusations. This timeframe is wholly under the AG's authority. The sooner a pleading is filed—and posted on the Board's website—the sooner the consuming public is on notice that action is being taken against a physician. Due to our involvement in the investigation, assigned trial deputies in charge of drafting the Accusation are more familiar with the case, allowing for some efficiencies in the filing of complex cases. Our standard continues to be to send pleadings to the Executive Director within thirty calendar days (or twenty working days) from the date an investigation is accepted for prosecution. The below graph reflects overall improvement in this regard.

Average Number of Days from "Accepted for Prosecution" to "Pleading Sent"
Accusations and Accusations/Petitions to Revoke Probation Combined

Calendar Year	2005	2006	2007	2008	2009	2010	2011	2012
Statewide	71.54	76.51	55.47	57.5	52.45	54	46.18	48.47

The above chart reflects that since implementation of the VE program, HQE has reduced its overall average filing time from 71.54 to 48.47. This represents a 32% reduction in filing time attributable to the VE program.[13] For the 2012 statistics, the median to file an accusation is 39 days.

Finally, the most significant statistical measure is disciplinary outcomes. Any assessment of the state of physician discipline in California necessarily requires an examination of disciplinary outcomes. Under the Medical Practice Act, disciplinary outcomes range from the most severe – outright revocation or surrender of licensure – to revocation stayed with a period of probation – and finally to the lowest level of post-accusation discipline, a public reprimand with or without educational courses. The first set of two tables below shows disciplinary outcomes Statewide with and without public reprimands included.

[13] The methodology utilized for this second key statistical measure is as follows: Using the "Opened" date in ProLaw for each year, the average number of days was calculated from the date the case was "Accepted for Prosecution" to the date "Pleading Sent" to the Medical Board for filing. Administrative cases that were initially "Accepted for Prosecution," only to be reviewed and returned to the Medical Board District Office for additional investigation, have been calculated separately deleting the time period of investigation. The cases reflected in the chart include out-of-state discipline cases. Calculations were done using matters that had been resolved.

Disciplinary Outcomes
Statewide

[The figures below calculate serious discipline as PLR, Probation and Revocation.]

Filed Accusations and Acc/PRP Only
(OSD discipline included)

	PLR	Prob	Rev/Sur r	Total SD	With	Dism	Total Cases	%
2009- 2010	51	95	82	**228**	12	7	**247**	**92.3**
2010-2011	57	87	65	**209**	13	7	**229**	**91.2**
2011-2012	52	111	94	**257**	9	6	**272**	**94.4**

[The figures below calculate serious discipline as Probation and Revocation]

Filed Accusations and Acc/PRP Only
(OSD discipline included)

	PLR	Prob	Rev/Sur	Total SD	With	Dism	Total Cases	%
2009- 2010	51	95	82	**177**	12	7	**247**	**71.6**
2010-2011	57	87	65	**152**	13	7	**229**	**66.3**
2011-2012	52	111	94	**205**	9	6	**272**	**75.3**

The following tables show the pattern of obtaining serious discipline by HQE office. The out-of-state discipline (OSD) cases, performed in San Francisco, are noted, as well.[14]

[14] AG statistics were previously supplied in calendar year format because VE was rolled out at the beginning of calendar year 2006. At the request of the Board, calculations are now being based on fiscal year numbers, as well as accounting administrative cases based on the fiscal year in which the decision and order was signed (not the effective date). Upon receipt of the Board's statistics we expect to revise our statistics, if necessary.

2009 – 2010

	PLR	Rev	Prob	With	Dism	Total SD	Total Cases	%
Los Angeles	7	18	26	2	2	44	55	80.0
Sacramento	10	4	11	2	1	15	28	53.5
San Diego	13	15	27	4	4	42	63	66.6
San Francisco	21	45	31	4	0	76	101	75.2
ALL	51	82	95	12	7	177	247	71.6
OSD	7	34	13	0	0	47	54	87.0
w/o OSD	44	48	82	12	7	130	193	67.3

2010 – 2011

	PLR	Rev	Prob	With	Dism	Total SD	Total Cases	%
Los Angeles	13	16	34	1	2	50	66	75.7
Sacramento	5	1	11	0	1	12	18	66.6
San Diego	13	14	21	5	4	35	57	61.4
San Francisco	26	34	21	7	0	55	88	62.5
ALL	57	65	87	13	7	152	229	66.3
OSD	15	23	7	6	0	30	51	58.8
w/o OSD	42	42	80	7	7	122	178	68.5

2011 – 2012

	PLR	Rev	Prob	With	Dism	Total SD	Total Cases	%
Los Angeles	13	25	46	1	0	71	85	83.5
Sacramento	5	6	12	4	0	18	27	66.6
San Diego	10	21	29	2	4	50	66	75.7
San Francisco	24	42	24	2	2	66	94	70.2
ALL	52	94	111	9	6	205	272	75.3
OSD	13	26	7	1	1	33	48	68.75
w/o OSD	39	68	104	8	5	172	224	76.78

Significantly, the above three tables[15] demonstrate that during the past three years, imposition of serious disciplinary action[16] in cases handled by HQE–Los Angeles, where over 25% of the physicians in California practice and where attorneys presently have greater involvement during the investigation stage, has been consistently, significantly higher—averaging 13 percentage points more—than the Northern California offices cited by the Board's report as less hands-on during the investigation phase. When out-of-state discipline cases are taken out of the mix[17]—they are not subject to VE/P—the average jumps to 17 points. Even the Board's numbers are similarly reflective. A cursory review[18] of the Board's table in Section 5 on page 97 of the Sunset Review Report discloses that the Los Angeles office had, on average, 8% more serious discipline over the seven years recorded, with 17% more serious discipline in three of the years. This table also demonstrates that between the 2006 inauguration of VE/P and 2012, the overall level of serious discipline has increased by 17 percentage points.[19]

The statistics substantiate the premise underlying VE/P, namely, that greater attorney involvement under the VE/P program translates into greater public protection.[20] The higher level

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[15] The column headings on the chart denote, in order from the left, public reprimands; revocations; probation orders greater than one year; withdrawals of accusations; dismissals of accusations after hearing; total serious discipline (adding the "Rev" and "Prob" columns); total number of cases (adding the PLR, Rev and Prob columns); and percentage of total cases in which serious discipline was obtained (Total SD/Total Cases). "OSD" refers to out-of-state discipline cases almost exclusively handled through HQE-San Francisco; such cases are not subject to vertical enforcement since they are never sent to a Medical Board District Office for investigation.

[16] Public reprimands obtained pursuant to Business and Professions Code section 2227 should be excluded from the definition of serious discipline because the same disciplinary outcome can be obtained, where the physician is willing, without the filing of an accusation and the subsequent prosecution by the Attorney General's office. Specifically, Business and Professions Code section 2233 authorizes the Board to issue a public letter of reprimand after a case has been investigated rather than filing or prosecuting a formal accusation. Use of this method of discipline is limited by section 2233 to minor violations.

[17] The last annual report to the Legislature filed by the MBC pursuant to Government Code section 12529.7 in March 2012 restated a recommendation that the MBC be given authority to handle all out-of-state discipline cases (p. 19, citing Recommendation No. 5 of the August 2010 report).

[18] Only a cursory review is possible since the Board has not yet provided the underlying data to our office as requested in our December 3, 2012, letter at page 2, ¶ 1.

[19] The table at the bottom of the same page in the Sunset Review Report, which purports to reflect the percentage of outcomes which resulted in the loss of the physician's license, is unquestionably inapposite since it discounts almost half the vertical enforcement cases prosecuted and presumably includes out-of-state discipline cases which are not the subject of vertical enforcement. Where the issue is the efficacy of the vertical enforcement model, these exclusions and inclusions make little sense.

[20] The methodology utilized to calculate serious discipline is as follows: "Serious discipline" is defined as: (1) outright revocation of licensure; (2) surrender of licensure; and (3) revocation of licensure, stayed, with a period of probation of at least one year. Using the "Opened" date in ProLaw for each calendar year, "serious discipline" was calculated using the above definition. In calculating each outcome, cases that were "declined to prosecute" and cases that did not reach an administrative outcome (i.e., Accusations filed but waiting administrative hearing) were

(continued...)

of serious discipline and the resulting public protection achieved through providing appropriate direction during investigations, including participating in interviews of the subject physician, should be the norm. The Attorney General's Office is taking steps to ensure consistent implementation of the VE/P process throughout the state.

The Board's Enforcement Program states in several places in its Report that the necessity of interaction between its investigators and deputy attorneys general leads to frustration --mainly in scheduling physician interviews;[21] lessened job satisfaction; and is a matter cited in the exit interviews of departing investigators. These circumstances might in part be addressed at the hiring stage when the nature of the job is described to potential hires and during the training phase, when new investigators attend the academy and thereafter work with their field training officers. There is no doubt about the nature of the job; it can be difficult. Nonetheless, it is the procedure established by the legislature after careful deliberation and input from all stakeholders. Further, the Vertical Enforcement and Prosecution Manual which defines the interactions between the investigators and the deputy attorneys general reflects both the statutory mandate that the HQE section direct the investigations and the collaboration between HQE and the Enforcement Program in establishing the procedures under which that that direction and the consequent investigation take place. The Attorney General's office remains receptive to proposals that may enhance the efficiency of the investigation process but which nonetheless remain true to the intent of the legislature found in Government Code section 12529.6 that "using a vertical enforcement and prosecution model . . . is in the best interests of the people of California."

In conclusion, implementation of the VE/P program has resulted in overall improvements in the key statistical measures that provide the most accurate picture of the state of physician discipline in California, including disciplinary outcomes.

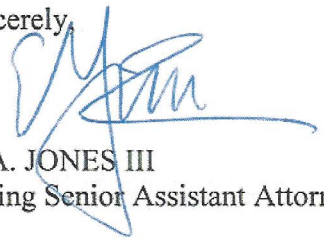
While the VE/P program continues to represent a vast improvement over the prior "Deputy-In-The-District-Office" Program, there is still nevertheless room for further improvement. We look forward to receiving and reviewing the Enforcement Program's detailed study of VE/P (the Sunset Review Report Supplemental 2013) and the supporting data.

(...continued)
omitted from the calculations. Out-of-state discipline cases were included in the calculations and their outcome separately listed on the bottom two rows. Inclusion of those cases, which are never investigated in the district office, tends to inflate the success rate.

[21] Attendance at witness interviews has never before been raised as an issue for discussion with HQE management. A review of cases reflects that, except in the instance of a sexual abuse complainant, a directive by our former Senior Assistant in April of 2010 has been followed by AG staff. Namely, DAG attendance at witness interviews requires SDAG approval and is granted on a case-by-case basis. We are open to a discussion of witness interviews generally so that AG directions regarding interviewing necessary witnesses are followed more uniformly.

We will thereafter explore further measures to improve the VE/P program in order to afford better protection to the consuming public.

Sincerely,



E. A. JONES III
Acting Senior Assistant Attorney General

For KAMALA D. HARRIS
Attorney General

EAJ:ml

cc: Kathleen Kenealy
Chief Assistant Attorney General
Civil Law Division
Los Angeles

Linda H. Whitney
Executive Director
Medical Board of California
Sacramento

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December 3, 2012

Linda K. Whitney
Executive Director of the Medical Board
2005 Evergreen Street, Suite 1200
Sacramento, CA 9581

RE: Sunset Review Report Statistics

Dear Linda:

Thank you for the copy of the Medical Board Sunset Review Report 2012, Volume I that you sent me. As I stated in my report at the October 26, 2012, Medical Board meeting, I do not agree with some of the statements and conclusions stated in Section 5 of the report. As I further stated in my report, I reserved my comments on this section until I can confirm that the statistics used in this report coincide with the statistics for Medical Board cases maintained at the Attorney General's Office.

As you know, the Health Quality Enforcement (HQE) Section maintains its data base and sorts its statistical reports by physician names, by calendar year and uses specific initiating and terminating events for aging determinations. In contrast, the Medical Board maintains a data base by fiscal year containing the physician's names as well as the investigation case numbers or a primary consolidated number in the case of multiple investigations being filed in one accusation. The Medical Board uses a different set of events for aging determinations, and in some cases, includes other types of administrative matters, such as out-of-state discipline cases, in its statistical measurements. These differences in data tabulation have led to two different sets of statistics each pointing to different conclusions regarding the success of the Vertical Enforcement Program. Further, the differing conclusions make it difficult to agree on recommendations that will improve the program. Fortunately, the Board has already produced its conclusions, and the raw data being requested here already exists, and will not result in your staff having to compile any new data.

In preparing my comments on the Board's Sunset Review Report, I want to make sure that in compiling our respective statistical data, the HQE Section and the Medical Board are comparing "apples to apples" and using the same cases, and the same time periods. I am also mindful of the repeated admonishment recently by Medical Board members that HQE and MBC statistics data should correspond with one another. We have endeavored over the past year to

reconcile more of our data on a monthly and quarterly basis, especially to agree upon the dates that administrative cases are considered transmitted to our office—an area of especially different data in the past between our offices. I recognize that reconciling both sets of data can be a time consuming process. Nonetheless, I believe that undertaking this process is essential to producing statistical data that is accurate and useful to our respective offices as well as to the legislature and other stake holders.

To start this process, however, we need your staff's assistance. I would appreciate receiving a copy of the statistics or data referenced in the following pages of your Sunset Review Report. We are referencing the page number of the report, and for most of these data requests we would need the data provided to be alphabetized by physician last names and to include the MBC case number or, in the case of multiple investigations, the primary consolidated case number. We also make some requests for methodology, and start and end point data markers.

1. At page 97, the list of all case names used to calculate the percentages in the two tables ["Percentage of Results in Serious Discipline" and "Percentage of Revocations/Surrenders"]. Please provide us with the case names and MBC numbers sorted by city, and by year as reflected in the chart.

2. At page 99, the data markers used to calculate the start and end points of the "average days to complete investigation in field operations." We would like to calculate our data consistent with MBC's markers, where feasible. Please provide us with the alphabetized physician names and include the MBC case numbers sorted by fiscal year as reflected in the chart.

3. At page 102 (Table 9a), the list of the 853 cases listed in columns "Accusations filed" for years 09-10 through 11-12. Please provide us with the alphabetized physician names and include the MBC case numbers sorted by fiscal year as reflected in the chart.

4. At page 102 (Table 9a), the list of 105 the cases listed in the columns "Accusations Withdrawn, Dismissed, Declined" for years 09-10 through 11-12. Please provide us with the alphabetized physician names and include the MBC case numbers sorted by category (withdrawn, dismissed declined) and fiscal year as reflected in the chart

5. At page 102 (Table 9a), the list of the 484 cases listed in columns "pending- No Accusation filed" for years 09-10 through 11-12. Please provide us with the alphabetized physician names and include the MBC case numbers sorted by fiscal year as reflected in the chart

6. At page 102 (Table 9a), the list of the 1,085 cases listed in columns "pending - Accusations filed" for years 09-10 through 11-12. Please provide us with the alphabetized physician names and include the MBC case numbers sorted by fiscal year as reflected in the chart. Please provide information on the how the category "pending – Accusations filed" in this

column is defined and how it differs with the data reflected in the row marked "Accusations filed" at the top of Table 9a.

7. At page 102 (Table 9b), the data markers used to calculate the start and end points of the "average days to complete." We would like to calculate our data consistent with your markers, where feasible.

8. At page 102 (Table 9b), for the term "AG Cases Initiated" and "AG Cases Pending" please advise us what types of administrative cases are being considered in each of these groupings (e.g., out of state discipline). Please provide us with the alphabetized physician names and include the MBC case numbers sorted by fiscal year as reflected in the chart.

9. At page 102 (Table 9b), for the disciplinary outcomes listed, we request a list of the cases counted in columns "Revocation" through "Probation" for years 09-10 through 11-12. Please provide us with the alphabetized physician names and include the MBC case numbers sorted by category (revocation through probation) and fiscal year as reflected in the chart.

10. At page 102 (Table 9b), the list of the 344 cases listed in columns "Public Reprimand" for years 09-10 through 11-12. Please provide information regarding whether this column includes both pre-accusation and post-accusation PLR outcomes. Please provide us with the alphabetized physician names and include the MBC case numbers sorted by fiscal year as reflected in the chart

11. At page 103 (Table 9b), the list of the 93 cases listed in columns "Petition to Revoke Probation Filed" for years 09-10 through 11-12. Please provide us with the alphabetized physician names and include the MBC case numbers sorted by fiscal year as reflected in the chart.

12. At page 103 (Table 9c), "Average Days to Close" is used in this table under "all investigations." Please provide the data markers used to calculate the average. Specifically, advise us whether the start point is the date a complaint is "referred to investigation" or the date a complaint is "assigned to an investigator" as these terms are used by your office. Please provide us with the alphabetized physician names and include the MBC case numbers sorted by fiscal year as reflected in the chart for the rows marked "first assigned," "closed" and "pending."

13. At page 103 (Table 9c), "Average Days to Close" is used in this table under "sworn investigations." Please provide the data markers used to calculate the average. Please provide us with the alphabetized physician names and include the MBC case numbers sorted by fiscal year as reflected in the chart for the rows marked "closed" and "pending." We have not requested the data listed under "non-sworn investigations" and "desk investigations" on the assumption that these are cases that were not subject to Vertical Enforcement. If this assumption is incorrect, then please provide information for those two categories as well.

14. At page 104 (Table 9c), the list of cases listed in the category "ISO & TRO issued" for years 09-10 through 11-12. Please provide us with the alphabetized physician names and include the MBC case numbers sorted by fiscal year as reflected in the chart.

15. At page 104 (Table 9c), the list of cases listed in the category "PC 23 Orders Requested" for years 09-10 through 11-12. Please provide us with the alphabetized physician names and include the MBC case numbers sorted by fiscal year as reflected in the chart.

16. At page 104 (Table 9c), the list of cases listed in column "Other Suspension Orders" for years 09-10 through 11-12. Please provide the types of administrative cases being included and analyzed in this category. For example, are automatic suspension orders included in this category? Please provide us with the alphabetized physician names and include the MBC case numbers sorted by fiscal year as reflected in the chart.

17. At page 104 (Table 9c), the list of cases listed in columns "public letter of reprimand" for years 09-10 through 11-12. Please provide information regarding whether this column includes both pre-accusation and post-accusation PLR outcomes. Please provide us with the alphabetized physician names and include the MBC case numbers sorted by fiscal year as reflected in the chart.

18. At page 104 (Table 9c), the list of cases listed in columns "compel examination granted" for years 09-10 through 11-12. Please provide us with the alphabetized physician names and include the MBC case numbers sorted by fiscal year as reflected in the chart.

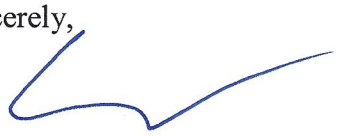
19. At page 104 (Table 10), please provide the data supporting the numbers appearing under the columns 08/09 through 11/12 for the headings "1 year" through "4 years" under Attorney General Cases. Please provide information on how the averages were calculated, and the general methodology being applied to this table. Please provide us with the alphabetized physician names and include the MBC case numbers sorted by fiscal year as reflected in the chart.

20. At page 104 (Table 10), please provide the case names supporting each number under columns 08/09 through 11/12 for the headings "90 days" through "over 3 years" under Investigations. Please provide information on how the averages were calculated, and the general methodology being applied to this table. Please provide us with the alphabetized physician names and include the MBC case numbers sorted by fiscal year as reflected in the chart.

21. At page 105, please provide the case names supporting each number under columns 06/07 through 11/12 for every heading in the table "Increases or Decreases in Disciplinary Action." Please provide us with the alphabetized physician names and include the MBC case numbers sorted by fiscal year as reflected in the chart.

Thank you for your anticipated cooperation in this matter. This data is essential to the HQE Section and the Attorney General's office evaluation of section 5 of the Board's Sunset Report and the Vertical Enforcement Program. Do not hesitate contact me if you have any questions regarding this matter.

Sincerely,



CARLOS RAMIREZ
Senior Assistant Attorney General
Health Quality Enforcement Section

For KAMALA D. HARRIS
Attorney General

CR:

cc: Gloria Castro
Supervising Deputy Attorney General
Health Quality Enforcement Section

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	January 15, 2013
ATTENTION:	Board Members
SUBJECT:	Supplemental Sunset Review Report
STAFF CONTACT:	Letitia Robinson, Research Specialist Kimberly Kirchmeyer, Deputy Director

RECOMMENDED ACTION:

Review the attached Supplemental Sunset Review Report, provide any additional items that need to be discussed and included, and identify a two (2) person subcommittee to work with the Executive Director to finalize the report to provide to the Business, Professions, and Economic Development (B&P) Committee in March 2013. Possibly appoint additional two person subcommittee to meet with staff and review the Vertical Enforcement/Prosecution Model (VE/P) data

BACKGROUND AND ANALYSIS:

Attached is the first draft of the Board's Supplemental Sunset Review Report. The purpose of the Supplemental Sunset Review Report is to provide pertinent information that was not covered in the initial report. This report also provides updates on some of the items that were in the original report, as topics were not fully addressed in the initial report, including some that need to be reviewed for possible future legislation.

The largest portion of the report contains extensive data on the VE/P. At the time of this memo, the Board the Board is still in the process of gathering and analyzing all the information on the AG billing hours, thus has not completed its full analysis of the VE/P. Therefore, Board staff will continue to gather and analyze this data over the next month in order finalize the report.

The Members need to review the attached document and determine if there are any other items that should be discussed and included as part of the Supplemental Sunset Review Report. Additionally, because this report is still in draft form and must be submitted to the B&P Committee prior to the next Board meeting, and because further statistics must be gathered and analyzed, the Board should establish one (or two) two person subcommittees to work with Board staff to finalize the supplemental report.

A report to Senate Business, Professions and Economic Development Committee

MEDICAL BOARD OF CALIFORNIA

SUNSET REVIEW REPORT

SUPPLEMENTAL 2013

FIRST DRAFT

Edmund G. Brown Jr., Governor
Sharon L. Levine, M.D., President, Medical Board of California
Linda K. Whitney, Executive Director, Medical Board of California

FIRST DRAFT

STATE OF CALIFORNIA

EDMUND G. BROWN JR., GOVERNOR
ANNA M. CABALLERO, SECRETARY, STATE AND CONSUMER SERVICES AGENCY
DENISE D. BROWN, DIRECTOR, DEPARTMENT OF CONSUMER AFFAIRS

MEDICAL BOARD OF CALIFORNIA

SHARON L. LEVINE, M.D., PRESIDENT
LINDA K. WHITNEY, EXECUTIVE DIRECTOR
KIMBERLY KIRCHMEYER, DEPUTY EXECUTIVE DIRECTOR

Additional copies of this report can be obtained from: www.mbc.ca.gov

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Introduction

Introduction

- General Information
- Licensing Information
- Enforcement Information

FIRST DRAFT

Introduction

The purpose of this Supplemental Sunset Report is to provide pertinent information that was not covered in the initial report. This report also includes additional information on topics not fully addressed in the initial report because they were either new or evolving. It also includes the evaluation of the Vertical Enforcement/Prosecution model (VE/P) of investigating and prosecuting cases. References will be made to the initial report where applicable. The initial report is available on the Board's Web site in the "Forms/Publication" section: http://www.mbc.ca.gov/publications/sunset_report_2012.pdf.

This report is divided into three sections: General Information, Licensing Program, and Enforcement Program. In the General Information section, the Board provides an update on its progress in implementing the new Department of Consumer Affairs (DCA) BreEZe computer system. Information on the Board's recruitment to fill behind its retired annuitant positions is also included. Lastly, this section includes information on the Medical and Pharmacy Boards' Joint Forum to Promote Appropriate Prescribing and Dispensing held on February 21 and 22, 2013 in South San Francisco. This Forum provided education to both physicians and pharmacists on solutions to prevent prescription drug abuse.

The Licensing Program Section contains an update on the applicant satisfaction survey and the Board's Outpatient Surgery Setting Accreditation Program. The information provided in the original report did not contain a significant number of responses from the applicants, as the Board had just implemented the satisfaction survey. Therefore, the Board is providing additional information in that section. The Board is also providing an update on a section of law, Business and Professions Code section 2135.7, that became effective on January 1, 2013. This section of law allows applicants who have graduated from an unrecognized or disapproved school to apply to the Board if they meet other requirements. Although the Board has not received a large number of applications, the information on those that have been received is provided.

The Board was notified that nine States have pilot programs to begin the process of Maintenance of Licensure (MOL). This supplemental report provides information on these programs. The Board plans to evaluate the outcomes from these pilot programs prior to taking any action in regards to MOL.

Since the initial report, the Board received information regarding changes to postgraduate training programs. This information indicated the Accreditation Council Graduate for Medical Education (ACGME) and the Royal College of Physicians and Surgeons of Canada are beginning to accredit training programs outside of the United States and Canada. Information was also obtained that ACGME has begun to accredit postgraduate training programs in hospitals that are accredited by the American Osteopathic Association-Healthcare Facilities Accreditation Program (AOA-HFAP). All of these new postgraduate training options, if the Board chooses to accept applicants from these programs for licensure, would need either legislative or regulatory changes. The Board will be evaluating these programs and its laws and regulations to determine how to address these programs.

In the new issues section of the Midwifery Program's initial Sunset Review Report, three issues were identified. Since this original report, the Board's Midwifery Advisory Council (MAC) identified another issue for the Midwifery Program. This issue relates to Certified Nurse-Midwives supervising

FIRST DRAFT

midwifery students. This issue and any others approved by the Board at its February 1, 2013 meeting is more fully explained in this supplemental report.

The Enforcement Program Section covers three topics, including an update on the Expert Reviewer Training, information on how the Board is implementing the Consumer Protection Enforcement Initiative (CPEI) positions, and an evaluation of the Board's VE/P. At the time of the initial report, the Board had only completed one expert reviewer training, in Northern California. This report provides an update on the training that was provided in Southern California.

To provide the Committee with further information on the Board's positions and its efforts to find ways to improve the enforcement timeframes, this supplemental report includes information on how the Board plans to use the CPEI positions. These positions will help the Board in reducing the time it takes to investigate a complaint and take disciplinary action against a physician.

In the last report, the Board stated that a full evaluation of the statistics on the VE/P would be provided in a supplemental report. The Enforcement Program Section includes a review, evaluation, and analysis of the data on the VE/P. This data includes statistics on the time it takes to investigate a complaint, to file an accusation, and to receive disciplinary documents. The Board has analyzed this data and is providing its recommended action in this supplemental report.

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Section 1

General Information

- BreEZe
- Retired Annuitants
- Medical and Pharmacy Boards' Joint Forum to Promote Appropriate Prescribing and Dispensing

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General Information

BreEZe

The BreEZe information was provided in Section 9 - Current Issues of the original Sunset Review Report. The initial report discussed the Board's efforts on implementing the Department of Consumer Affairs' (DCA) new computer system known as BreEZe. The Board continues to spend a significant amount of hours participating in the efforts to launch the new system.

Board staff is now in the testing, training, and data validation phases of the project. A substantial amount of hours have been spent on performing test scripts. These test scripts are used to confirm the functionality of each portion of the system and provide feedback on any improvements and/or enhancements that may be necessary.

Additionally, staff have been reviewing the data that has been converted into the BreEZe system from the legacy systems to ensure the data from the older system is being placed in the correct areas and that it is all being converted to the new system. This ensures that no data is lost in the conversion.

In January 2013, Board staff began training on the BreEZe system, which is expected to be released for the Board to use in Spring 2013. Each staff member has been scheduled to receive at least 4 hours of training, however, most staff require 16-40 hours of training, based upon job duties. The training will cover the system's functionality, fields, and terminology associated with the BreEZe system. A significant amount of staff will receive additional specialized training in their areas of expertise.

The Board has six staff who are trainers not only for the Board staff but also for other staff at the DCA. These staff had to attend four weeks of Train the Trainer sessions in order to be familiar with the system and to understand their role as a trainer.

The Board expects to spend in excess of 6,000 hours on its efforts to help develop the BreEZe system and over 3,000 hours training Board staff. This is a significant workload issue but managers have maintained staff's enthusiasm for the system while ensuring the workload is getting done with minimal overtime.

Retired Annuitants

In June, 2012 the Board was notified that due to side letter agreements with the unions that all mission critical retired annuitants would be terminated on August 31, 2012. In lieu of retired annuitants, the Board was encouraged to hire seasonal or permanent intermittent (temporary) employees. At the time of notification, the Board had 50 retired annuitants working for the Board. The Board identified 19 retired annuitants that it deemed did not meet the mission critical definition and could be easily replaced with temporary employees and were therefore terminated in June 2012. The Board requested 31 retired annuitants be able to remain with the Board as they were mission critical. Of those 31 retired annuitants, the Board was authorized to keep 20 retired annuitants and had to separate 11 that were not deemed mission critical. However, only two (2) of the remaining 20 retired annuitants can remain with the Board after June 20, 2013. All others (18) must be separated by June 30, 2013. The Board was allowed to keep these retired annuitants either to finish a special project or to provide assistance during the time the Board went through the process to hire the temporary staff.

FIRST DRAFT

The Board has advertised for several seasonal and permanent intermittent employees and is in the process of interviewing and hiring these individuals. The Board is recruiting permanent intermittent Office Technicians (OT) to replace the retired annuitants in the district offices. These OTs are used to perform the clerical duties in the offices. The Board will begin recruiting permanent intermittent Special Investigators to replace those currently performing background investigations. Although the Board does not know if there are individuals interested in a part-time Special Investigator position, it will go through the recruitment process. The Board is also recruiting for Staff Services Analysts in the Licensing Program to replace the retired annuitants who process licensing applications. The Board will continue to seek these temporary employees to replace the retired annuitants.

Medical and Pharmacy Boards' Joint Forum to Promote Appropriate Prescribing and Dispensing

As stated in the Board's Sunset Review Report, prescription drug abuse and the resulting deaths are something the Board recognizes as an issue that must be given the utmost priority. As a consumer protection agency, the Board wants to address those individuals that prescribe inappropriately and to provide education to its licensees and the public in an effort to prevent prescription drug abuse. To that end, the Board, in collaboration with the Pharmacy Board, held a "Joint Forum to Promote Appropriate Prescribing and Dispensing" for all interested parties on February 21-22, 2013.

The Forum focused on 1) the problem, including inappropriate prescribing, inappropriate security of drugs, etc; 2) the responsible parties, including prescribers, dispensers, patients, and regulators/law enforcement; and 3) the solutions, including education, enforcement, and necessary tools (CURES). The Forum's keynote speaker from the White House Office of National Drug Control Policy discussed the global issues of prescription drug abuse and the roles of the Federal and State Governments. The Drug Enforcement Administration speaker discussed the nature of prescription drug abuse and what the State should be doing to respond. Other speakers and panelists provided a physician's, a pharmacist's, and a prosecutor's perspective to the issue of prescription drug abuse. The Forum provided a discussion on how education and cooperation between physicians and pharmacists can address the problem and what to do when a patient is addicted to prescription drugs.

A presentation was made on the CURES system (California's prescription drug monitoring program) and its significance in battling prescription drug abuse and inappropriate prescribing, as well as an update on its current status. A panel discussion was held on the problems and issues with prosecuting inappropriate prescribing and dispensing cases and areas where more collaboration is needed.

Lastly, the forum looked to the future and identified steps that must be taken in order to make the prevention of prescription drug abuse a reality. The Medical and Pharmacy Boards requested licensees, legislators, regulators, and law enforcement to come together to find ways to significantly impact this problem in an effort to save thousands of lives in the future.

Both the Medical and Pharmacy Board provided free continuing education credits to those licensees in attendance. The Forum was free to all in attendance and was held in the San Francisco Bay Area. A video of the Forum is on the Board's Web site for individuals to view for reference and education. The Board believes that the Forum was a step toward preventing prescription drug abuse and furthering its mission of consumer protection.

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Since the date of the forum was immediately prior to the release of this Supplemental Sunset Report, a summary of the forum recommendations will be produced in a separate standalone report.

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Section 2

Licensing Program

- Applicant Satisfaction Survey
- Outpatient Surgery Setting Accreditation Program
- International Medical Graduates (B&P Code section 2135.7)
- Maintenance of Licensure
- International Postgraduate Training Accreditation
- Allopathic and Osteopathic Postgraduate Training Programs
- Midwifery Program

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Licensing Program

Applicant Satisfaction Survey

In Section 2 – Performance Measures and Customer Satisfaction Surveys of the Sunset Review Report information was provided on the Board's new Applicant Satisfaction Survey. This report included each question with responses and measurement of satisfaction. The Board has continued to collect data from this survey, which has assisted in creating new and efficient ways to enhance its services to applicants.

The Applicant Satisfaction Survey's previous report contained responses from only 77 applicants between the timeframe of August 22 and October 5, 2012. The Survey's current report includes a total of 242 applicant responses. Since the Survey's inception in August the Board's database of applicant feedback has more than tripled. These additional responses provide the Board a clearer picture of the applicant's experience with the application process.

The 242 responses show the Board is maintaining applicant satisfaction as stated in the initial report. 91% of applicants responded that the Board's instructions clearly state how to complete the application. 86% stated that the Board's Web site clearly indicates the requirements and how to apply for licensure. Among the applicants who visited the Board's Web site with questions concerning their application, 76% indicated that the Web site was comprehensive and informative. In October 2012, the Board released a new, updated version of the physician's and surgeon's license application. This version implemented changes to address common applicant concerns. In the future the Board will continue to assess applicant concerns in order to better serve the applicant population.

In the responses collected since the Board's initial report, applicant satisfaction has remained the same. The data shows only minor fluctuation of one to three percent in response to the questions. 68% of applicants were either very satisfied or somewhat satisfied with the Web Applicant Access System used to track their application progress online. Further, 71% of applicants were either very satisfied or somewhat satisfied with the time it took the Board to process their application. Responses to other questions reveal only minor changes since the initial report.

The Board must ensure that it continues to provide the same level of service identified in the surveys once it begins using the new BreEZe system.

Outpatient Surgery Setting Accreditation Program

In Section 4 – Licensing Program of the original Sunset Review Report, the Board discussed its Outpatient Surgery Setting Accreditation process and action taken to begin implementation of Senate Bill 100 Price (Statutes 2011, Chapter 645). The Board continues to make progress in implementing this bill. Further, more recent legislation has been passed that aims to improve patient care in outpatient cosmetic surgery centers. Therefore, the Board provides this update on its efforts to implement these bills.

The Board's Licensing Program and Information Systems Branch have been successful in designing the new Outpatient Surgery Settings database. This database is used to store information submitted to the Board from the four, Board-approved, accreditation agencies and is maintained on the Board's Web site. SB 100 amended Health and Safety Code section 1248.2, which now requires the Board to provide the following information on the status of outpatient surgery center settings on its Web site: the name, address, and telephone number of any owners, and their medical license numbers; the

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name and address of the facility; the name and telephone number of the accreditation agency, the effective and expiration dates of the accreditation, and whether an outpatient setting is accredited or the setting's accreditation has been revoked, suspended, or placed on probation, or the setting has received a reprimand by the accreditation agency.

The information contained in the Outpatient Surgery Setting database is received directly from the accreditation agencies as required by law. These agencies are mandated to inform the Board on any new settings that are accredited, as well as, to provide updates on any changes to existing settings. Upon receipt of new and updated information from the agencies, the Board reflects those changes on its database.

Consumers may search for an accredited Outpatient Surgery Setting by setting name or owner name (as available) on the Board's Outpatient Surgery Setting Database. In the future, the online database will include copies of the Final Inspection Reports, which are public documents. The Board's staff will work on developing this for the Board's Web site, after the Board's successful implementation of its new computer system (BreEZe) for Licensing and Enforcement. Currently, the Board provides these documents to consumers upon request.

The Board continues to work directly with the accreditation agencies to ensure compliance with the reporting requirements. Since each accreditation agency uses different data collection and reporting methods, the Board created a standardized reporting form. This form must be used by the accreditation agencies to provide the required information to the Board. At this time, three out of the four accreditation agencies are in compliance. One agency has not provided the newly, required information, including ownership information, expiration dates of accreditation, and complete inspection reports. This agency has not provided the Board with a plan to meet the reporting requirements. The Board is preparing to formally notify the non-compliant agency of the Board's expectations for compliance. Specifically, advising the agency to provide written documentation identifying a specific timeframe, that is acceptable by the Board, to submit the required information. Further, informing the agency that if it fails to response appropriately, the Board may begin the process of seeking revocation of the accreditation.

Changes to Health and Safety Code Section 1248 now require the Board to investigate complaints related to a violation of the law or, upon discovery that an outpatient setting is not in compliance with a specific provision. This section also requires the Board to bring an appropriate action through or in conjunction with a district attorney to enjoin an outpatient setting's operation. The Board has developed procedures to handle complaints regarding outpatient surgery centers.

SB 100 made outpatient settings subject to the adverse event reporting requirements currently required for licensing health facilities. Adverse events are reported to the California Department of Public Health (CDPH) and the setting can be subject to penalties by CDPH for failing to report adverse events. If the adverse event report/complaint is not within the jurisdiction of CDPH, CDPH should forward the adverse event report/complaint to the Board in order for the Board to determine if the report of adverse events is within the jurisdiction of the Board. The Board has been in contact with CDPH requesting it to forward any adverse event reports/complaints that it receives that are not within the jurisdiction of CDPH to the Board. The Board is fully prepared to take appropriate action if and when an adverse report/complaint is received from CDPH. As of January 16, 2013, the Board has not received any reports/complaints from CDPH.

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One of the provisions of SB 100 requires the Board to adopt regulations on or before January 1, 2013 on the issue of physician availability, specifically regarding the appropriate level of physician availability needed within clinics or other settings using laser or intense pulse light devices for elective cosmetic procedures. The regulations do not apply to FDA approved devices sold over the counter for self-use. On October 26, 2012, the Board held a regulatory hearing and approved the following regulatory language:

"Whenever an elective cosmetic procedure involving the use of a laser or intense pulse light device is performed by a licensed health care provider acting within the scope of his or her license, a physician with relevant training and expertise shall be immediately available to the provider. For the purposes of this section, "immediately available" means contactable by electronic or telephonic means without delay, interruptible, and able to furnish appropriate assistance and direction throughout the performance of the procedure and to inform the patient of provisions for post procedure care. Such provisions shall be contained in the licensed health care provider's standardized procedures or protocols. "

The Board is currently in the process of preparing and submitting the final statement of reason to the Department of Consumer Affairs and then Office of Administrative Law for consideration and approval.

Assembly Bill 1548 (Carter, Chapter 140) prohibits outpatient cosmetic surgery centers from violating the prohibition of the corporate practice of medicine and enhances Business and Professions Code section 2417 with the addition of section 2417.5. Section 2417.5 creates the following penalty for corporations violating the prohibition of the corporate practice of medicine: a public offense punishable by imprisonment for up to five years and/or by a fine not exceeding $50,000. The purpose of the bill was 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 bill also defined "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 Board does not foresee any impact to the program as the bill enhanced existing law by creating additional penalties for violating the corporate practice of medicine prohibition.

International Medical Graduates (B&P Code section 2135.7)

Section 1 – Background of the Board's Sunset Review Report discussed legislation affecting the Board, including SB 122 Price (Statutes 2012, Chapter789). To date, the Board has received two applications pursuant to this new section (B&P Code section 2135.7). Both applications contain deficiencies that need to be resolved prior to processing. Once the applications are complete or as complete as they can be due to facility closures, they will be prepared and presented to the Board's Application Review Committee (ARC).

The Board also received an application in which the applicant does not meet the criteria of B&P Code section 2135.7 at this time. Additionally, one previous applicant had requested an Administrative Hearing. The hearing was held and the final decision was to have the applicant reviewed by the ARC. This application is not complete at this time. Once the application is complete the application will be prepared and presented to the ARC.

At this time, the Board only has only held one ARC, thus it is too early to determine many of the regulations that are needed until more applications are received pursuant to B&P Code section

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2135.7. However, the Board will need regulations, once it has been able to identify some of the issues that may arise to warrant the need for regulations. This will be a continual process as new factors are discovered.

Maintenance of Licensure

In 2004, the Federation of State Medical Board (FSMB), House of Delegates (HOD) adopted a policy statement that *"State medical boards have a responsibility to the public to ensure the ongoing competence of physicians seeking licensure."* After seven years of careful study, which included input and guidance from physicians and health care organizations across the spectrum of medicine, a framework for Maintenance of Licensure (MOL) was formally adopted by the HOD in 2010.

MOL is a process by which licensed physicians periodically provide, as a condition of license renewal, evidence that they are actively participating in a program of continuous professional development that is relevant to their areas of practice, measured against objective data sources, and aimed at improving performance over time. MOL encourages and supports lifelong learning by all physicians and creates a system to confirm their practice improvement efforts.

While MOL still is several years away from being adopted by any state medical board, the FSMB currently is working to develop and implement five pilot projects to help states prepare for MOL and to determine the best practices.

While all 70 state medical boards (representing both allopathic physicians and osteopathic physicians) are aware of FSMB's efforts in regards to MOL, and have, in one manner or another, discussed the framework at their meetings, only 12 state boards expressed any interest in participating in the pilot. When it came time for a final decision, only nine boards were able to commit resources to any one of the five pilots: the Osteopathic Medical Board of California, and the medical boards of Colorado, Delaware, Iowa, Massachusetts, Mississippi, Oregon, Virginia, and Wisconsin.

All nine volunteer boards participated in the *State Readiness Inventory Pilot.* This pilot, administered during October and November, 2012, used an electronic survey designed to facilitate state medical boards' discussion of the best approach to implementation of MOL. The goal is to identify issues state medical boards need to consider and possibly resolve to ensure the successful implementation of MOL. The data collected is currently being collated and reviewed.

There are four other pilots that will be part of the larger MOL process; each is expected to begin sometime during 2013. It is not expected that all nine boards will participate in each pilot nor is expected that any single board will participate in every pilot. Further, while FSMB has extended an invitation to all state medical boards to participate in the MOL process, it is doubtful that any new boards will join. The following describe the four additional pilots:

- *Physician Acceptability Survey to Assess MOL Activities Pilot:* Serves to collect opinions from licensed physicians about the potential features of a comprehensive MOL system.

- *State Board License Renewal Process Integration Pilot:* Focuses on identifying how the proposed MOL system can be integrated into existing license renewal policies and procedures.

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- *Describing the Attributes of Physician Practices in Support of MOL Pilot:* Begins the work that makes MOL "practice relevant". The first phase of the pilot is to develop models for describing individual physician practices that, in turn, will facilitate identification of relevant and meaningful educational and practice improvement activities.

- *Reporting of Maintenance of Certification Data to State Medical Boards Pilot:* Facilitates successful reporting of MOC participation data to state medical boards for their use in evaluating board certified physicians' compliance with MOL program requirements. State medical boards will be asked to evaluate whether the detail and format of the provided data are adequate to enable decisions regarding board certified physician licensees' compliance with MOL requirements.

The Board looks forward to receiving the outcomes from these pilots, anticipated during 2014, and then will undertake its own evaluation of the data provided, before making a decision on how best the Board will move forward with MOL to improve consumer protection.

International Postgraduate Training Accreditation: ACGME and RCPSC

To obtain a California Physician's and Surgeon's License, applicants must have a minimum number of years of satisfactory completion of Accreditation Council Graduate for Medical Education (ACGME) and/or Royal College of Physicians and Surgeons of Canada (RCPSC) accredited postgraduate training in the United States or Canadian.

For the past 30 years, ACGME only evaluated postgraduate training residency and/or fellowship programs in the U.S. The RCPSC previously only evaluated postgraduate training residency programs in Canada. ACGME has announced it will be evaluating postgraduate training in other countries, as ACGME-International (ACGME-I). The RCPSC has created a new division Royal College Canada International (RCCI) and is currently providing postgraduate training consultation services to other countries.

ACGME-I recently completed the first phase of a partnership with the Ministry of Health in Singapore to restructure the GME accreditations system in that country. ACGME-I has already accredited 40 postgraduate training programs in Singapore at the National University of Singapore. In addition, Duke University School of Medicine has opened a new medical school in Singapore in a joint venture with the National University of Singapore. Meanwhile, the ACGME-I has signed contracts in Qatar and Abu Dhabi in the United Arab Emirates and is in negotiation with officials in Oman.

The ACGME-I standards are not identical to the U.S. standards. ACGME-I has incorporated the different delivery systems between U.S. and international countries.
The ACGME-I will continue to expand and accredit postgraduate training programs in other countries with standards similar to the standards in the U.S.

RCCI has recently provided services in the following countries and/or worked with organizations or medical schools/teaching hospitals, within these countries and/or organizations:

- Australia - Royal Australasian College of Physicians and the Royal Australasian College of Surgeons.
- Haiti - RCCI delivered simulation training to health professionals in Haiti to improve front-line care.

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- La Francophonie - At the 2011 annual Conference International Des Doyens De Faculte De Medecine D'Expression Francasie, RCCI presented the CanMEDs frame work and provided an overview of the RCPSC accreditation standards.
- Chile - A RCCI team was recently (2011) invited by the Pontifical Catholic University in Santiago, Chile to review up to eight residency training programs utilizing Canadian standards.
- India - RCCI is exploring opportunities with medical organizations in India to help Indian authorities implement national standards for the evaluation and assessment of postgraduate medical trainees.
- Oman - RCCI has signed an agreement with Oman Medical Specialties Board to develop a lasting educational partnership and RCCI reviewed a number of postgraduate training programs;
- Saudi Arabia - RCCI has signed agreements with the Saudi Commission on Health Specialties and medical education organizations in Saudi Arabia to facilitate the transfer of Canadian expertise and standards in postgraduate medical education to Saudi Arabian educators. Saudi Arabia is looking to implement (with modifications that reflect local needs and realities) enhanced standards in medical education and residency training that draw upon Canadian standards, experience and advice.
- China - RCCI is exchanging knowledge with a number of Chinese organizations involved in medical education and postgraduate medical training. They are exploring how RCCI might offer Canadian expertise and standards in postgraduate medical education.

RCCI runs conferences, short courses and workshops for international medical faculty on all aspects of the CanMEDS competencies and standards. This includes physician evaluation and assessment, curriculum development, examiner and surveyor training, accreditation standards for residency programs and the training of clinician educators.

RCCI also provides conferences, short courses and workshops for practitioners that include online bio-ethics modules for physicians and simulation workshops that equip physicians and health care teams with training in difficult critical care situations. RCCI can deliver workshops using high-fidelity simulation platform or "virtual patient" technology- either onsite or remotely.

RCCI uses Canadian standards to perform operational reviews of international specialty residency programs, providing its partners with an assessment of their strengths and opportunities for improvement. In addition, RCCI offers consulting services covering postgraduate medical education standards, systems and tools as well as continuing professional development standards and programming. RCCI also provides advice on issues involving human resources and health system reform.

Based upon the information available, it appears RCCI may move into the accreditation of postgraduate training residency programs in other countries. The initial programs likely will be in the UK and Australia since the postgraduate training programs in those countries are similar to Canada's. To date, RCCI has not accredited any international postgraduate training programs.

RCCI has already taken the first step of consulting and setting up new international postgraduate training programs to be equivalent to RCPSC accredited postgraduate training programs. It is safe to assume that RCCI accreditation to these new postgraduate training programs will be following in the near future.

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These two new programs are going to be presented to the Licensing Committee at its meeting on January 31, 2013. The Board will review and asses these new programs to determine how to address them when considering postgraduate training.

Allopathic and Osteopathic Postgraduate Training Programs

Currently the Board recognizes Accreditation Council Graduate for Medical Education (ACGME) accredited postgraduate training for the purposes of allopathic medical school students' clinical clerkship training and for the required postgraduate training for licensure as a physician and surgeon. ACGME accredited postgraduate training programs are at hospitals that are accredited by the Joint Commission. Recently ACGME has accredited postgraduate training programs in hospitals that are accredited by the American Osteopathic Association-Healthcare Facilities Accreditation Program (AOA-HFAP). B&P Code section 2089.5 specifically references the "Joint Commission on Accreditation of Hospitals" as the hospital accreditation agency for ACGME postgraduate training programs.

American Osteopathic Association (AOA) accredits postgraduate training for licensure purposes for osteopathic medical school graduates. AOA accredited postgraduate training programs are usually obtained in hospitals that are accredited by the AOA-HFAP.

ACGME and AOA have reached an agreement for ACGME to approve all postgraduate training programs for both Allopathic medical schools (M.D. degrees awarded) and Osteopathic medical school (D.O. degrees awarded) graduates. This change will require an amendment to B&P Code section 2089.5 to include the AOA-HFAP as an approved accreditation agency for hospitals offering ACGME accredited postgraduate training programs.

The need to amend B&P Code section 2089.5 will be presented to the Licensing Committee and the Full Board at the Board's January 31, 2013 through February 1, 2013, meeting.

Midwifery Program

In addition to the new issues listed in Appendix 1 – Midwifery Program of the Sunset Review Report, the Midwifery Advisory Committee (MAC) identified an additional issue at its December 6, 2012. The MAC determined that Business and Professions Code (B&P) section 2514 does not include certified nurse midwives (CNM) as being able to supervise midwifery students. The MAC supported amending B&P section 2514 to include CNMs, who are licensed by the Board of Registered Nursing (BRN), as individuals who can supervise midwifery students. The Board will need to seek the BRN's input on this issue too.

Currently both physicians and CNMs are identified as being able to sign off on clinical experience for license midwife students pursuant to B&P section 2513, but supervision of training is not specifically identified in law.

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Section 3

Enforcement Program

- Expert Reviewer Training
- Consumer Protection Enforcement Initiative Positions
- Vertical Enforcement/Prosecution

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Enforcement Program

Expert Reviewer Training

In Section 5 – Enforcement Program, of the initial Sunset Review Report the Board's enhancements to its Expert Reviewer Training program was discussed. Under the sub-section, "Performance Targets/Expectations" the Board reported 100 expert reviewers attended its first scheduled training using the new interactive components of the training.

Since the initial report was submitted, the Board has conducted a second training session, held in Irvine. This session was held on February 9, 2013 and was attended by over (*will post number once training is completed*) expert reviewers. The participants also received continuing medical education credits.

Consumer Protection Enforcement Initiative Positions

In July 2009 there were several negative articles written regarding the length of time it was taking the Board of Registered Nursing to discipline a registered nurse who was in violation of the law. The articles also looked at the length of time it was taking other healing arts boards under the Department of Consumer Affairs (DCA) to complete investigations. It was determined by DCA that the enforcement processes of these boards was lengthy and needed to be improved to provide better consumer protection. In response to these articles, the DCA developed the CPEI. This initiative's main goal was to reduce the enforcement completion timelines by addressing three specific areas. These areas included administrative improvements, staffing and information technology resources, and legislative changes. For the staffing resources, the DCA developed a Budget Change Proposal (BCP) requesting resources for all healing arts boards. This BCP went through the budget process and was approved in 2010. Due to this BCP, the Medical Board of California (Board) received 22.5 positions effective fiscal year (FY) 2010/2011.

The Board began to fill these positions by hiring an additional manager and one Staff Services Analyst in the Central Complaint Unit. The manager would provide the review of the complaints, and the analyst's duties included seeking experts to perform the upfront review, preparing the complaint for mailing to the expert, and conducting the follow-up to ensure timely response by the expert. The Board management knew that the timeframe for the upfront expert review was increasing and these two resources would assist in this area. This left the Board with 20.5 CPEI positions.

Because the Board conducted investigations for the Osteopathic Medical Board of California (OMBC) and the Board of Psychology (BOP), 2.5 of the CPEI positions authorized for the Board were to assist in those boards' investigations. However, these boards determined that they would rather have the positions under their specific authority. Therefore, in FY 2011/2012, those 2.5 positions were taken from the Board and provided to the OMBC and the BOP. This left the Board with 18 CPEI positions.

During FY 2010/2011, the Board was required to decrease its positions due to a requested workforce cap drill. The Board had not moved to fill any of its positions due to the uncertainty of the number of positions it would lose. The final direction on how many positions the Board would lose due to the workforce cap (2.5 positions) was not provided to the Board until June 2011. With the loss of these 2.5 positions, the Board had 15.5 remaining CPEI positions.

Although the Board began to identify where to establish these 15.5 positions and into which classification, the Board was also under a hiring freeze, which required the Board to request hiring freeze exemptions for any position the Board wanted to fill. The Board had several investigator and

medical consultant positions that required exemptions, as well as several licensing positions that were vacant, and determined that those exemptions were higher priority than the establishment of new positions.

The hiring freeze was lifted in November of 2011 and the Board again began discussion to fill these positions. However, in early 2012, the Board was notified that it would be required to eliminate 18.1 positions due to the 5% salary savings reduction. Rather than eliminate existing staff, the Board used the 15.5 CPEI positions (and 2.6 vacant positions) to meet the reduction.

The Board was notified in September 2012 that it could reestablish these positions in the temporary help blanket as long as the Board always maintains a 5% vacancy rate to meet the required salary reduction level. The Board has determined that it will request the re-establishment of 14.5 positions in the following areas in order to improve the enforcement timeframes as originally planned in the CPEI.

- Six (6) positions will be used to establish a Northern Operation Safe Medicine Unit (OSM), identical to the OSM in the South. The Northern OSM will consist of 1 Supervising Investigator, 4 Investigators, and 1 Office Technician. The establishment of this office will take the unlicensed activity cases from the workload of the investigators in the northern district offices. This will reduce the investigators caseloads in the field offices and will assist in decreasing the investigation time for physicians who violate the law. This basically adds four (4) investigators for general workload.
- Two (2) positions will be used to provide the Tustin and Rancho Cucamonga district offices with the full complement of investigators. All other district offices have six investigators. Due to budget reductions several years ago, these two offices were reduced to five investigators. This increase in investigators will assist in the reduction of the number of cases assigned to each investigator thus reducing the investigation timeframe.
- Two (2) positions will be added to the Board's Expert Reviewer Program. These analyst positions will assist in the recruitment and training of the Board's expert reviewers. The Board needs additional experts and has determined that training experts not only improves the time to provide an opinion, but also improves the quality of the opinion.
- Three (3) positions will be added to the Central Complaint Unit (CCU) and the Discipline Coordination Unit (DCU) to assist in the ever increasing workload in these areas. One analyst will be assigned to the Quality of Care section and will assist with the processing of those complaints, reducing the analysts workload in this section. One analyst will be assigned to the DCU and will process the administrative cases in an effort to reduce the time it takes to prepare the disciplinary documents. Lastly, one position will be used to establish a clerical position to assist with these duties in both the CCU and the DCU. All three of the positions will assist in improving the enforcement timeframes.
- One and a half (1.5) positions will be used to conduct malpractice investigations. It is believed that this workload could be processed beginning with a desk investigation thereby reducing the number of cases referred to the field investigative staff. This will reduce the investigators workload and reduce the time it takes to investigate a complaint.

Board staff is working on preparing the paperwork for the establishment of these positions, which also requires the review and approval by DCA. All of these positions will help the Board in reducing the enforcement timeframe and meeting the original goal of the CPEI. Thus far the following positions have been sent to DCA for approval: the Northern OSM positions; the additional two investigator positions; and the three CCU/DCU positions.

Vertical Enforcement/Prosecution (VE/P)

In Section 1 – Background and Description of the Board and Regulated Profession, and Section 5 – Enforcement Program, of the Sunset Review Report, the Vertical Enforcement/Prosecution Model (VE/P) and its origination was briefly discussed. In the Report, it stated that additional information, including a review of pertinent data, would be provided in this Supplemental Report. Pursuant to Government Code section 12529.7 the Board must provide a report to the Legislature regarding the VE/P model. The Board provided a report to the Legislature in March 2012, however, the report did not contain a detailed report with statistical data regarding the program. The Board includes the full report including an analysis of the data and recommendations in this supplemental report.

A portion of the Board's mission is to protect consumers through the vigorous, objective enforcement of the Medical Practice Act. Historically, the Board has faced criticism because of the time it takes from receipt of a complaint to the conclusion of prosecution. In an attempt to solve this pervasive challenge, legislation was enacted via Senate Bill (SB) 1950 (Figueroa), Chapter 1085, Statutes of 2002, which mandated the appointment of an Enforcement Program Monitor (hereinafter "Monitor") to "monitor and evaluate the disciplinary system and procedures" of the Board for a period of two years. In both the initial and final reports of the *Medical Board of California Enforcement Program Monitor*, the Monitor recommended the vertical prosecution model whereby "the trial attorney and the investigator are assigned as the team to handle a complex case as soon as it is opened as a formal investigation." The Monitor opined that the vertical prosecution model would improve efficiency and reduce case cycle time, and, thereby, ensure the quality and safety of medical care to the people of California. Consequently, SB 231, Chapter 674, Statutes of 2005, was enacted into law, codifying the use of the vertical prosecution model, effective January 1, 2006.

Under SB 231, the Board and the Department of Justice (DOJ) Health Quality Enforcement Section (HQES) were required to implement a vertical prosecution model to conduct its investigations and prosecutions. Under the legislation, each complaint referred to a Board district office for investigation is simultaneously and jointly assigned to a Board investigator and a HQES deputy. The legislative goal of VE/P was to bring Board investigators and HQES Deputies Attorney General (DAG) together from the beginning of an investigation with the goal of increasing public protection by improving coordination and teamwork, increasing efficiency, and reducing investigation and prosecution delays. Additionally, the Board hoped the relationship between Board investigators and HQES would enhance the Board's ability to recruit and retain experienced investigators, particularly if Board investigators were compensated commensurate to DOJ Agents for the complexity of the investigations they undertake.

The Board and HQES agreed that VE/P included three basic elements. First, each complaint of alleged misconduct by a physician referred to a Board office for investigation would be simultaneously and jointly assigned to a Board investigator and a HQES DAG. Second, that joint assignment would exist for the duration of the case. Third, under the direction of a DAG, the assigned Board investigator would be responsible for obtaining the evidence required to permit the DAG to advise the Board on legal matters such as whether a formal accusation should be filed, whether the case should be closed, or whether other action should be taken.

As mandated, the Board and the HQES implemented the vertical prosecution model on January 1, 2006. Since not all of the Board's cases lead to prosecution (approximately 60% of the cases result in closure with no need for prosecution), the name of the new model was changed from the Vertical Prosecution Model to the Vertical Enforcement/Prosecution model, (although statute still refers to a vertical prosecution model). Due to staffing limitations, the VE/P model was also changed from pairing a

DAG with a Board investigator from the outset of an investigation until the matter was resolved to instead assigning a "lead" DAG to a district office to provide legal support and direction to investigators until a "primary" DAG was assigned. Sexual misconduct cases, or cases where there is a potential imminent threat to the consumer, were immediately assigned to a "primary" DAG.

Initial statistical data from the implementation pilot (January 2006 – April 2007) identified trends which suggested that VE/P could more quickly identify cases for closure, expedite egregious complaints, and reduce the time to complete investigations. The pilot did not, however, provide sufficient time to address concerns regarding the time to complete a prosecution because some Board investigations may take over 18 months to complete. The available statistics at that time only covered a 16-month period. The analysis of the initial pilot showed promise in reducing the time frames to: obtain medical records, obtain a physician interview, obtain a medical expert opinion, close a case without prosecution, file an Interim Suspension Order and file an Accusation. Therefore, VE/P was continued.

In August 2010, a program evaluation summary report resulting from a study of VE/P was prepared by Benjamin Frank, LLC. Mr. Frank concluded that the insertion of DAGs into the investigative process did not translate into more positive disciplinary outcomes or a decrease in investigation completion times. Mr. Frank recommended scaling back and optimizing DAG involvement in investigations. His report identified that the best practices and most fiscally sound use of DAG hours were found to occur in Northern California, where DAGs did not typically attend complainant/witness and subject interviews unless the case facts supported their attendance. Northern California disciplinary timelines statistics were superior to those of the Los Angeles area, where DAGs were significantly more involved in every aspect of the investigation. According to Mr. Frank's assessment, this translated into unnecessary costs. He also identified in his report significant Board investigator frustration. This was due to both how the VE/P was implemented in the legislation and how it impacted the initial investigation time. Mr. Frank, identified these two factors as contributors to staff attrition.

On November 1, 2012, the Board submitted its *Sunset Review Report 2012* to the Senate Business, Professional and Economic Development (B&P) Committee. Section 5 provided a review and summary of the Board's "Enforcement Program." While VE/P was discussed narratively within Section 5, statistical data to depict the timelines of cases was not included. The Board explained it was conducting a thorough review of statistics related to VE/P, to be relayed to the B&P Committee in a Spring 2013 report. The report would include a review of factors to assess the efficacy of VE/P and any recommendations from the Board regarding its continuation.

Although the recommendation for VE/P and its initial assessment after 16 months of implementation appeared to have promise for long-term improved efficiencies and a reduction in case cycle time, the statistical data over an eight year time period does not reflect an overall improvement, but it does show improvement in certain types of cases.

The following chart reflects the investigation timeframe averages prior to and continuing into VE/P implementation (FY 04/05 through FY 11/12). Over time with increases and decreases in the number of cases closed and the average days to close cases, from FY 04/05 (before VE/P) through FY 11/12 there was no change in the average days to complete an investigation. For example, the average days from the initiation of an investigation to closure or referral in FY 04/05, prior to the VE/P, was 296 days. The VE/P was implemented beginning in the second half of FY 05/06, but the average remained relatively the same that FY at 312 days. FYs 06/07 through 10/11 the average spiked during full VE/P implementation between 336 to an all-time high of 401 days. FY 11/12 decreased to 298 days,

returning to relatively the same average as the pre-VE/P FY 04/05 of 296 days. Even though there is no change in the overall closure average, there is now a slight reduction of 12 days in the time for cases referred to disciplinary action.

INVESTIGATION TIME FRAMES

	Avg. Days	# Cases	Avg. Days	# Cases	Avg. Days	# Cases	Avg. Days	# Cases	Avg. Days	# Cases	Avg. Days	# Cases	Avg. Days	# Cases	Avg. Days	# Cases
Fiscal Year	04/05		05/06		06/07		07/08		08/09		09/10		10/11		11/12	
All Investigation Closures	**296**	***1,204***	**312**	***1,062***	**336**	***941***	**374**	***961***	**401**	***847***	**382**	***1,003***	**356**	***1,089***	**298**	***1,132***
Closed - No Further Action	269	*860*	290	*749*	324	*645*	354	*701*	384	*568*	355	*635*	330	*701*	272	*749*
Referred for Disciplinary Action	362	*344*	365	*313*	364	*296*	426	*260*	437	*279*	427	*368*	404	*388*	350	*383*

Discussion of Attached Statistical Charts

Attachment A provides the overall and subcategorized data. The statistical data is displayed to show each of the main case types investigated by the Board and to identify whether VE/P had produced efficiencies. The case types examined were gross negligence/incompetence, inappropriate prescribing, unlicensed activity, sexual misconduct, mental/physical illness, self-abuse of drugs/alcohol, fraud, conviction, unprofessional conduct, and internet prescribing.

What Attachment A indicates, is that when VE/P was first implemented there were significant increases in the overall average and median days to process investigations. The averages are now back to and lower than the pre VE/P. The anticipation is that the overall averages would continue at the current level or decrease. The data clearly indicates that there must have been many factors that needed to be overcome in the integration of the VE/P into the investigative process.

It was anticipated that VE/P would produce improvements in the time it takes to investigate gross negligence cases that can be delayed when the physician fails to produce medical records. With a DAG assigned to the case from inception, if a subpoena for records was required, the DAG would be available to review and enforce the subpoena. However, there has not been a substantial improvement, only a 21 day reduction in the average time it takes to have these cases referred for disciplinary action.

Subpoena enforcement actions for obtaining medical records and a physician interview are critical as the Board is unable to determine how egregious the physician's actions are until the medical records have been obtained and reviewed and the physician interviewed. The Board adopted a "zero tolerance" policy in 2009 for delays in medical record acquisition and the physician interview. In addition, it sponsored legislation to require a physician's attendance at an interview. The DAG's attention to the process of subpoena enforcement is essential and if the DAG's time is spent on other investigative cases and is not available for subpoena enforcement the Board will not see a continued reduction in the time to complete and refer these cases for prosecution.

Subpoena enforcement actions continue to contribute to case aging problems. The length of time it is taking to file the supporting documents to enforce a subpoena for medical records and/or the attendance of a physician at an interview continues to increase the case age and, at best, the timeframes will remain relatively similar to pre-VE/P timelines.

Attachment B provides the overall and subcategorized data for investigation initiated to suspension issued and investigation completed to suspension issued. The categories are basically the same as in Attachment A. What Attachment B indicates is that there has been a significant decrease in the all case types, and in most subcategories, in the time it takes to obtain a suspension. Overall, investigation to suspension has decreased by almost 100 days.

It was anticipated that VE/P would produce improvements in the time it takes to obtain a suspension order. Suspension orders are critical in that they are issued in cases when the harm to the public appears imminent and the physician must be removed or restricted from practicing medicine as quickly as possible.

Cases involving a physician's physical or mental illness and sexual misconduct typically result in a suspension order. However the timeframe to obtain these suspensions has increased, therefore more DAG time needs to be focused on these cases to ensure consumer protection. Having the DAGs working on the case from inception ensures that they are familiar with the details of the case in order to draft the necessary documents in an expeditious manner.

Attachment C provides the overall and subcategorized data for investigation initiated to accusation filed and investigation completed to accusation filed. The categories are basically the same as in Attachment A.

The data indicates that VE/P has made a slight improvement in the average time it takes to investigate all case types and file an accusation. The average time was 551 days in FY 04/05 and 519 day in FY 11/12, a decrease of 32 days. However, there has not been an improvement in all of the individual case types. Overall the majority of the case types indicate increased timeframes. For example:

- Cases alleging inappropriate prescribing have seen a 16 day increase
- Cases alleging self-abuse of drugs/alcohol has seen a 157 day increase
- Cases alleging mental/physical illness have seen an 87 day increase

However, there are case types with decreased timeframes:

- Cases alleging gross negligence/incompetence saw a 55 day decrease
- Cases based upon a criminal conviction saw a 114 day decrease (these cases result from the arrest of a physician)

Attachment D provides the overall and subcategorized data for investigation initiated to stipulated decision received and investigation completed to stipulated decision received. The categories are basically the same as in Attachment A. Because of the DAGs' involvement, in certain types of cases, the time from investigation to stipulation received went down. The statistics indicate that the DAGs' involvement in all types of cases has not decreased the investigative time but indicates there is a slight increase. However it has decreased the amount of time it takes the DAG to obtain a stipulation. More focused DAG time on those cases where the time went up, such as sexual misconduct, mental/physical illness, and inappropriate prescribing might bring those averages down.

Attachment E provides the overall and subcategorized data for investigation initiated to submittal of the matter to an ALJ and investigation completed to submittal of the matter to an ALJ. The categories are basically the same as in Attachment A. What Attachment E indicates is that the overall time from the initiation of an investigation until the matter was submitted had a decrease of 77 days. The significance

of this chart is that the time from investigation closed until the matter is heard by the ALJ has significantly decreased in almost every category. This is an indication that having the DAG involved in the case that goes to hearing and knowing the underlying circumstances has had a positive impact in getting the case heard.

Attachment F provides the overall and subcategorized data for investigation initiated to default decision received and investigation completed to default decision received. The categories are basically the same as in Attachment A. The cases that resulted in a default decision did not see any improvement, but in fact saw an increase in both timeframes. From FY 04/05 to FY 11/12 for the timeframe from investigation initiated until the default decision was received increased by 213 days, with hardly any decreases seen between those years. The time it took from the investigation completed until the default decision increased by 92 days.

Attachment G represents the cases declined by the Attorney General's office and those cases needing supplemental investigation after referral to the AG's office. Even though these numbers are small, the cases declined has stayed consistent over the years. However the expectation of VE/P was that this number would decline. The same would hold true for cases needing supplemental investigation.

The chart below provides a synopsis of the charts discussed above and provided in the attachments. The chart below provides the timeframes for all case types. It also shows the average time in calendar days.

TIME TO FILE AN ACCUSATION	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12
All Case Types - (Number of cases)	**164**	**166**	**171**	**173**	**154**	**206**	**198**	**232**
From Investigation Initiated to Accusation	551	564	533	566	608	575	580	519
From Investigation Completed to Accusation	149	169	166	146	132	124	126	121
TIME TO ISSUE A SUSPENSION	**04/05**	**05/06**	**06/07**	**07/08**	**08/09**	**09/10**	**10/11**	**11/12**
All Case Types - (Number of cases)	**30**	**28**	**26**	**20**	**25**	**18**	**27**	**31**
From Investigation Initiated to Suspension Issued	392	307	315	471	358	228	451	297
From Investigation Completed to Suspension Issued	168	120	93	215	105	66	191	109
TIME TO STIPULATED DECISION RECEIVED	**04/05**	**05/06**	**06/07**	**07/08**	**08/09**	**09/10**	**10/11**	**11/12**
All Case Types - (Number of cases)	**156**	**141**	**143**	**145**	**118**	**135**	**120**	**160**
From Investigation Initiated to Stipulation Received	922	1,039	923	940	818	916	912	914
From Investigation Completed to Stipulation Received	528	636	542	518	410	431	477	459
TIME TO MATTER SUBMITTED TO ALJ OR PROPOSED DECISION RECEIVED	**04/05**	**05/06**	**06/07**	**07/08**	**08/09**	**09/10**	**10/11**	**11/12**
All Case Types - (Number of cases)	**42**	**30**	**37**	**39**	**33**	**27**	**37**	**38**
From Investigation Initiated to Proposed Decision	1,115	1,161	926	1,161	1,102	850	973	1,038
From Investigation Completed to Proposed Decision	713	747	604	751	700	437	513	565
TIME TO DEFAULT DECISION RECEIVED	**04/05**	**05/06**	**06/07**	**07/08**	**08/09**	**09/10**	**10/11**	**11/12**
All Case Types - (Number of cases)	**12**	**7**	**11**	**8**	**12**	**7**	**11**	**8**
From Investigation Initiated to Default Decision Received	477	554	673	591	732	771	690	678
From Investigation Completed to Default Decision Received	190	211	411	304	441	374	322	282

Board staff is still examining the hours expending by the DAGs in the investigation and prosecution of cases. This will be provided in the final report as it is not available for this first draft.

The overall statistics do not find that the VE/P has dramatically improved the timeframes to discipline physicians found in violation of the law. Although, with the decrease in investigative time in the last two years, decreases should be reflected in the overall disciplinary timeframes in FY 13/14 and ongoing.

The VE/P was enacted to streamline the investigatory and prosecution timelines, however, there have been many factors that resulted in this not happening as expeditiously as anticipated.

Some of the unanticipated consequences of VE/P relate to DAGS having to devote substantial time to cases that will not result in referral for discipline. DAGs are unable to fulfill other critical legal obligations (e.g., subpoena enforcement actions) because they are working on lower priority cases. As a result, the urgent investigations/cases must wait for the DAG availability while they are tending to less severe cases.

In addition, investigators find themselves waiting at numerous stages of the investigation for DAG availability, feedback or approval to continue in the course of the investigation. Under the protocol established between MBC and HQE, investigators must wait the following number of days for availability or contact from a DAG at each milestone:

- 5 days for a DAG to approve their Initial Plan and Progress Report
- 15-20 days for the investigator to schedule an interview (due to coordinating with the DAG's schedule)
- 10 days to review the expert package
- 10 days to review closure

Up to 40 days could be added to an investigation because of the VE/P review process.

Recommended Modifications

The Board believes that the VE/P model should be modified. Approximately 60% of cases that are investigated by the Board's district offices result in closures without disciplinary action taken. A majority of those could be eliminated from the DAGs' workload that would allow them more time to focus on urgent or complex cases (specifically: sexual misconduct, mental/physical illness, peer review investigations), and time to process and follow-up on the enforcement of subpoenas. With this proposed model and the continuation of all of the improvements already implemented in the enforcement program (as outlined in the initial report, Section 5), the timeframes both for the investigation and prosecution phases will decrease and consumer protection will be enhanced.

In reviewing the data, the Board is recommending legislation be enacted to modify the VE/P model. The Board does recognize that DAG involvement in "high profile" or "urgent" cases is critical, as evidenced by the decrease in the time it take to obtain a suspension order. It is recommended that the VE/P model be continued for the following types of cases:

1. Sexual Misconduct
2. Physical or Mental Illness
3. Peer Review (805) Cases

In all other cases (e.g., prescribing, gross negligence, incompetence, conviction of crime) designation to VE/P should be jointly considered by Board staff and HQES staff as the case is assigned at the field office. This assignment could be regularly reconsidered as the case progresses to ensure appropriate use of HQES resources and that a DAG is brought into the case when necessary.

Investigation Initiated to Investigation Closure Timeframes - Average Calendar Days

The chart below illustrates the average calendar days for all case types and then a breakdown by each individual type. This chart captures the average calendar days from the time the district office initiated the investigation to the time the investigation was closed for all closures. Further, it breaks down the closure timeframes between those cases closed with no further action and those referred for disciplinary action.

This data excludes the following case types: out-of-state, headquarters, Operation Safe Medicine, probation violations, petitions for modification/termination of probation terms, and petitions for reinstatement. It also excludes all cases that were referred solely to the District/City Attorney for criminal action as they are not in VE/P.

Fiscal Years	04/05		05/06		06/07		07/08		08/09		09/10		10/11		11/12	
	Avg. Days	# Cases	Avg. Days	# Cases	Avg. Days	# Cases	Avg. Days	# Cases	Avg. Days	# Cases	Avg. Days	# Cases	Avg. Days	# Cases	Avg. Days	# Cases
All Case Types																
All Investigation Closures	**296**	**1,204**	**312**	**1,062**	**336**	**941**	**374**	**961**	**401**	**847**	**382**	**1,003**	**356**	**1,089**	**298**	**1,132**
Closed - No Further Action	269	860	290	749	324	645	354	701	384	568	355	635	330	701	272	**749**
Referred for Disciplinary Action	362	344	365	313	364	296	426	260	437	279	427	368	404	388	350	**383**
Gross Negligence/Incompetence																
All Investigation Closures	**329**	**756**	**343**	**650**	**380**	**516**	**395**	**546**	**451**	**454**	**427**	**538**	**396**	**632**	**342**	**515**
Closed - No Further Action	.295	545	316	464	358	341	363	410	403	328	388	379	357	430	321	366
Referred for Disciplinary Action	416	211	412	186	422	175	490	136	577	126	519	159	478	202	395	149
Inappropriate Prescribing																
All Investigation Closures	**367**	**76**	**373**	**59**	**382**	**51**	**490**	**41**	**439**	**49**	**497**	**67**	**427**	**69**	**422**	**90**
Closed - No Further Action	335	51	335	43	364	35	438	19	420	26	375	36	357	32	308	41
Referred for Disciplinary Action	431	25	477	16	422	16	534	22	462	23	638	31	488	37	518	49
Unlicensed Activity																
All Investigation Closures	**197**	**74**	**258**	**54**	**326**	**66**	**324**	**68**	**414**	**54**	**376**	**41**	**274**	**37**	**220**	**58**
Closed - No Further Action	186	66	231	47	323	62	312	63	430	49	359	36	258	33	213	51
Referred for Disciplinary Action	280	8	437	7	367	4	480	5	258	5	495	5	409	4	276	7
Sexual Misconduct																
All Investigation Closures	**266**	**58**	**245**	**84**	**282**	**68**	**333**	**53**	**420**	**54**	**400**	**55**	**317**	**65**	**273**	**75**
Closed - No Further Action	283	30	227	51	300	49	316	41	364	33	318	32	300	45	244	49
Referred for Disciplinary Action	247	28	274	33	235	19	393	12	508	21	515	23	355	20	329	26
Mental/Physical Illness																
All Investigation Closures	**221**	**37**	**188**	**23**	**288**	**42**	**357**	**29**	**221**	**27**	**353**	**31**	**340**	**34**	**187**	**41**
Closed - No Further Action	220	24	176	14	296	26	335	16	227	20	270	18	370	20	151	23
Referred for Disciplinary Action	223	13	208	9	275	16	384	13	202	7	468	13	296	14	233	18
Self-abuse of Drugs/Alcohol																
All Investigation Closures	**177**	**52**	**250**	**48**	**221**	**47**	**323**	**58**	**229**	**42**	**323**	**36**	**241**	**41**	**276**	**64**
Closed - No Further Action	164	34	256	26	213	24	369	30	256	15	330	23	216	21	263	33
Referred for Disciplinary Action	202	18	243	22	229	23	274	28	214	27	312	13	267	20	290	31
Fraud																
All Investigation Closures	**244**	**30**	**290**	**30**	**288**	**41**	**373**	**50**	**426**	**32**	**412**	**18**	**361**	**23**	**425**	**24**
Closed - No Further Action	248	22	298	19	251	25	403	32	432	22	263	8	397	15	390	13
Referred for Disciplinary Action	235	8	275	11	346	16	318	18	412	10	530	10	294	8	467	11
Conviction of Crime																
All Investigation Closures	**173**	**51**	**191**	**47**	**217**	**43**	**235**	**34**	**250**	**58**	**194**	**125**	**239**	**101**	**161**	**157**
Closed - No Further Action	158	35	200	27	229	28	270	23	277	29	175	54	205	56	142	108
Referred for Disciplinary Action	206	16	180	20	196	15	162	11	224	29	208	71	281	45	205	49
Unprofessional Conduct																
All Investigation Closures	**242**	**61**	**260**	**62**	**256**	**56**	**350**	**76**	**321**	**69**	**310**	**87**	**273**	**85**	**262**	**104**
Closed - No Further Action	217	45	234	54	256	45	356	62	366	41	357	48	305	47	279	63
Referred for Disciplinary Action	311	16	434	8	254	11	321	14	255	28	251	39	234	38	237	41
Internet Prescribing																
All Investigation Closures	**127**	**8**	**220**	**4**	**245**	**8**	**253**	**5**	**307**	**7**	**425**	**2**	**115**	**2**	**554**	**3**
Closed - No Further Action	140	7	220	4	245	8	155	4	146	4	681	1	115	2	494	1
Referred for Disciplinary Action	38	1	0	0	0	0	645	1	523	3	169	1	0	0	584	2

Investigation Initiated to Investigation Closure Timeframes - Median Calendar Days

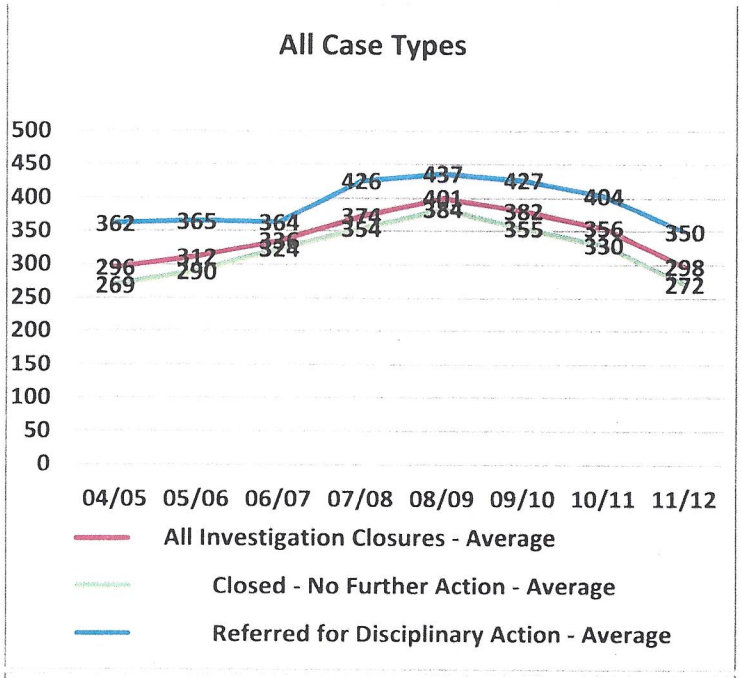
The chart below illustrates the median calendar days for all case types and then a breakdown by each individual type. This chart captures the median calendar days from the time the district office initiated the investigation to the time the investigation was closed for all closures. Further, it breaks down the closure timeframes between those cases closed with no further action and those referred for disciplinary action.

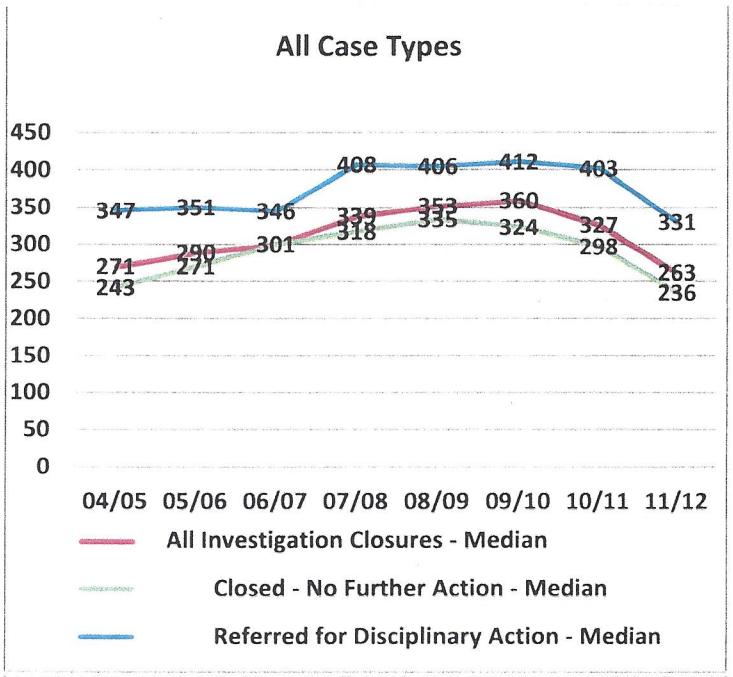
This data excludes the following case types: out-of-state, headquarters, Operation Safe Medicine, probation violations, petitions for modification/termination of probation terms, and petitions for reinstatement. It also excludes all cases that were referred solely to the District/City Attorney for criminal action as they are not in VE/P.

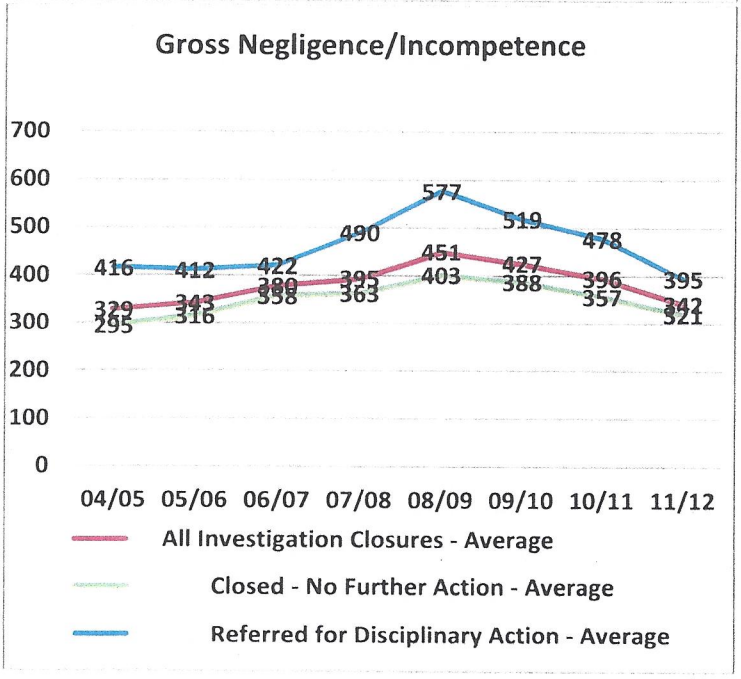
Fiscal Years	04/05		05/06		06/07		07/08		08/09		09/10		10/11		11/12	
	Med. Days	# Cases	Med. Days	# Cases	Med. Days	# Cases	Med. Days	# Cases	Med. Days	# Cases	Med. Days	# Cases	Med. Days	# Cases	Med. Days	# Cases
All Case Types																
All Investigation Closures	**271**	**1,204**	**290**	**1,062**	**301**	**941**	**339**	**961**	**353**	**847**	**360**	**1,003**	**327**	**1,089**	**263**	**1,132**
Closed - No Further Action	243	860	271	749	301	645	318	701	335	568	324	635	298	701	236	**749**
Referred for Disciplinary Action	347	344	351	313	346	296	408	260	406	279	412	368	403	388	331	**383**
Gross Negligence/Incompetence																
All Investigation Closures	**303**	**756**	**326**	**650**	**354**	**516**	**364**	**546**	**423**	**454**	**405**	**538**	**369**	**632**	**315**	**515**
Closed - No Further Action	274	545	299	464	337	341	329	410	365	328	376	379	325	430	289	366
Referred for Disciplinary Action	395	211	385	186	382	175	476	136	545	126	504	159	472	202	387	149
Inappropriate Prescribing																
All Investigation Closures	**308**	**76**	**299**	**59**	**308**	**51**	**457**	**41**	**441**	**49**	**499**	**67**	**422**	**69**	**426**	**90**
Closed - No Further Action	274	51	282	43	316	35	412	19	316	26	378	36	351	32	289	41
Referred for Disciplinary Action	401	25	413	16	292	16	491	22	533	23	610	31	463	37	486	49
Unlicensed Activity																
All Investigation Closures	**149**	**74**	**221**	**54**	**301**	**66**	**276**	**68**	**325**	**54**	**408**	**41**	**222**	**37**	**203**	**58**
Closed - No Further Action	142	66	213	47	303	62	265	63	325	49	408	36	208	33	203	51
Referred for Disciplinary Action	284	8	450	7	407	4	365	5	167	5	591	5	473	4	138	7
Sexual Misconduct																
All Investigation Closures	**247**	**58**	**233**	**84**	**231**	**68**	**240**	**53**	**319**	**54**	**358**	**55**	**303**	**65**	**246**	**75**
Closed - No Further Action	265	30	228	51	268	49	214	41	284	33	277	32	277	45	194	49
Referred for Disciplinary Action	236	28	251	33	208	19	329	12	421	21	513	23	393	20	325	26
Mental/Physical Illness																
All Investigation Closures	**183**	**37**	**166**	**23**	**225**	**42**	**350**	**29**	**187**	**27**	**330**	**31**	**319**	**34**	**103**	**41**
Closed - No Further Action	199	24	120	14	236	26	333	16	184	20	226	18	335	20	93	23
Referred for Disciplinary Action	174	13	218	9	251	16	359	13	220	7	363	13	305	14	228	18
Self-abuse of Drugs/Alcohol																
All Investigation Closures	**131**	**52**	**224**	**48**	**183**	**47**	**211**	**58**	**171**	**42**	**248**	**36**	**183**	**41**	**199**	**64**
Closed - No Further Action	123	34	209	26	169	24	211	30	174	15	259	23	187	21	219	33
Referred for Disciplinary Action	149	18	252	22	197	23	193	28	144	27	128	13	169	20	170	31
Fraud																
All Investigation Closures	**177**	**30**	**223**	**30**	**285**	**41**	**372**	**50**	**334**	**32**	**365**	**18**	**363**	**23**	**390**	**24**
Closed - No Further Action	177	22	213	19	274	25	395	32	328	22	197	8	363	15	328	13
Referred for Disciplinary Action	210	8	257	11	332	16	254	18	447	10	424	10	295	8	434	11
Conviction of Crime																
All Investigation Closures	**156**	**51**	**142**	**47**	**157**	**43**	**198**	**34**	**240**	**58**	**141**	**125**	**185**	**101**	**111**	**157**
Closed - No Further Action	153	35	142	27	181	28	274	23	234	29	125	54	174	56	100	108
Referred for Disciplinary Action	179	16	139	20	150	15	166	11	240	29	148	71	203	45	170	49
Unprofessional Conduct																
All Investigation Closures	**183**	**61**	**232**	**62**	**165**	**56**	**321**	**76**	**279**	**69**	**227**	**87**	**176**	**85**	**243**	**104**
Closed - No Further Action	176	45	213	54	215	45	329	62	322	41	315	48	218	47	269	63
Referred for Disciplinary Action	300	16	424	8	97	11	277	14	108	28	59	39	17	38	206	41
Internet Prescribing																
All Investigation Closures	**144**	**8**	**231**	**4**	**204**	**8**	**134**	**5**	**196**	**7**	**425**	**2**	**115**	**2**	**533**	**3**
Closed - No Further Action	148	7	231	4	204	8	134	4	120	4	681	1	115	2	494	1
Referred for Disciplinary Action	38	1	0	0	0	0	645	1	520	3	169	1	0	0	584	2

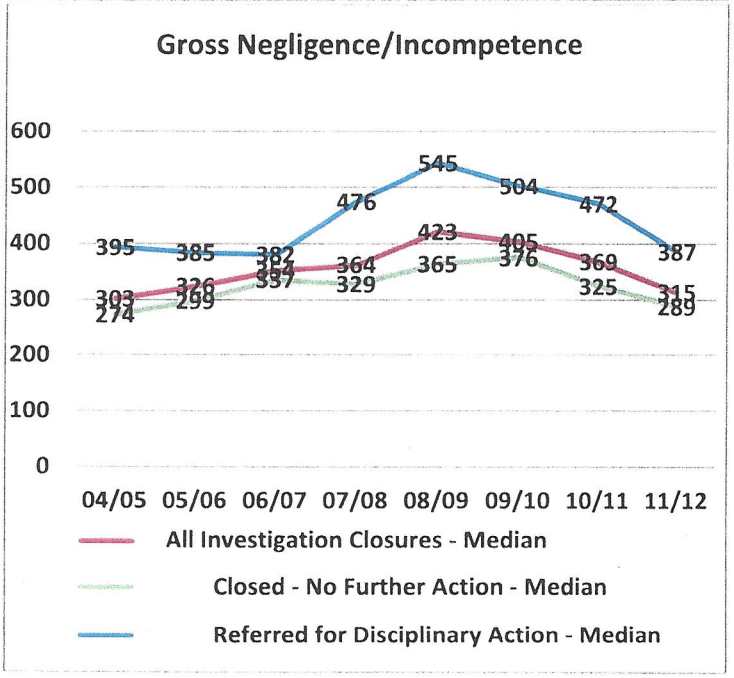
Investigation Initiated to Investigation Closure Timeframes - Average/Median Calendar Days
The graphs below illustrate the average (left column) and median (right column) calendar days for all case types and then a breakdown by each individual type. These graphs show three different measurements. One line shows the average/median calendar days from the time the district office initiated the investigation to the time the investigation was closed for all closures. The two other lines breakdown the closure timeframes between those cases closed with no further action and those referred for disciplinary action.

This data excludes the following case types: out-of-state, headquarters, Operation Safe Medicine, probation violations, petitions for modification/termination of probation terms, and petitions for reinstatement. It also excludes all cases that were referred solely to the District/City Attorney for criminal action as they are not in VE/P.









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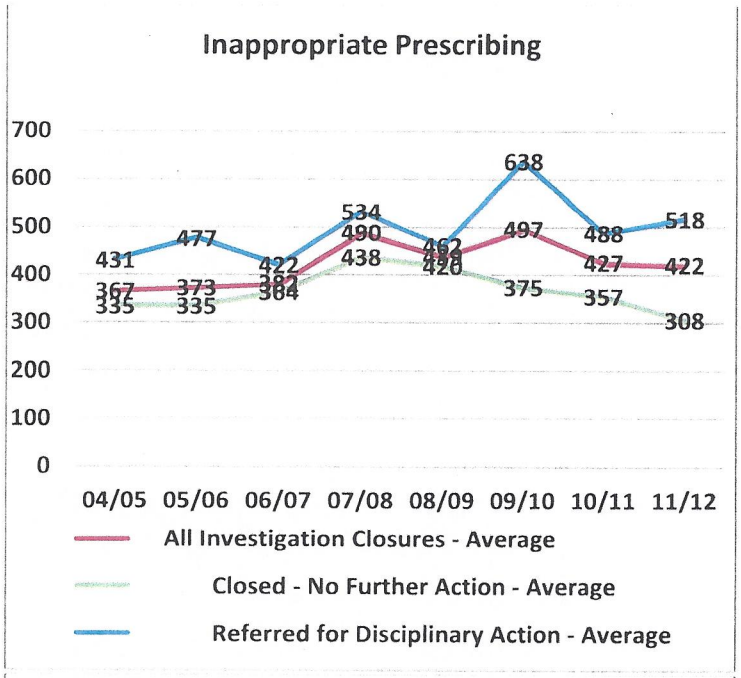

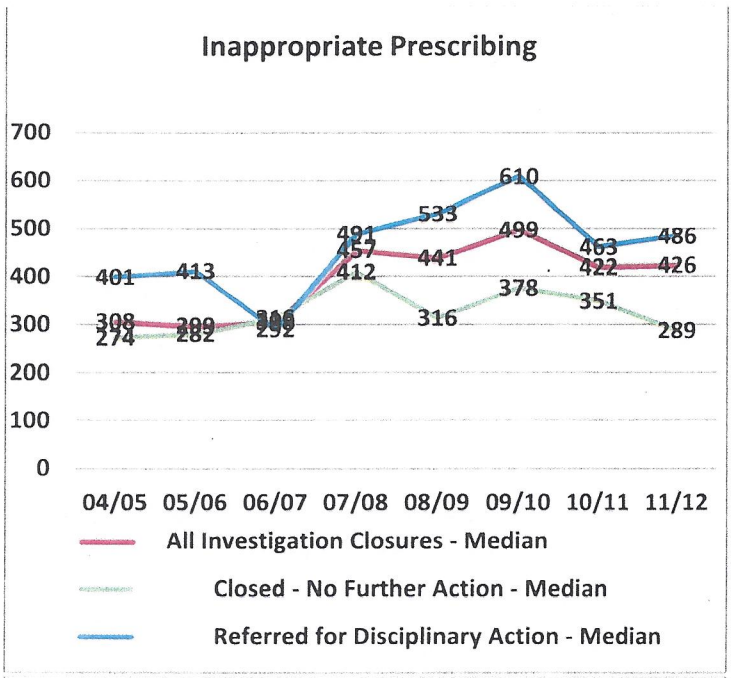

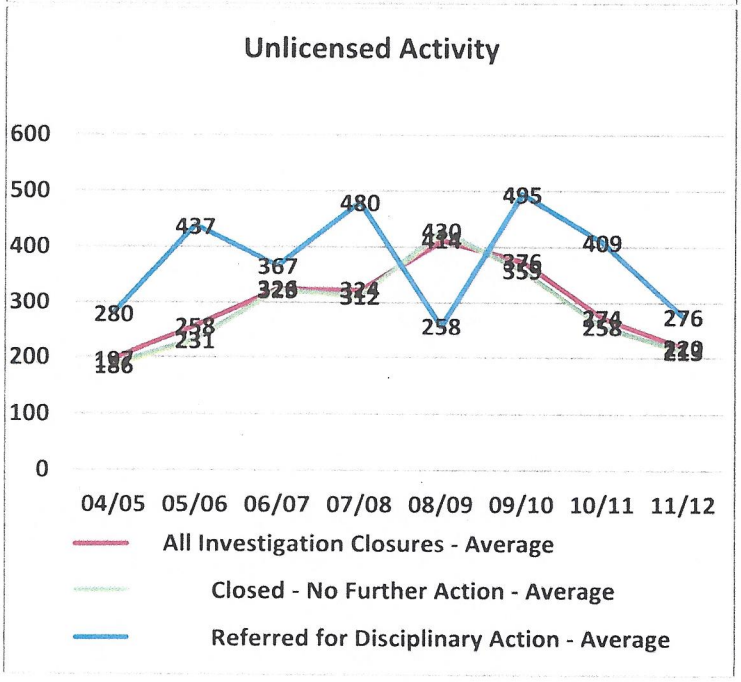

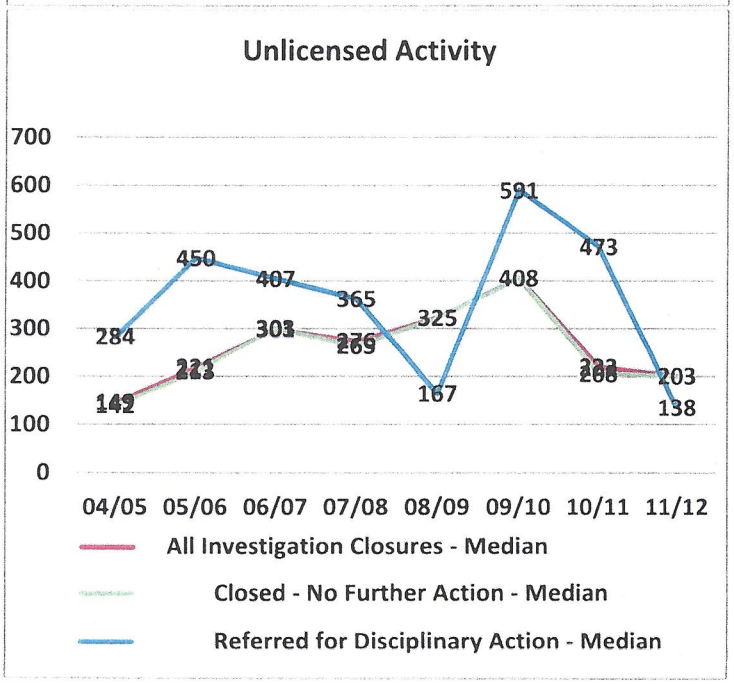

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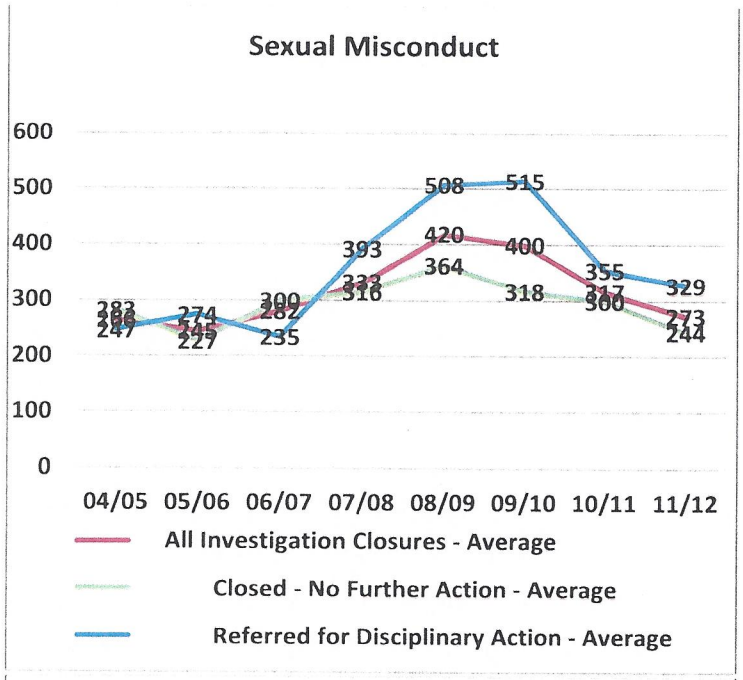

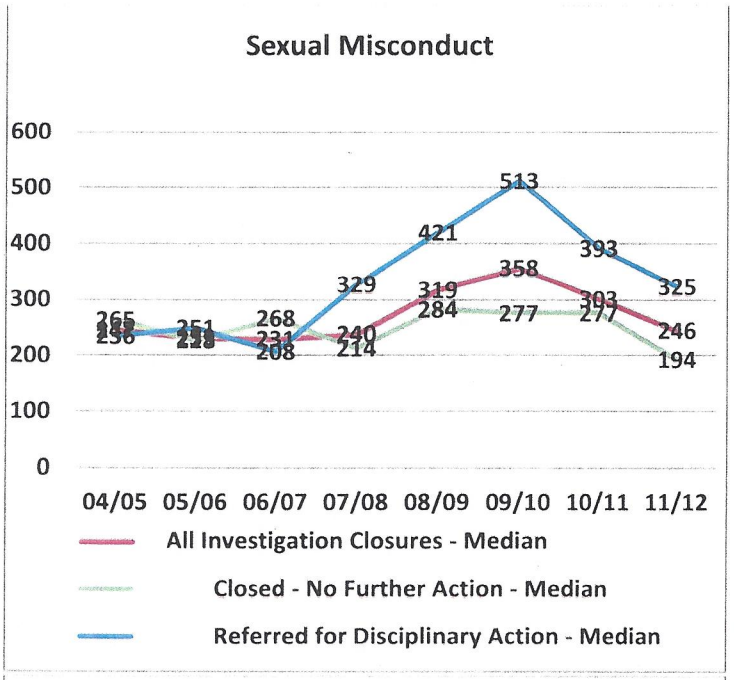

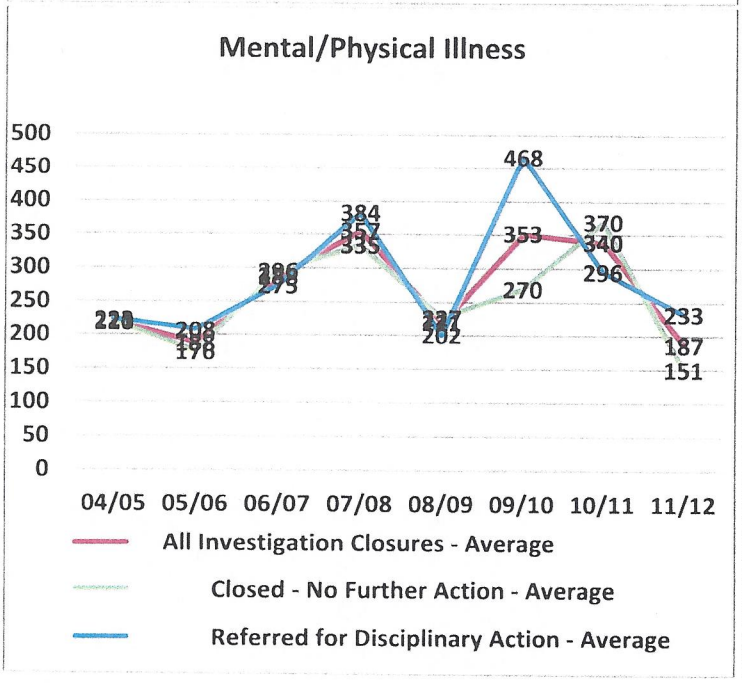

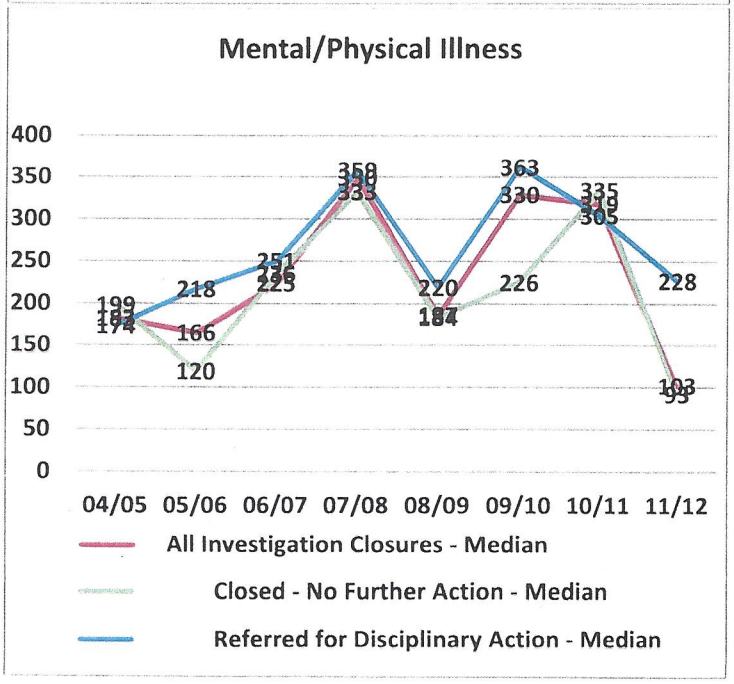

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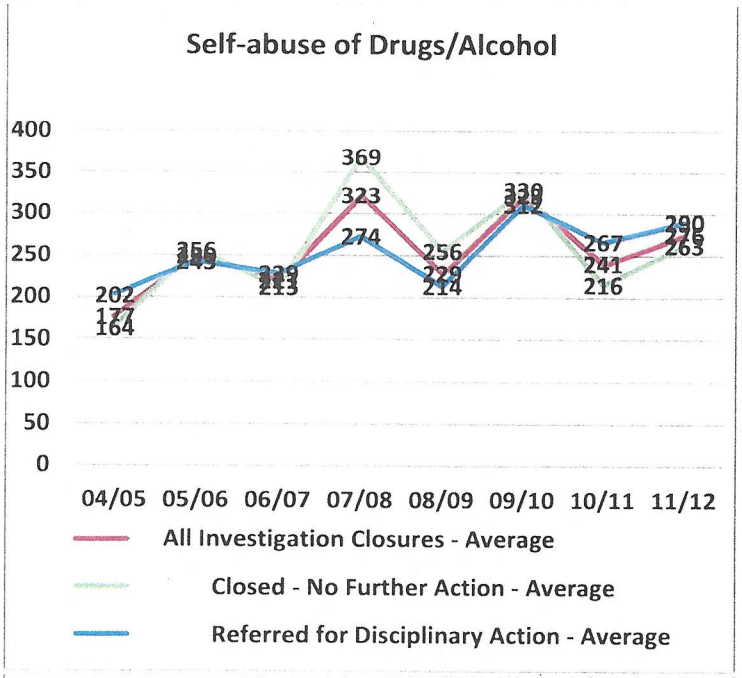

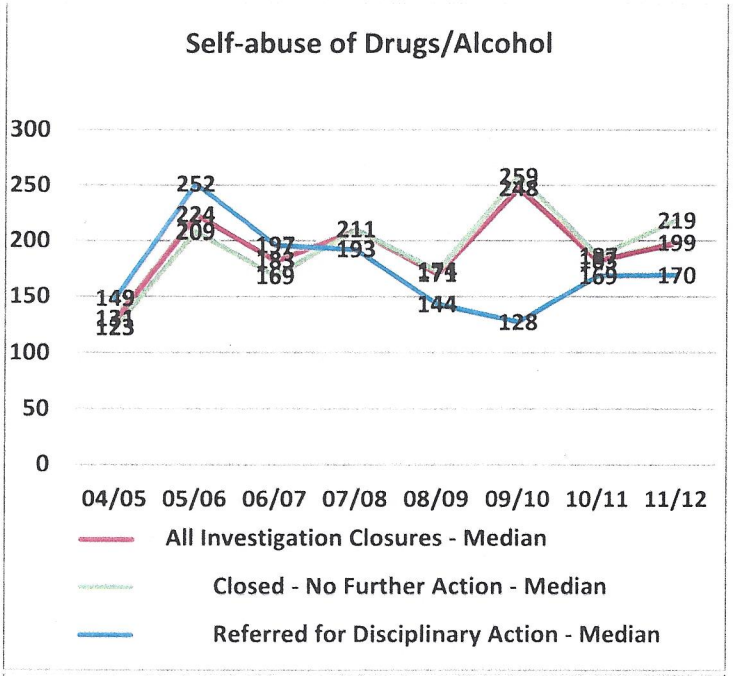

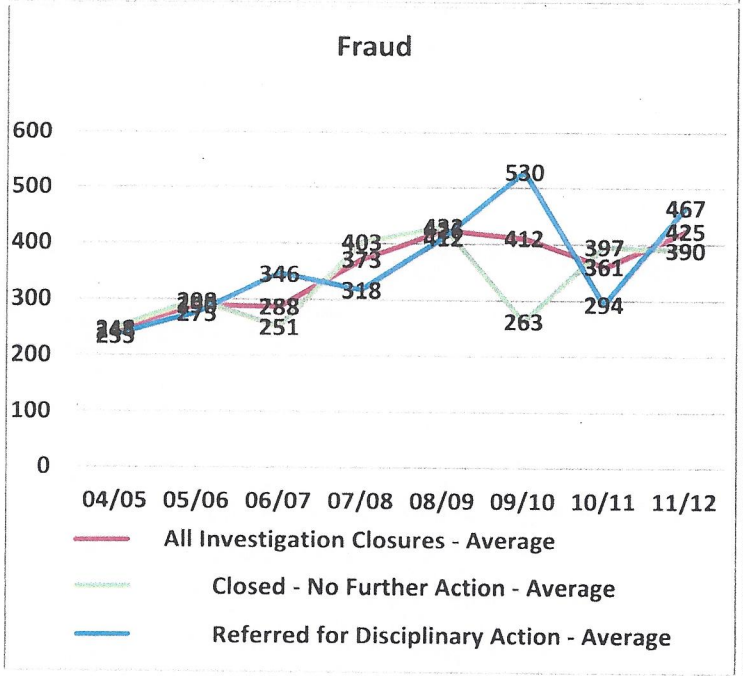

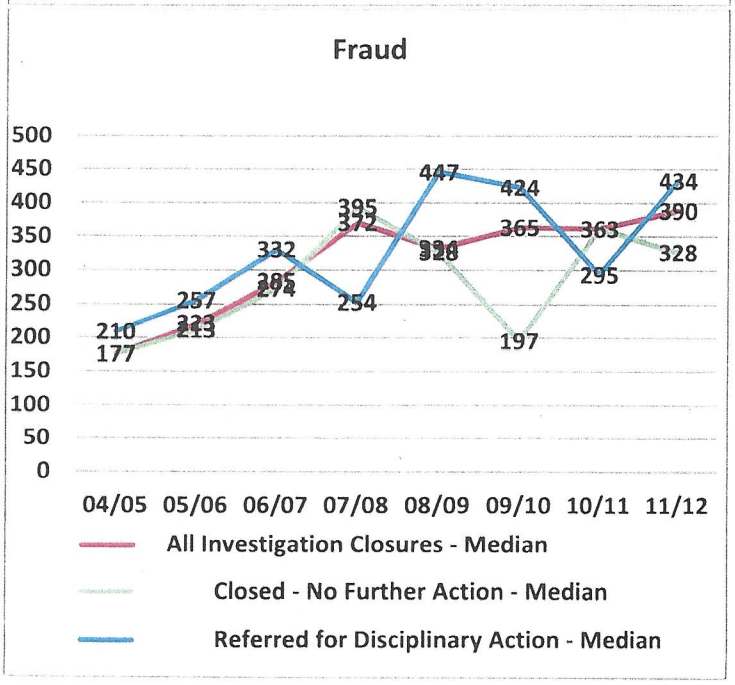

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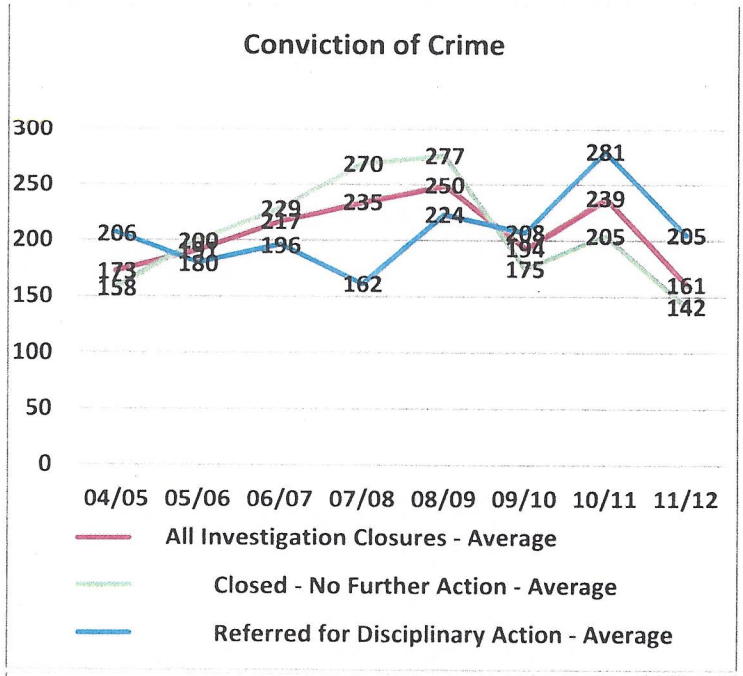

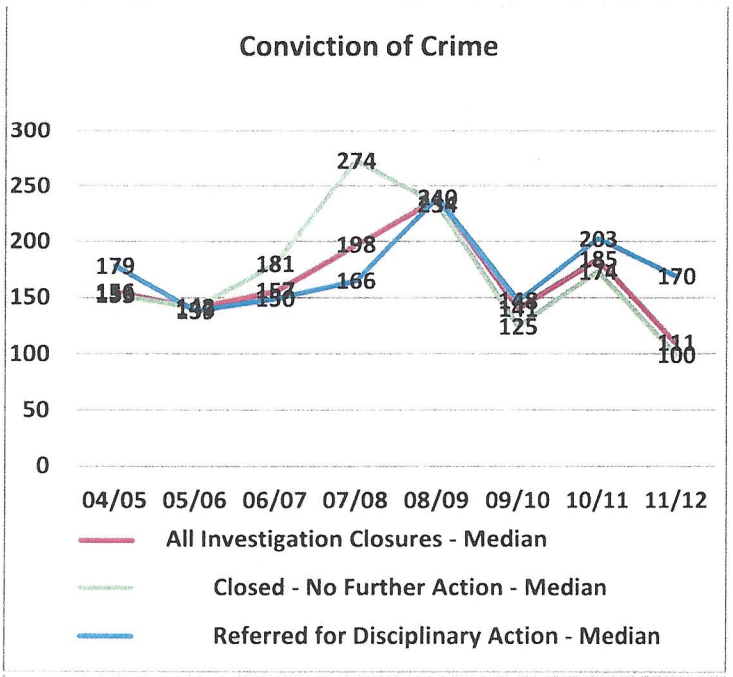

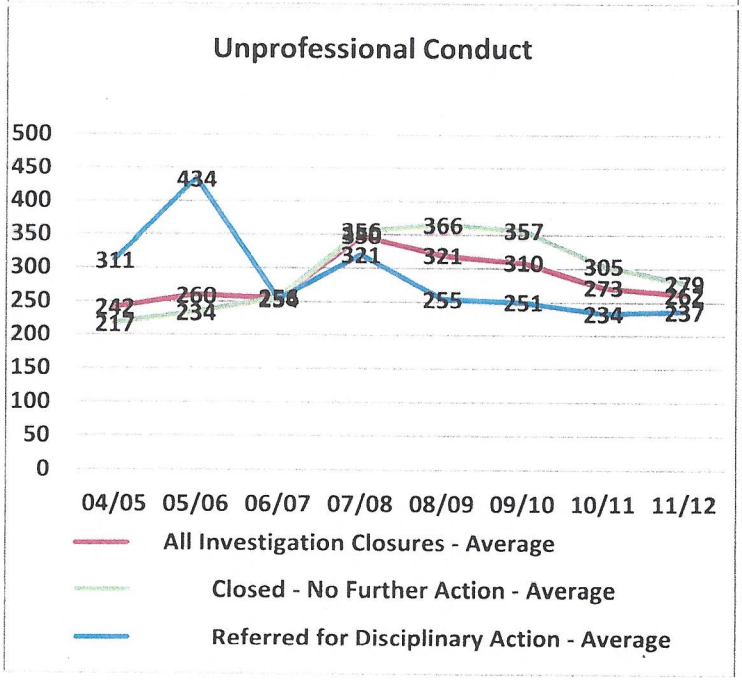

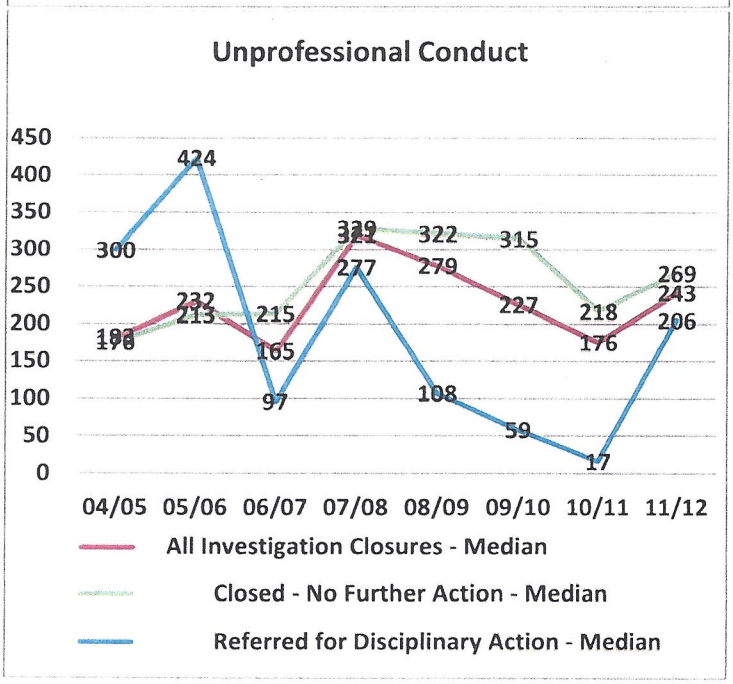

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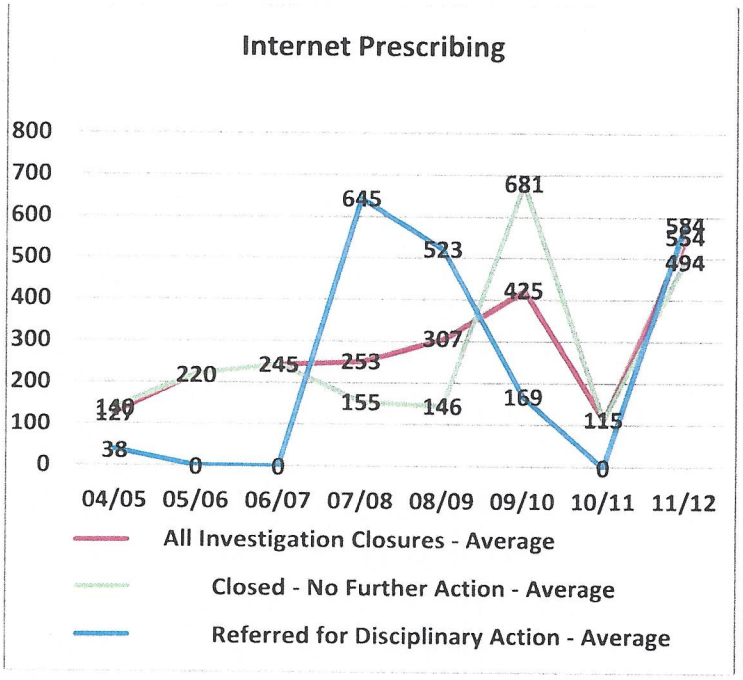

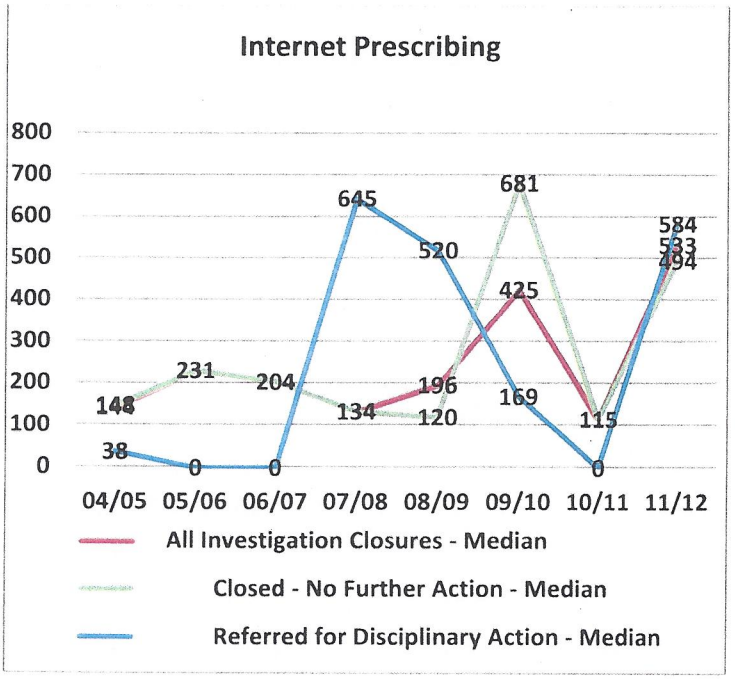

Investigation Initiated/Completed to Suspension Order Issued Timeframes
Average Calendar Days

The chart below illustrates the average calendar days for all case types and then a breakdown by each individual type. This chart captures the average calendar days from the time the district office initiated the investigation to the time a Suspension Order was issued and the average calendar days from the time the district office completed the investigation to the time a Suspension Order was issued.

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Fiscal Years	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12
All Case Types - (Number of cases)	**30**	**28**	**26**	**20**	**25**	**18**	**27**	**31**
Investigation Initiated to Suspension Issued - Average	**392**	**307**	**315**	**471**	**358**	**228**	**451**	**297**
Investigation Completed to Suspension Issued - Average	**168**	**120**	**93**	**215**	**105**	**66**	**191**	**109**
Gross Negligence/Incompetence - (Number of cases)	7	2	2	1	5	1	7	4
Investigation Initiated to Suspension Issued - Average	766	488	193	521	235	378	970	690
Investigation Completed to Suspension Issued - Average	439	163	33	267	170	2	452	222
Inappropriate Prescribing - (Number of cases)	3	4	0	3	4	1	4	3
Investigation Initiated to Suspension Issued - Average	745	769	0	1,147	761	232	499	221
Investigation Completed to Suspension Issued - Average	108	241	0	572	224	2	260	103
Sexual Misconduct - (Number of cases)	11	10	7	7	3	4	6	3
Investigation Initiated to Suspension Issued - Average	258	204	394	397	556	436	40	250
Investigation Completed to Suspension Issued - Average	110	112	145	278	166	161	8	143
Mental/Physical Illness - (Number of cases)	2	3	6	2	3	5	5	6
Investigation Initiated to Suspension Issued - Average	142	309	201	752	221	182	544	214
Investigation Completed to Suspension Issued - Average	52	173	95	60	45	80	170	85
Self-abuse of Drugs/Alcohol - (Number of cases)	6	7	6	5	8	5	4	12
Investigation Initiated to Suspension Issued - Average	164	131	316	150	177	136	73	283
Investigation Completed to Suspension Issued - Average	50	45	76	34	26	20	11	92
Fraud - (Number of cases)	0	0	3	1	1	1	0	0
Investigation Initiated to Suspension Issued - Average	0	0	634	386	686	22	0	0
Investigation Completed to Suspension Issued - Average	0	0	95	81	2	2	0	0
Conviction of Crime - (Number of cases)	1	2	2	1	0	1	1	3
Investigation Initiated to Suspension Issued - Average	57	334	23	47	0	147	150	116
Investigation Completed to Suspension Issued - Average	51	63	9	2	0	40	2	46
Unprofessional Conduct - (Number of cases)	0	0	0	0	1	0	0	0
Investigation Initiated to Suspension Issued - Average	0	0	0	0	303	0	0	0
Investigation Completed to Suspension Issued - Average	0	0	0	0	44	0	0	0

Investigation Initiated/Completed to Suspension Order Issued Timeframes
Median Calendar Days

The chart below illustrates the median calendar days for all case types and then a breakdown by each individual type. This chart captures the median calendar days from the time the district office initiated the investigation to the time a Suspension Order was issued and the median calendar days from the time the district office completed the investigation to the time a Suspension Order was issued.

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Fiscal Years	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12
All Case Types - (Number of cases)	**30**	**28**	**26**	**20**	**25**	**18**	**27**	**31**
Investigation Initiated to Suspension Issued- Median	**217**	**239**	**209**	**370**	**294**	**180**	**377**	**180**
Investigation Completed to Suspension Issued - Median	**53**	**43**	**20**	**48**	**7**	**27**	**39**	**42**
Gross Negligence/Incompetence - (Number of cases)	7	2	2	1	5	1	7	4
Investigation Initiated to Suspension Issued- Median	617	488	193	521	107	378	971	791
Investigation Completed to Suspension Issued - Median	305	163	33	267	2	2	376	83
Inappropriate Prescribing - (Number of cases)	3	4	0	3	4	1	4	3
Investigation Initiated to Suspension Issued- Median	1039	721	0	855	715	232	387	248
Investigation Completed to Suspension Issued - Median	46	83	0	428	192	2	91	82
Sexual Misconduct - (Number of cases)	11	10	7	7	3	4	6	3
Investigation Initiated to Suspension Issued- Median	209	84	209	220	521	327	28	91
Investigation Completed to Suspension Issued - Median	86	33	2	19	2	60	2	4
Mental/Physical Illness - (Number of cases)	2	3	6	2	3	5	5	6
Investigation Initiated to Suspension Issued- Median	142	336	200	752	270	193	542	217
Investigation Completed to Suspension Issued - Median	52	169	106	60	56	113	164	41
Self-abuse of Drugs/Alcohol - (Number of cases)	6	7	6	5	8	5	4	12
Investigation Initiated to Suspension Issued- Median	137	115	387	154	86	121	65	171
Investigation Completed to Suspension Issued - Median	27	4	80	11	6	24	11	32
Fraud - (Number of cases)	0	0	3	1	1	1	0	0
Investigation Initiated to Suspension Issued- Median	0	0	358	386	686	22	0	0
Investigation Completed to Suspension Issued - Median	0	0	2	81	2	2	0	0
Conviction of Crime - (Number of cases)	1	2	2	1	0	1	1	3
Investigation Initiated to Suspension Issued- Median	57	334	23	47	0	147	150	137
Investigation Completed to Suspension Issued - Median	51	63	9	2	0	40	2	13
Unprofessional Conduct - (Number of cases)	0	0	0	0	1	0	0	0
Investigation Initiated to Suspension Issued- Median	0	0	0	0	303	0	0	0
Investigation Completed to Suspension Issued - Median	0	0	0	0	44	0	0	0

Investigation Initiated/Completed to Suspension Order Issued Timeframes
Average/Median Calendar Days

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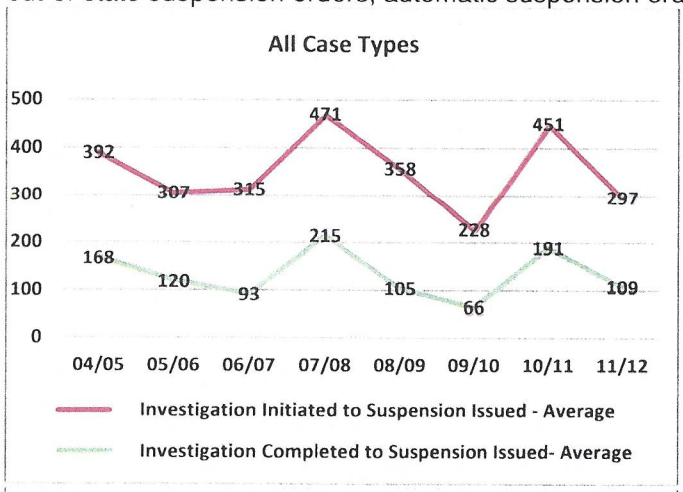

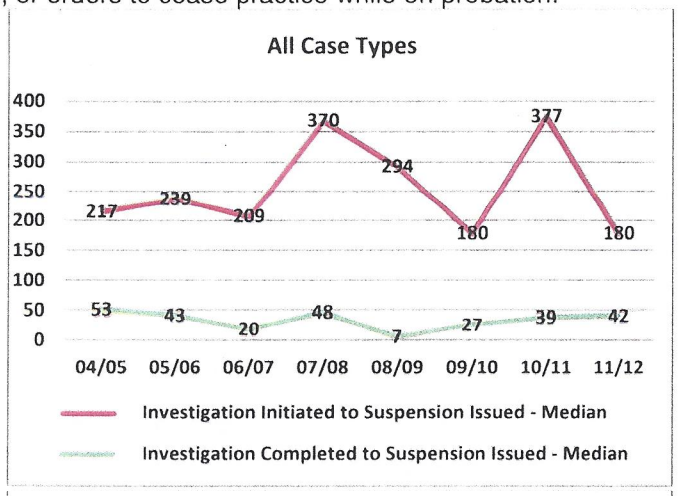

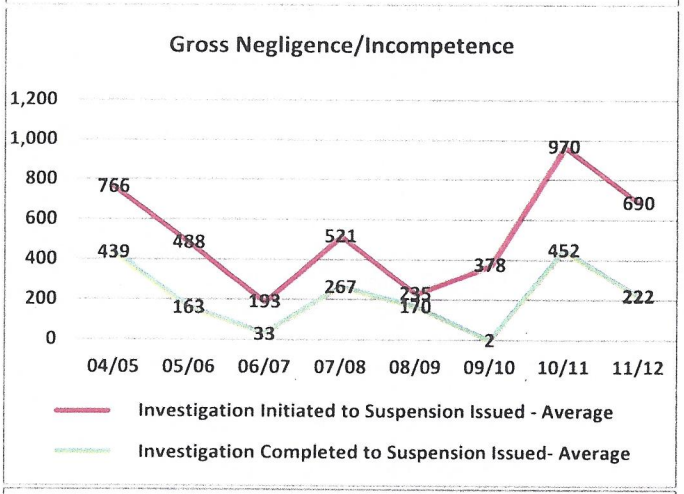

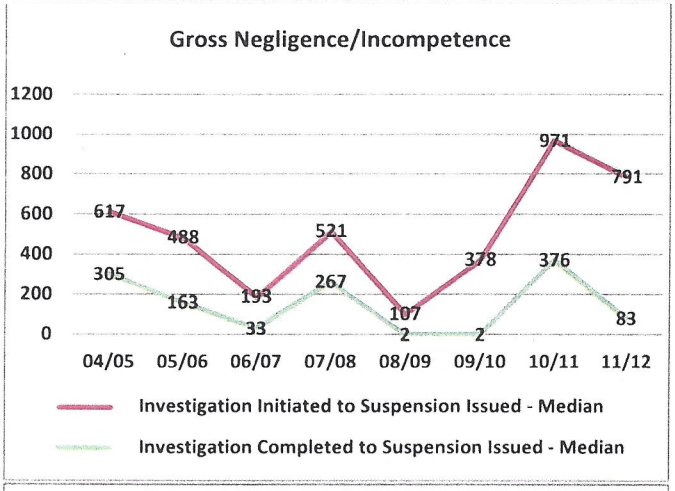

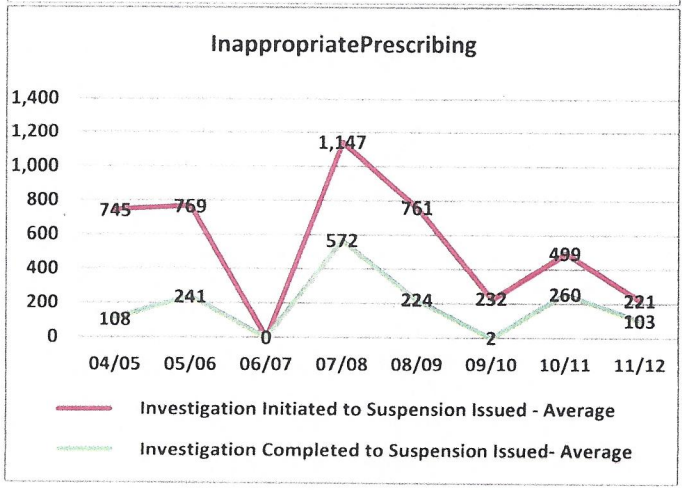

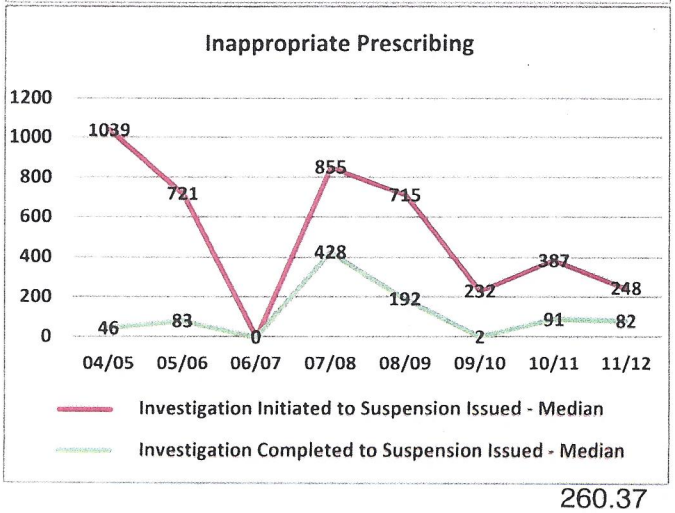

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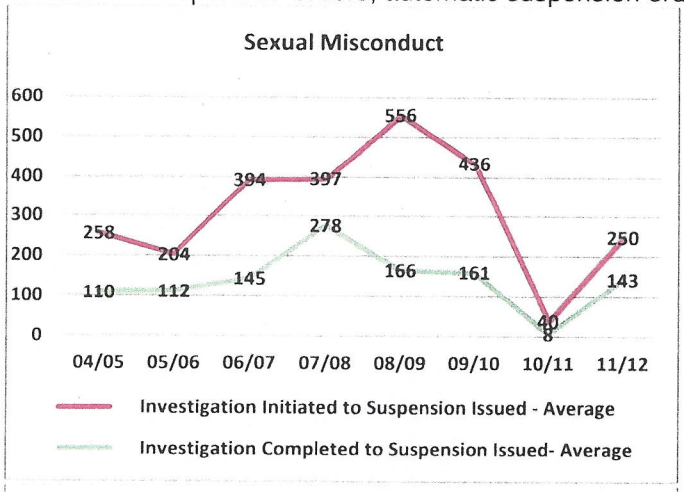
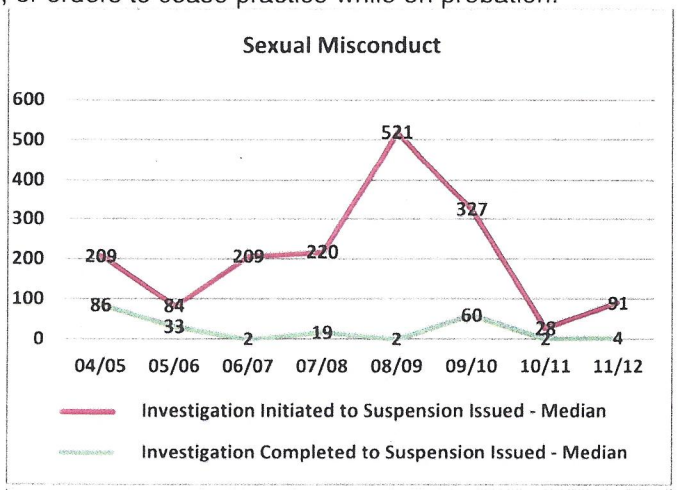
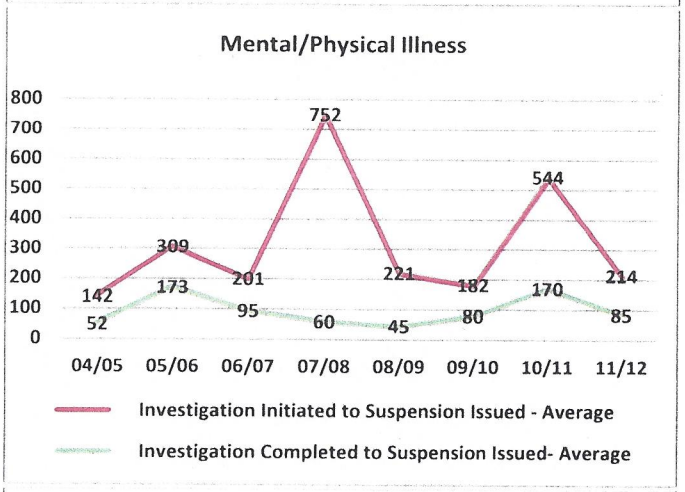
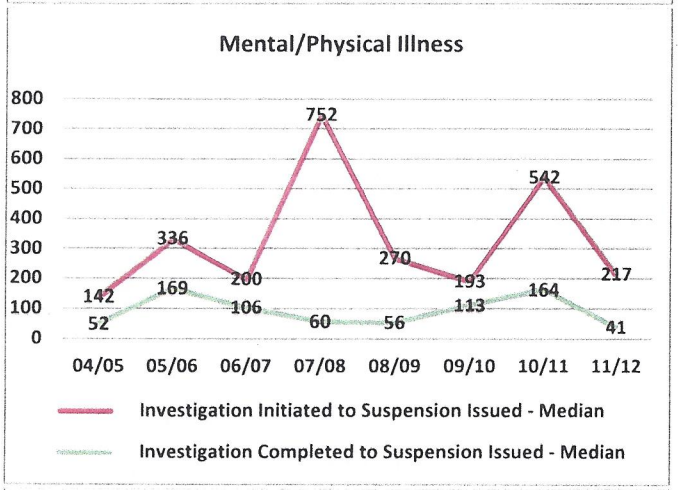
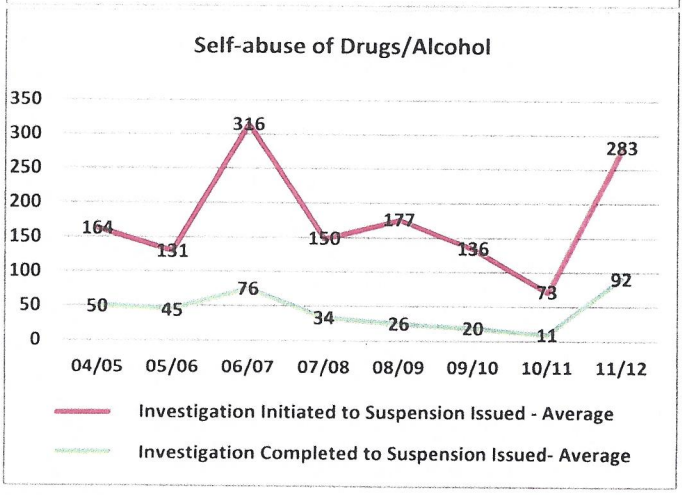
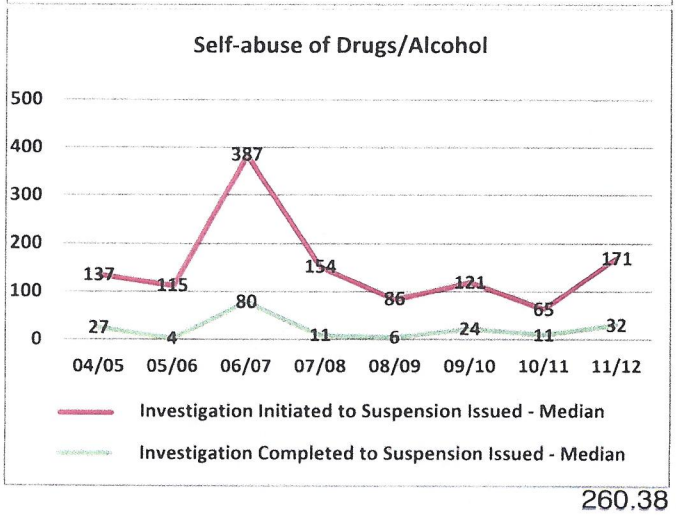








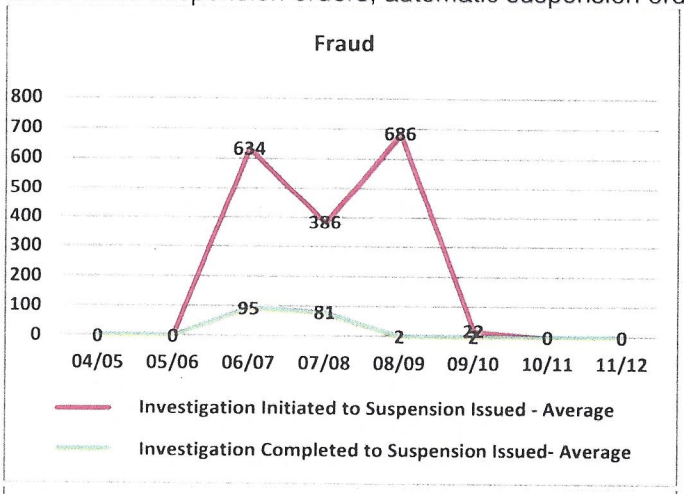


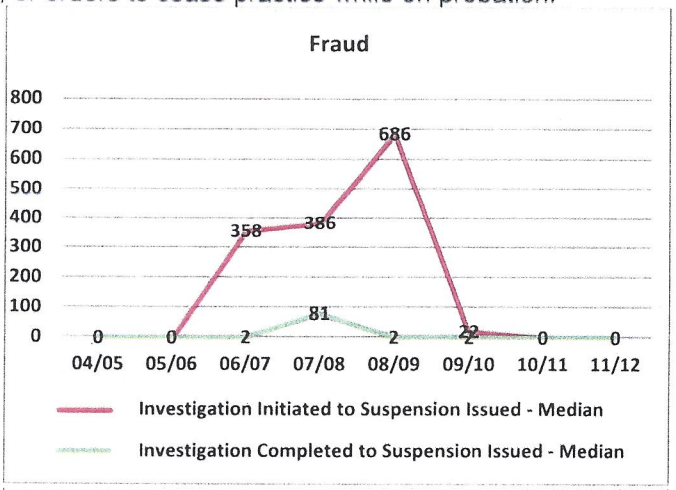


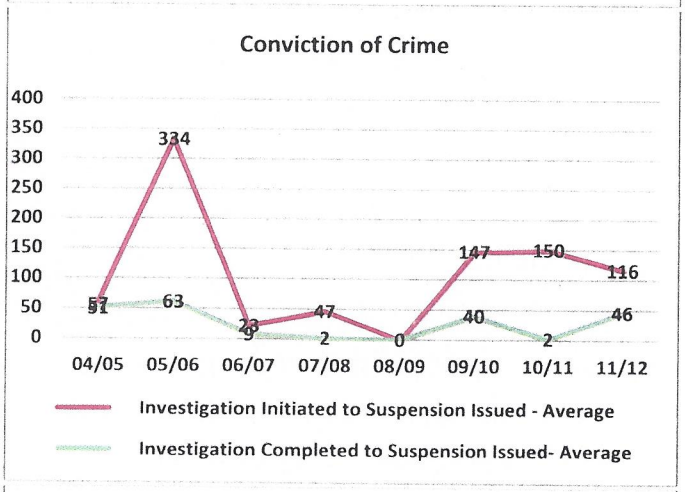
Investigation Initiated/Completed to Suspension Order Issued Timeframes
Average/Median Calendar Days

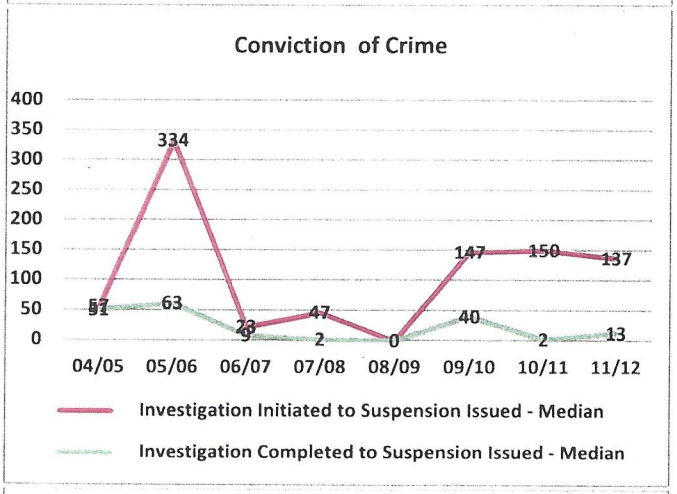
The graphs below illustrate the average (left column) and median (right column) calendar days for all case types and then a breakdown by each individual type. These graphs show two measurements. The top lines represent the average/median calendar days from the time the district office initiated the investigation to the time a Suspension Order was issued. The bottom lines are a subset of the top line and represent the average/median calendar days from the time the district office completed the investigation to the time a Suspension Order was issued.

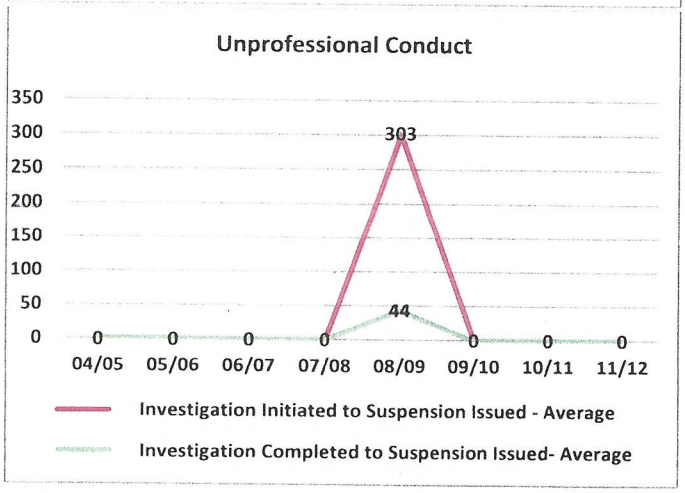
This data excludes the following case types: out-of-state, headquarters, Operation Safe Medicine, probation violations, petitions for modification/termination of probation, petitions for reinstatement, and subsequent discipline on probationers. This data includes the following suspension orders: interim suspension orders, Penal Code section 23 restrictions, stipulated agreements to restrictions/suspension, and temporary restraining orders. It does not include out-of-state suspension orders, automatic suspension orders, or orders to cease practice while on probation.

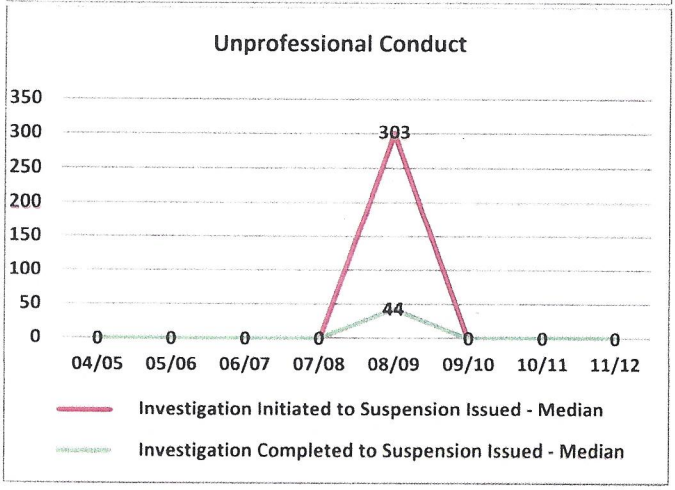












Investigation Initiated/Completed to Accusation Filed – Average Calendar Days

The chart below illustrates the average calendar days for all case types and then a breakdown by each individual type. This chart captures the average calendar days from the time the district office initiated the investigation to the time an Accusation was filed and the average calendar days from the time the district office completed the investigation to the time an Accusation was filed.

This data excludes the following case types: out-of-state, headquarters, Operation Safe Medicine, probation violations, petitions for modification/termination of probation, petitions for reinstatement, and subsequent discipline on probationers. This data also excludes cases that had a petition to compel examination granted and those where an offer for a public letter of reprimand was rejected by the respondent.

Fiscal Years	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12
All Case Types - (Number of cases)	**164**	**166**	**171**	**173**	**154**	**206**	**198**	**232**
Investigation Initiated to Accusation Filed - Average	**551**	**564**	**533**	**566**	**608**	**575**	**580**	**519**
Investigation Completed to Accusation Filed - Average	**149**	**169**	**166**	**146**	**132**	**124**	**126**	**121**
Gross Negligence/Incompetence - (Number of cases)	93	97	107	99	84	107	116	108
Investigation Initiated to Accusation Filed - Average	610	621	595	622	721	626	639	555
Investigation Completed to Accusation Filed - Average	153	161	176	152	144	106	114	114
Inappropriate Prescribing - (Number of cases)	17	9	7	14	18	15	12	34
Investigation Initiated to Accusation Filed - Average	644	623	756	659	612	790	647	660
Investigation Completed to Accusation Filed - Average	148	157	273	136	130	167	209	104
Unlicensed Activity - (Number of cases)	2	5	2	5	2	5	2	7
Investigation Initiated to Accusation Filed - Average	619	1,068	413	848	384	430	693	664
Investigation Completed to Accusation Filed - Average	33	498	66	269	152	109	78	350
Sexual Misconduct - (Number of cases)	18	20	11	13	4	18	8	12
Investigation Initiated to Accusation Filed - Average	434	344	437	632	693	768	472	435
Investigation Completed to Accusation Filed - Average	182	93	182	243	228	274	166	81
Mental/Physical Illness - (Number of cases)	9	4	7	7	6	4	8	15
Investigation Initiated to Accusation Filed - Average	356	286	258	453	368	462	538	443
Investigation Completed to Accusation Filed - Average	98	89	64	85	107	106	141	145
Self-abuse of Drugs/Alcohol - (Number of cases)	14	8	17	19	23	21	21	23
Investigation Initiated to Accusation Filed - Average	264	391	385	324	313	344	405	421
Investigation Completed to Accusation Filed - Average	59	126	124	63	76	93	85	140
Fraud - (Number of cases)	1	8	7	7	4	6	8	10
Investigation Initiated to Accusation Filed - Average	1,025	391	552	263	525	488	439	577
Investigation Completed to Accusation Filed - Average	292	208	163	132	170	70	157	178
Conviction of Crime - (Number of cases)	3	8	9	7	7	23	14	16
Investigation Initiated to Accusation Filed - Average	358	370	247	343	302	315	453	244
Investigation Completed to Accusation Filed - Average	234	147	100	98	70	120	140	68
Unprofessional Conduct - (Number of cases)	5	4	4	2	3	6	9	6
Investigation Initiated to Accusation Filed - Average	738	551	544	491	763	710	580	247
Investigation Completed to Accusation Filed - Average	309	123	227	198	157	73	175	74
Internet Prescribing - (Number of cases)	2	3	0	0	3	1	0	1
Investigation Initiated to Accusation Filed - Average	463	1,013	0	0	861	265	0	709
Investigation Completed to Accusation Filed - Average	78	659	0	0	189	97	0	75

Investigation Initiated/Completed to Accusation Filed – Median Calendar Days

The chart below illustrates the median calendar days for all case types and then a breakdown by each individual type. This chart captures the median calendar days from the time the district office initiated the investigation to the time an Accusation was filed and the median calendar days from the time the district office completed the investigation to the time an Accusation was filed.

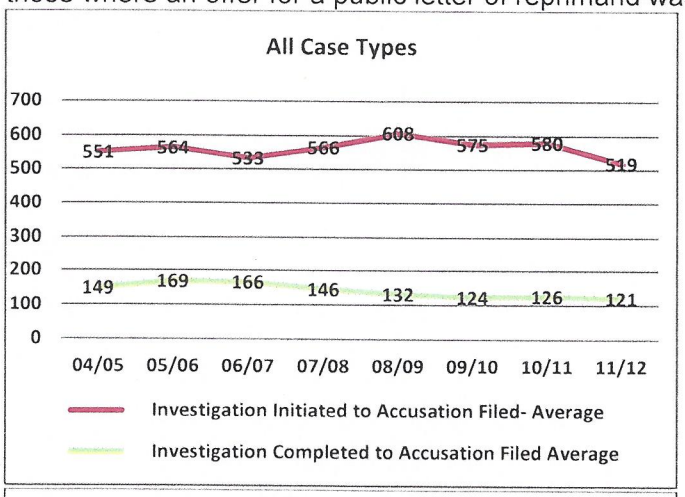
This data excludes the following case types: out-of-state, headquarters, Operation Safe Medicine, probation violations, petitions for modification/termination of probation, petitions for reinstatement, and subsequent discipline on probationers. This data also excludes cases that had a petition to compel examination granted and those where an offer for a public letter of reprimand was rejected by the respondent.

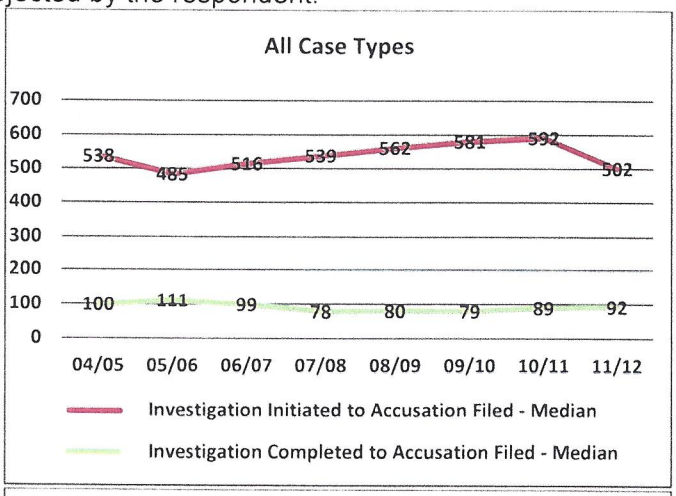
Fiscal Years	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12
All Case Types - (Number of cases)	**164**	**166**	**171**	**173**	**154**	**206**	**198**	**232**
Investigation Initiated to Accusation Issued- Median	**538**	**485**	**516**	**539**	**562**	**581**	**592**	**502**
Investigation Completed to Accusation Issued - Median	**100**	**111**	**99**	**78**	**80**	**79**	**89**	**92**
Gross Negligence/Incompetence - (Number of cases)	93	97	107	99	84	107	116	108
Investigation Initiated to Accusation Issued- Median	605	622	573	602	750	652	648	542
Investigation Completed to Accusation Issued- Median	128	114	129	93	83	74	89	94
Inappropriate Prescribing - (Number of cases)	17	9	7	14	18	15	12	34
Investigation Initiated to Accusation Issued- Median	619	601	663	607	534	920	618	611
Investigation Completed to Accusation Issued - Median	106	157	176	62	91	161	147	100
Unlicensed Activity - (Number of cases)	2	5	2	5	2	5	2	7
Investigation Initiated to Accusation Issued- Median	619	727	413	887	384	477	693	580
Investigation Completed to Accusation Issued - Median	33	159	66	255	152	94	78	118
Sexual Misconduct - (Number of cases)	18	20	11	13	4	18	8	12
Investigation Initiated to Accusation Issued- Median	432	324	462	615	716	767	515	485
Investigation Completed to Accusation Issued - Median	177	75	115	114	45	114	79	76
Mental/Physical Illness - (Number of cases)	9	4	7	7	6	4	8	15
Investigation Initiated to Accusation Issued- Median	283	325	201	459	404	358	592	441
Investigation Completed to Accusation Issued - Median	74	92	37	41	86	81	73	93
Self-abuse of Drugs/Alcohol - (Number of cases)	14	8	17	19	23	21	21	23
Investigation Initiated to Accusation Issued- Median	192	363	333	243	349	226	320	369
Investigation Completed to Accusation Issued - Median	52	60	78	50	47	52	68	80
Fraud - (Number of cases)	1	8	7	7	4	6	8	10
Investigation Initiated to Accusation Issued- Median	1025	394	554	284	515	462	428	533
Investigation Completed to Accusation Issued - Median	292	144	148	96	34	59	114	111
Conviction of Crime - (Number of cases)	3	8	9	7	7	23	14	16
Investigation Initiated to Accusation Issued- Median	246	310	251	332	282	254	443	215
Investigation Completed to Accusation Issued - Median	74	107	71	78	72	69	92	58
Unprofessional Conduct - (Number of cases)	5	4	4	2	3	6	9	6
Investigation Initiated to Accusation Issued- Median	712	443	522	491	720	775	481	91
Investigation Completed to Accusation Issued - Median	78	55	49	198	155	79	62	81
Internet Prescribing - (Number of cases)	2	3	0	0	3	1	0	1
Investigation Initiated to Accusation Issued- Median	463	993	0	0	773	265	0	709
Investigation Completed to Accusation Issued - Median	78	659	0	0	189	97	0	75

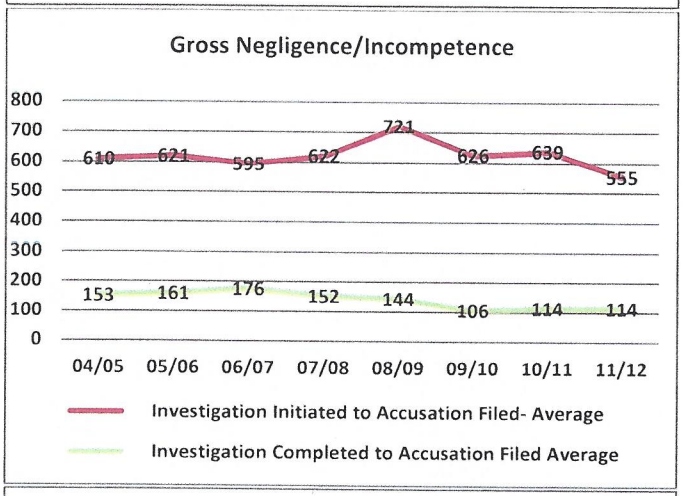
Investigation Initiated/Completed to Accusation Filed – Average/Median Calendar Days

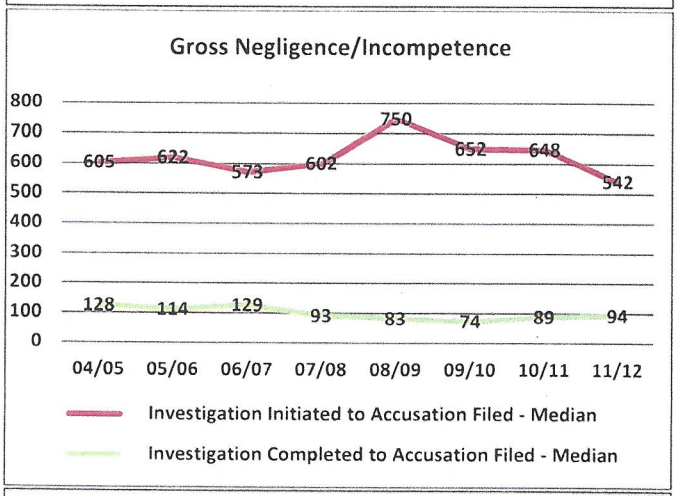
The graphs below illustrate the average (left column) and median (right column) calendar days for all case types and then a breakdown by each individual type. These graphs show two measurements. The top lines represent the average/median calendar days from the time the district office initiated the investigation to the time an Accusation was filed. The bottom lines are a subset of the top lines and represent the average/median calendar days from the time the district office completed the investigation to the time an Accusation was filed.

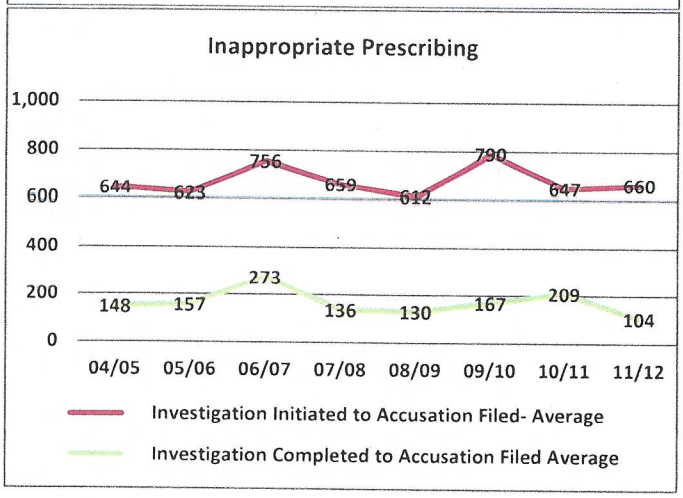
This data excludes the following case types: out-of-state, headquarters, Operation Safe Medicine, probation violations, petitions for modification/termination of probation, petitions for reinstatement, and subsequent discipline on probationers. This data also excludes cases that had a petition to compel examination granted and those where an offer for a public letter of reprimand was rejected by the respondent.

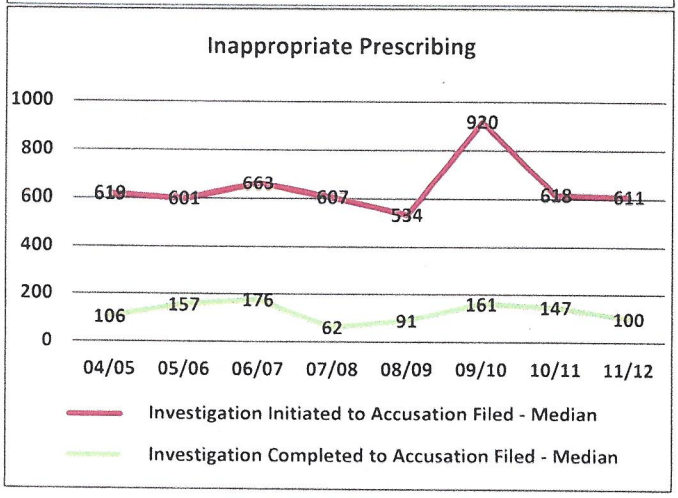












Investigation Initiated/Completed to Accusation Filed – Average/Median Calendar Days

The graphs below illustrate the average (left column) and median (right column) calendar days for all case types and then a breakdown by each individual type. These graphs show two measurements. The top lines represent the average/median calendar days from the time the district office initiated the investigation to the time an Accusation was filed. The bottom lines are a subset of the top lines and represent the average/median calendar days from the time the district office completed the investigation to the time an Accusation was filed.

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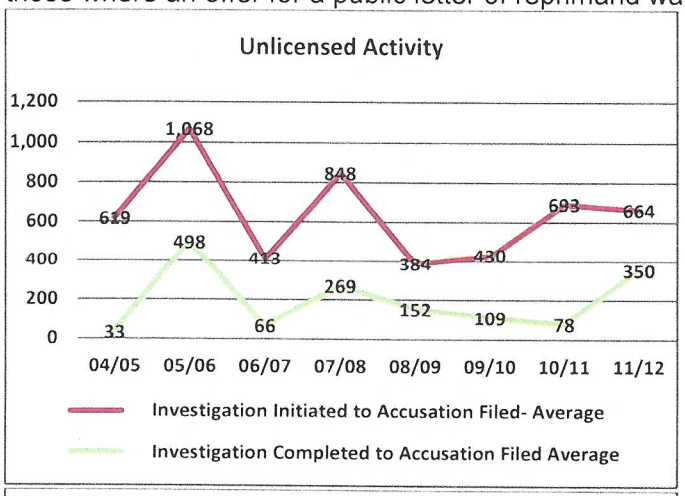
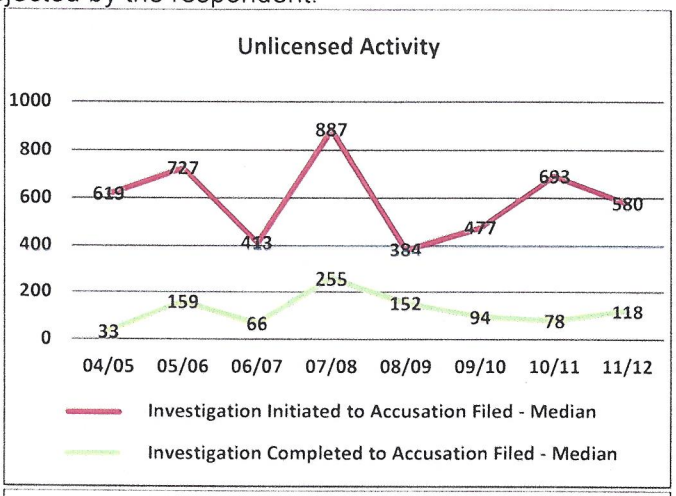
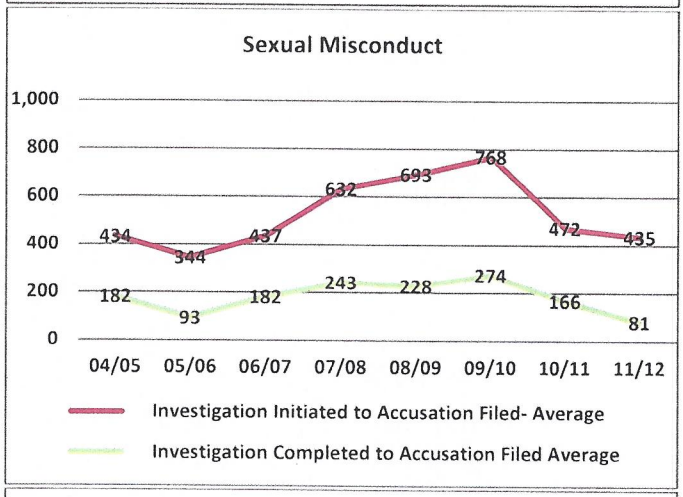
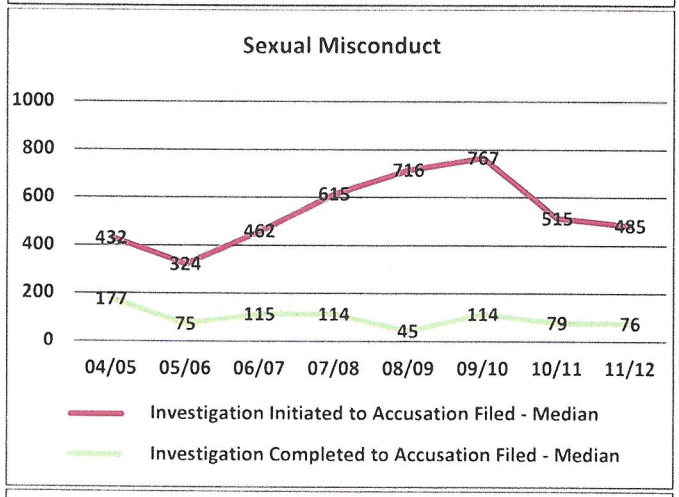
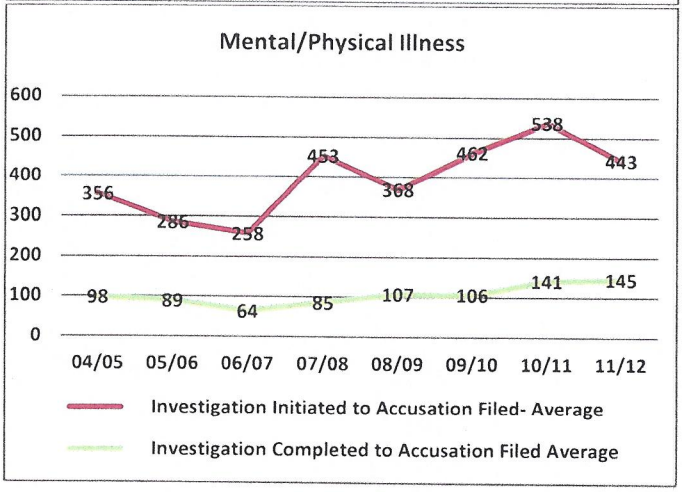
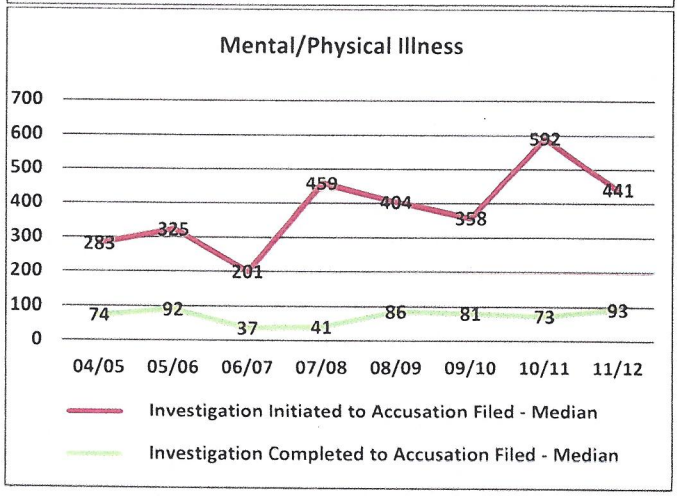








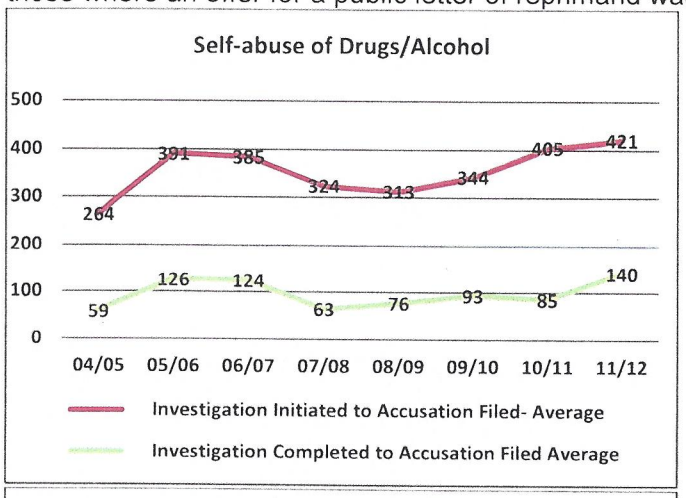


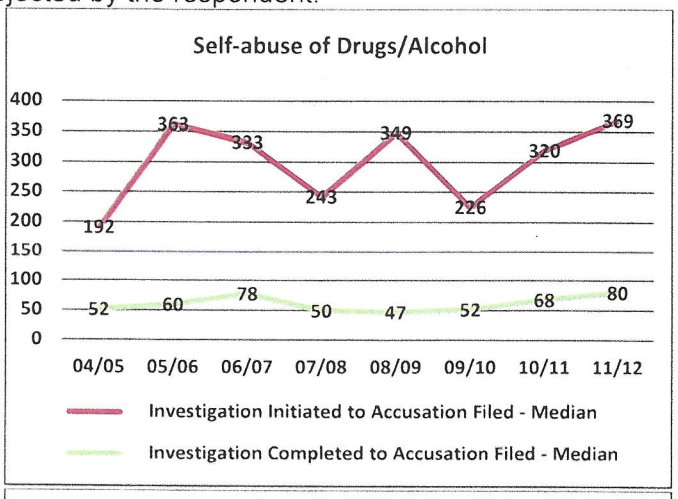


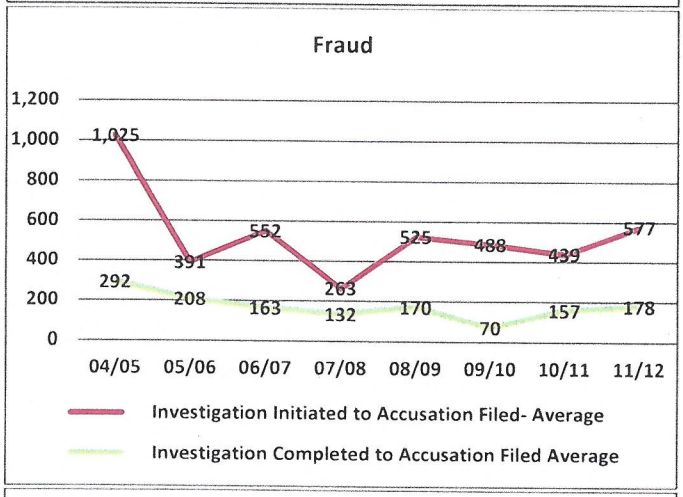
Investigation Initiated/Completed to Accusation Filed – Average/Median Calendar Days

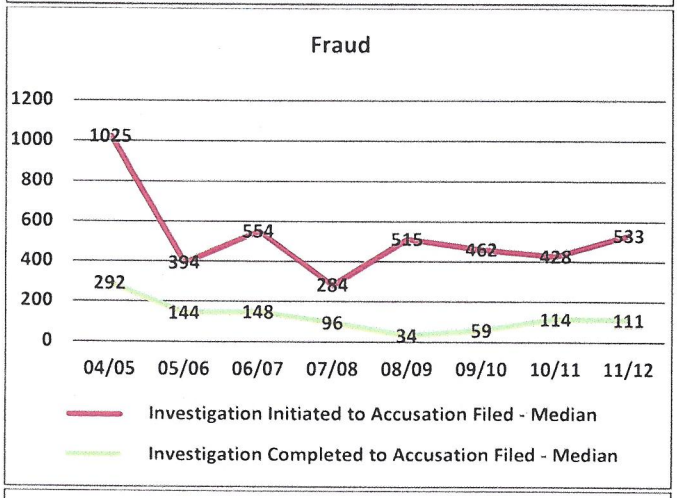
The graphs below illustrate the average (left column) and median (right column) calendar days for all case types and then a breakdown by each individual type. These graphs show two measurements. The top lines represent the average/median calendar days from the time the district office initiated the investigation to the time an Accusation was filed. The bottom lines are a subset of the top lines and represent the average/median calendar days from the time the district office completed the investigation to the time an Accusation was filed.

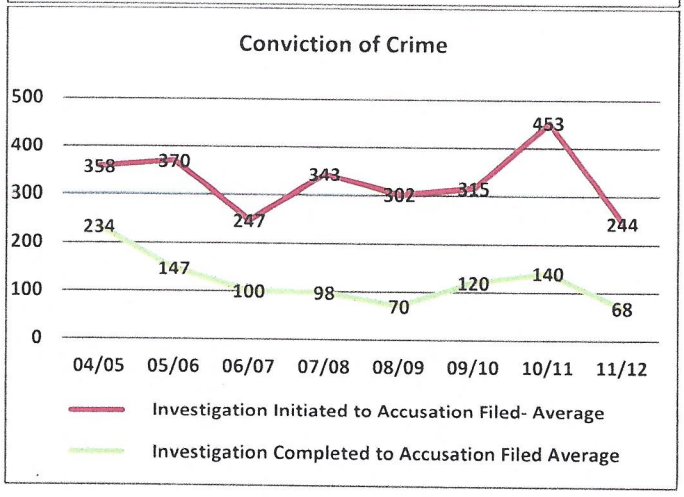
This data excludes the following case types: out-of-state, headquarters, Operation Safe Medicine, probation violations, petitions for modification/termination of probation, petitions for reinstatement, and subsequent discipline on probationers. This data also excludes cases that had a petition to compel examination granted and those where an offer for a public letter of reprimand was rejected by the respondent.

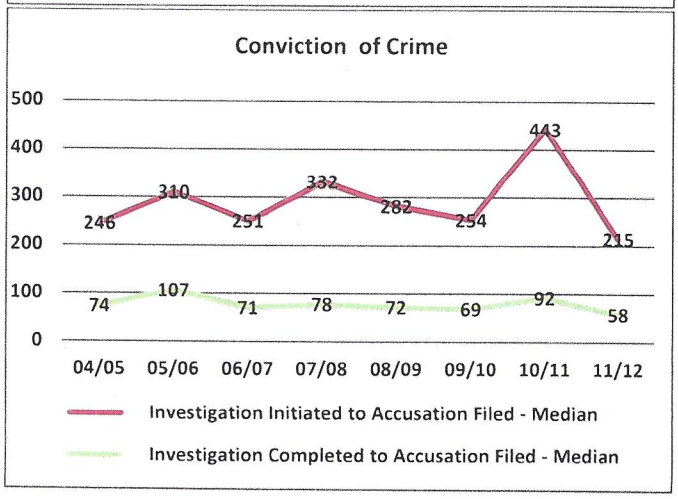








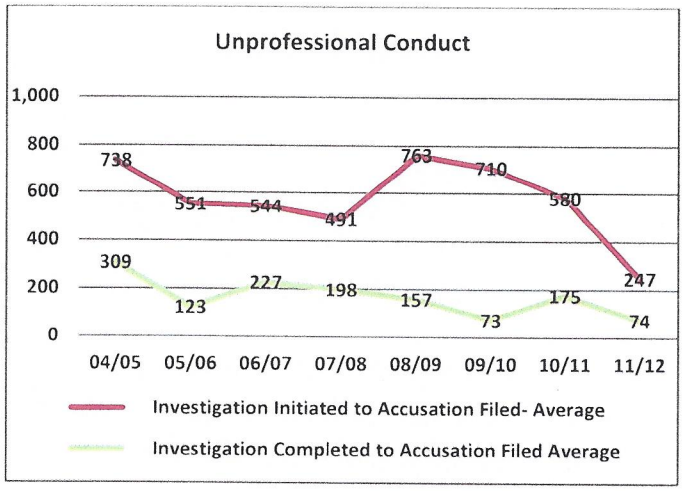


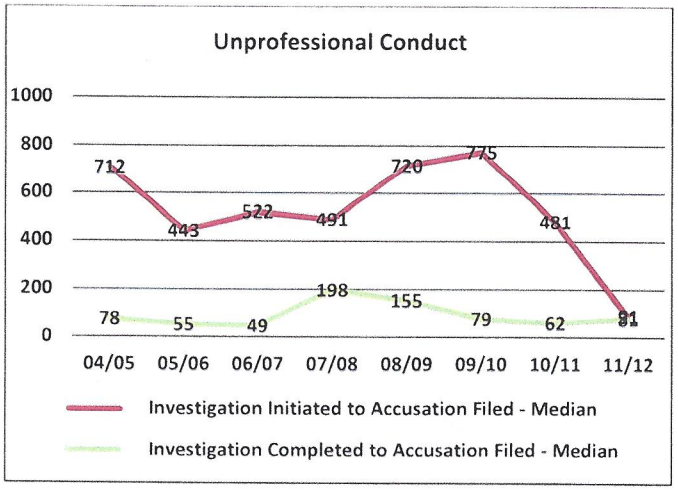


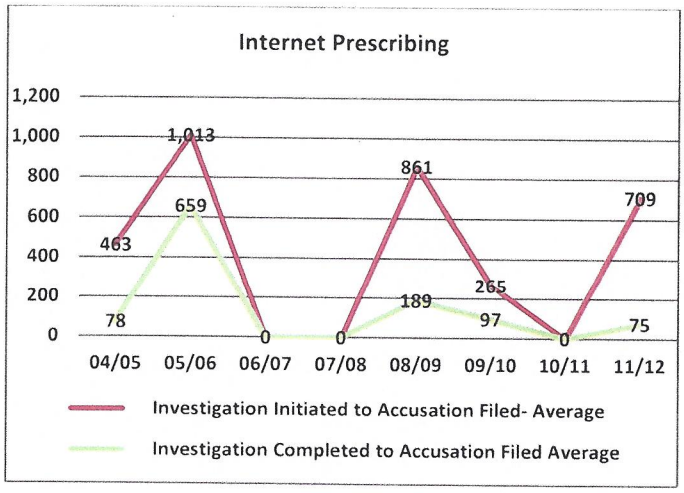
Investigation Initiated/Completed to Accusation Filed – Average/Median Calendar Days

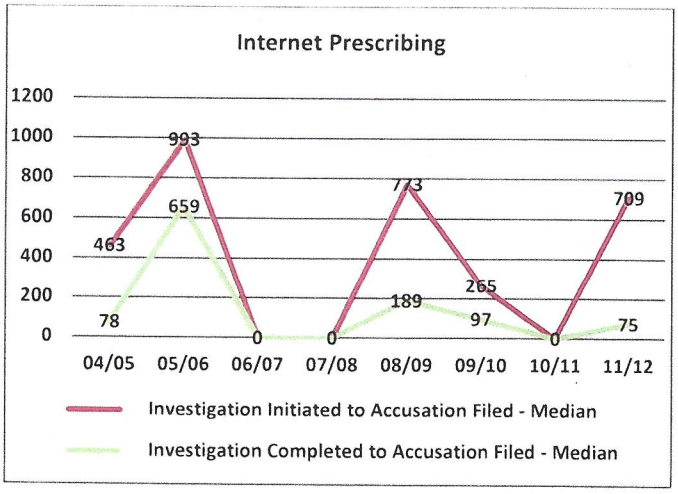
The graphs below illustrate the average (left column) and median (right column) calendar days for all case types and then a breakdown by each individual type. These graphs show two measurements. The top lines represent the average/median calendar days from the time the district office initiated the investigation to the time an Accusation was filed. The bottom lines are a subset of the top lines and represent the average/median calendar days from the time the district office completed the investigation to the time an Accusation was filed.

This data excludes the following case types: out-of-state, headquarters, Operation Safe Medicine, probation violations, petitions for modification/termination of probation, petitions for reinstatement, and subsequent discipline on probationers. This data also excludes cases that had a petition to compel examination granted and those where an offer for a public letter of reprimand was rejected by the respondent.









Investigation Initiated/Completed to Stipulated Decision Received
Average Calendar Days

The chart below illustrates the average calendar days for all case types and then a breakdown by each individual type. The chart captures the average calendar days from the time the district office initiated the investigation to the time a Stipulated Decision was received and the average calendar days from the time the district office completed the investigation to the time a Stipulated Decision was received.

This data excludes the following case types: out-of-state, headquarters, Operation Safe Medicine, probation violations, petitions for modification/termination of probation terms, petitions for reinstatement, and subsequent discipline on probationers.

Fiscal Years	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12
All Case Types - (Number of cases)	**156**	**141**	**143**	**145**	**118**	**135**	**120**	**160**
Investigation Initiated to Stipulation Received- Average	**922**	**1,039**	**923**	**940**	**818**	**916**	**912**	**914**
Investigation Completed to Stipulation Received- Average	**528**	**636**	**542**	**518**	**410**	**431**	**477**	**459**
Gross Negligence/Incompetence - (Number of cases)	90	88	82	86	69	76	57	90
Investigation Initiated to Stipulation Received- Average	979	1,083	1,032	997	965	1,012	1,025	974
Investigation Completed to Stipulation Received- Average	559	665	582	536	495	447	499	452
Inappropriate Prescribing - (Number of cases)	18	16	7	10	9	14	10	14
Investigation Initiated to Stipulation Received- Average	913	1,193	1,163	945	895	1,002	1,312	1,097
Investigation Completed to Stipulation Received- Average	458	704	590	491	455	419	726	529
Unlicensed Activity - (Number of cases)	6	2	2	7	3	1	3	4
Investigation Initiated to Stipulation Received- Average	1,233	1,119	964	1,386	677	843	803	1,285
Investigation Completed to Stipulation Received- Average	1,157	532	754	856	175	408	472	855
Sexual Misconduct - (Number of cases)	9	12	9	7	4	9	8	6
Investigation Initiated to Stipulation Received- Average	812	715	620	1,057	736	1,286	1,050	917
Investigation Completed to Stipulation Received- Average	374	438	387	665	263	806	637	539
Mental/Physical Illness - (Number of cases)	8	2	11	9	5	5	4	12
Investigation Initiated to Stipulation Received- Average	792	599	449	627	358	304	867	632
Investigation Completed to Stipulation Received- Average	267	533	275	306	178	110	531	360
Self-abuse of Drugs/Alcohol - (Number of cases)	10	8	10	11	17	10	17	16
Investigation Initiated to Stipulation Received- Average	414	588	495	522	503	462	536	743
Investigation Completed to Stipulation Received- Average	224	357	263	310	217	290	288	456
Fraud - (Number of cases)	2	2	9	8	2	4	2	6
Investigation Initiated to Stipulation Received- Average	1,052	1,808	1,048	809	526	583	787	657
Investigation Completed to Stipulation Received- Average	762	1,297	649	410	330	263	261	339
Conviction of Crime - (Number of cases)	5	2	8	4	7	10	14	5
Investigation Initiated to Stipulation Received- Average	850	1,437	534	810	584	594	619	711
Investigation Completed to Stipulation Received- Average	667	1,028	439	536	354	359	380	361
Unprofessional Conduct - (Number of cases)	6	7	1	1	2	5	3	7
Investigation Initiated to Stipulation Received- Average	976	990	680	184	723	938	1,058	789
Investigation Completed to Stipulation Received- Average	537	544	214	184	430	403	450	474
Internet Prescribing - (Number of cases)	2	2	3	2	0	1	1	0
Investigation Initiated to Stipulation Received- Average	970	969	2,046	1,319	0	1,141	588	0
Investigation Completed to Stipulation Received- Average	520	610	1,613	830	0	622	420	0

Investigation Initiated/Completed to Stipulated Decision Received
Median Calendar Days

The chart below illustrates the median calendar days for all case types and then a breakdown by each individual type. The chart captures the median calendar days from the time the district office initiated the investigation to the time a Stipulated Decision was received and the median calendar days from the time the district office completed the investigation to the time a Stipulated Decision was received.

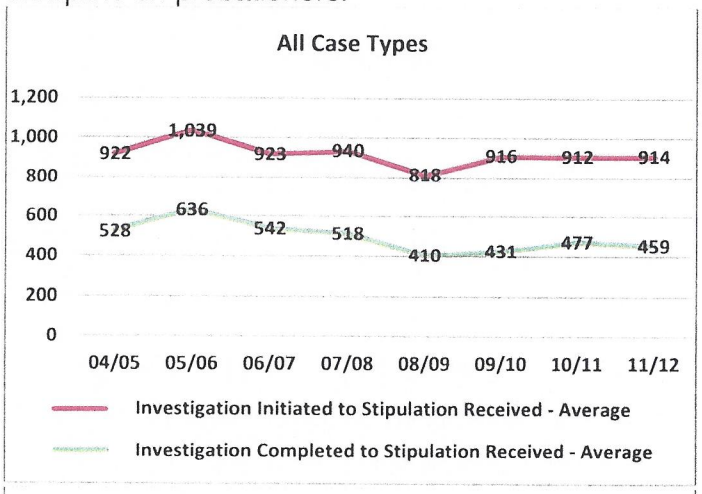
This data excludes the following case types: out-of-state, headquarters, Operation Safe Medicine, probation violations, petitions for modification/termination of probation terms, petitions for reinstatement, and subsequent discipline on probationers.

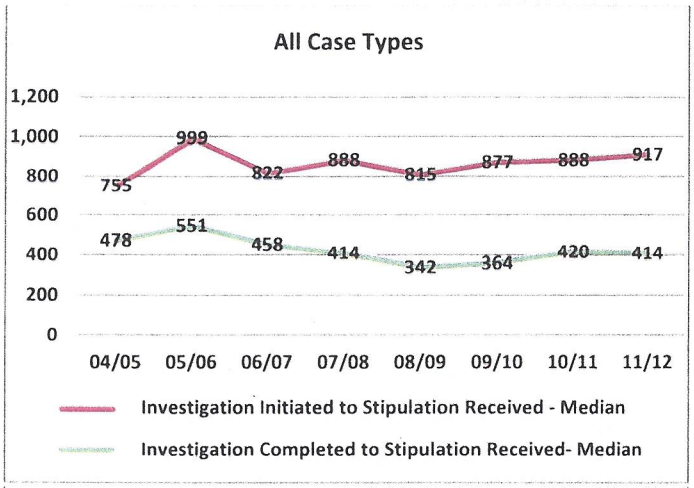
Fiscal Years	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12
All Case Types - (Number of cases)	**156**	**141**	**143**	**145**	**118**	**135**	**120**	**160**
Investigation Initiated to Stipulation Received - Median	**755**	**999**	**822**	**888**	**815**	**877**	**888**	**917**
Investigation Completed to Stipulation Received- Median	**478**	**551**	**458**	**414**	**342**	**364**	**420**	**414**
Gross Negligence/Incompetence - (Number of cases)	90	88	82	86	69	76	57	90
Investigation Initiated to Stipulation Received - Median	981	1,036	1,010	939	918	1,007	1,017	972
Investigation Completed to Stipulation Received- Median	531	612	534	429	421	388	455	436
Inappropriate Prescribing - (Number of cases)	18	16	7	10	9	14	10	14
Investigation Initiated to Stipulation Received - Median	903	1,141	821	989	883	998	1,107	1,142
Investigation Completed to Stipulation Received- Median	419	655	502	325	273	341	711	594
Unlicensed Activity - (Number of cases)	6	2	2	7	3	1	3	4
Investigation Initiated to Stipulation Received - Median	1,262	1,119	964	1,152	989	843	704	1,282
Investigation Completed to Stipulation Received- Median	1,197	532	754	678	171	408	579	1,026
Sexual Misconduct - (Number of cases)	9	12	9	7	4	9	8	6
Investigation Initiated to Stipulation Received - Median	828	662	629	1053	601	1156	1139	935
Investigation Completed to Stipulation Received- Median	358	309	338	666	202	583	365	514
Mental/Physical Illness - (Number of cases)	8	2	11	9	5	5	4	12
Investigation Initiated to Stipulation Received - Median	720	599	454	602	338	310	860	536
Investigation Completed to Stipulation Received- Median	164	533	245	203	99	128	534	260
Self-abuse of Drugs/Alcohol - (Number of cases)	10	8	10	11	17	10	17	16
Investigation Initiated to Stipulation Received - Median	363	442	483	496	478	419	430	702
Investigation Completed to Stipulation Received- Median	149	299	216	281	204	264	222	442
Fraud - (Number of cases)	2	2	9	8	2	4	2	6
Investigation Initiated to Stipulation Received - Median	1,052	1,808	707	808	526	572	787	577
Investigation Completed to Stipulation Received- Median	762	1,297	391	432	330	479	261	344
Conviction of Crime - (Number of cases)	5	2	8	4	7	10	14	5
Investigation Initiated to Stipulation Received - Median	832	1,437	457	895	527	597	590	574
Investigation Completed to Stipulation Received- Median	528	1,028	376	433	373	341	287	269
Unprofessional Conduct - (Number of cases)	6	7	1	1	2	5	3	7
Investigation Initiated to Stipulation Received - Median	939	1,083	680	184	723	1,040	1,092	667
Investigation Completed to Stipulation Received- Median	587	485	214	184	430	365	318	407
Internet Prescribing - (Number of cases)	2	2	3	2	0	1	1	0
Investigation Initiated to Stipulation Received - Median	970	969	1447	1319	0	1141	588	0
Investigation Completed to Stipulation Received- Median	520	610	1158	830	0	622	420	0

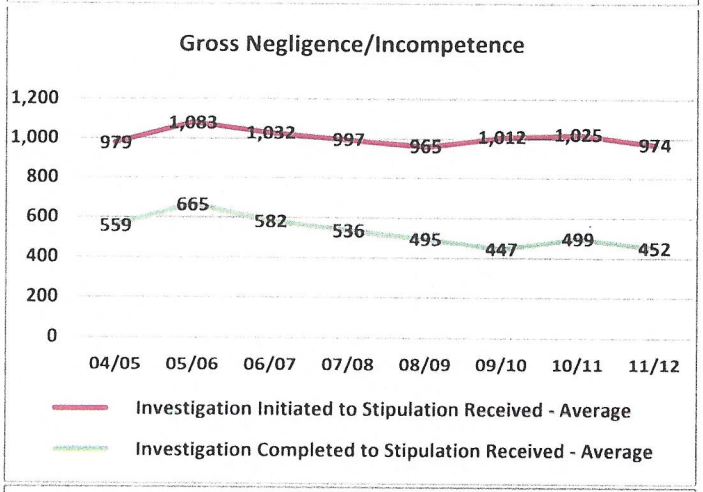
Investigation Initiated/Completed to Stipulated Decision Received Average/Median Calendar Days

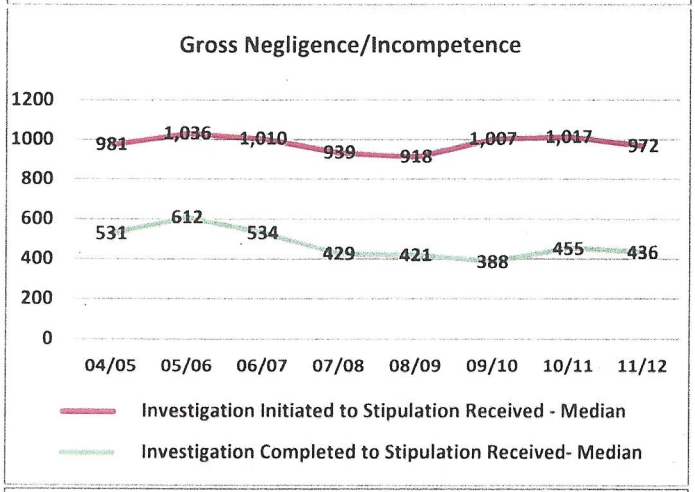
The graphs below illustrate the average (left column) and median (right column) calendar days for all case types and then a breakdown by each individual type. These graphs show two measurements. The top lines represent the average/median calendar days from the time the district office initiated the investigation to the time a Stipulated Decision was received. The bottom lines are a subset of the top lines and represent the average/median calendar days from the time the district office completed the investigation to the time a Stipulated Decision was received.

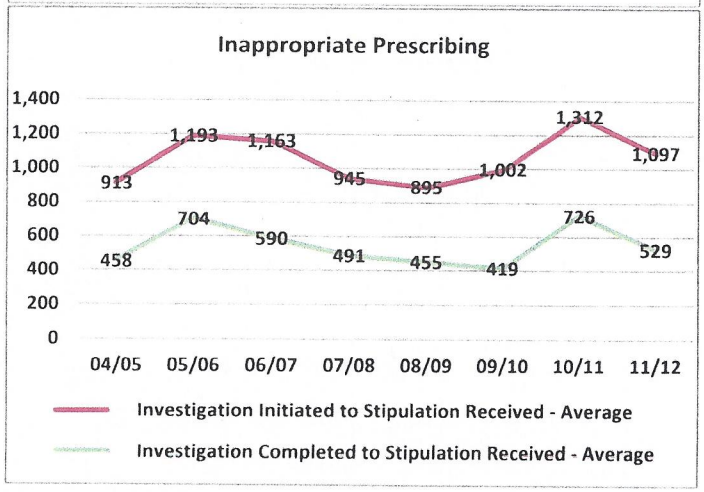
This data excludes the following case types: out-of-state, headquarters, Operation Safe Medicine, probation violations, petitions for modification/termination of probation terms, petitions for reinstatement, and subsequent discipline on probationers.

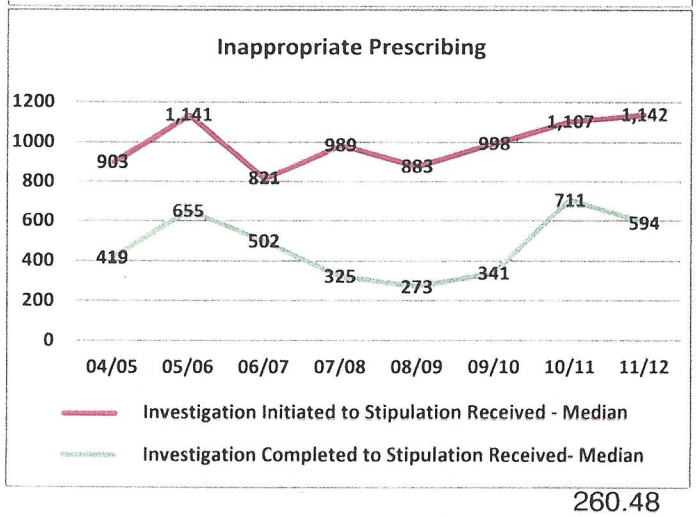












Investigation Initiated/Completed to Stipulated Decision Received Average/Median Calendar Days

The graphs below illustrate the average (left column) and median (right column) calendar days for all case types and then a breakdown by each individual type. These graphs show two measurements. The top lines represent the average/median calendar days from the time the district office initiated the investigation to the time a Stipulated Decision was received. The bottom lines are a subset of the top lines and represent the average/median calendar days from the time the district office completed the investigation to the time a Stipulated Decision was received.

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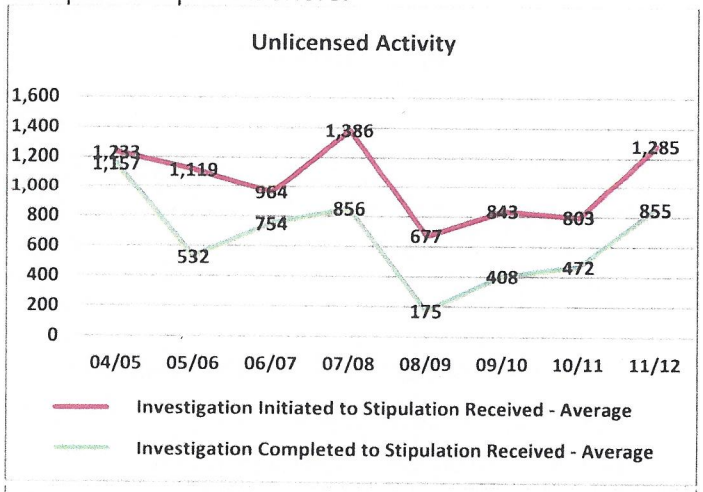

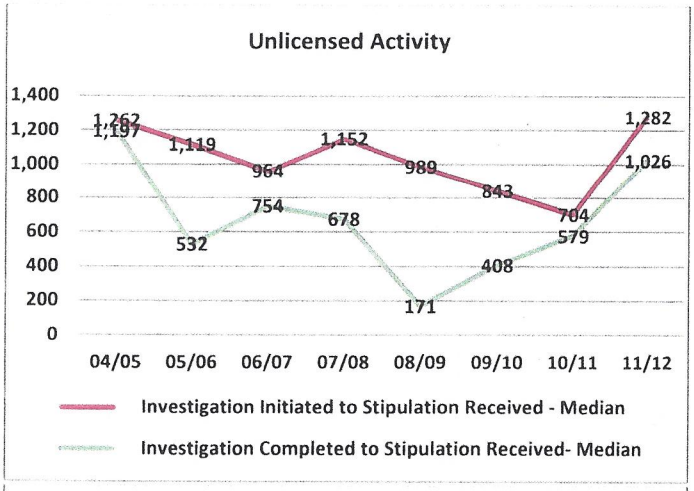

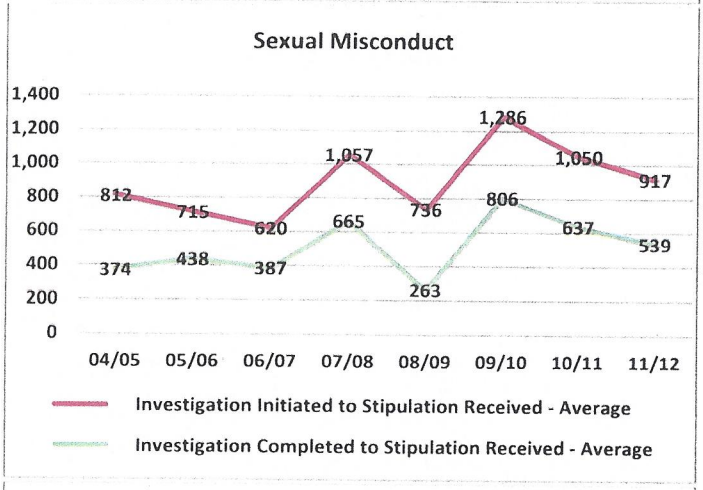

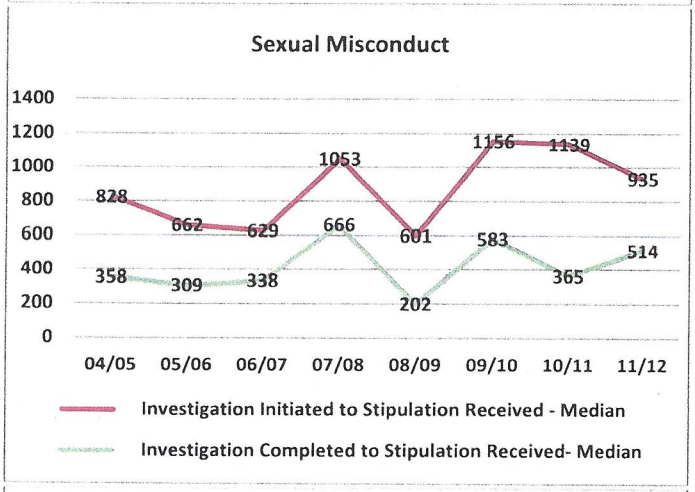

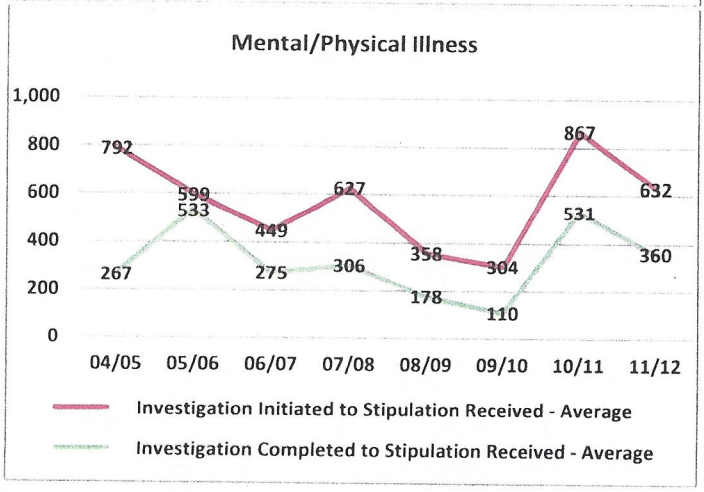

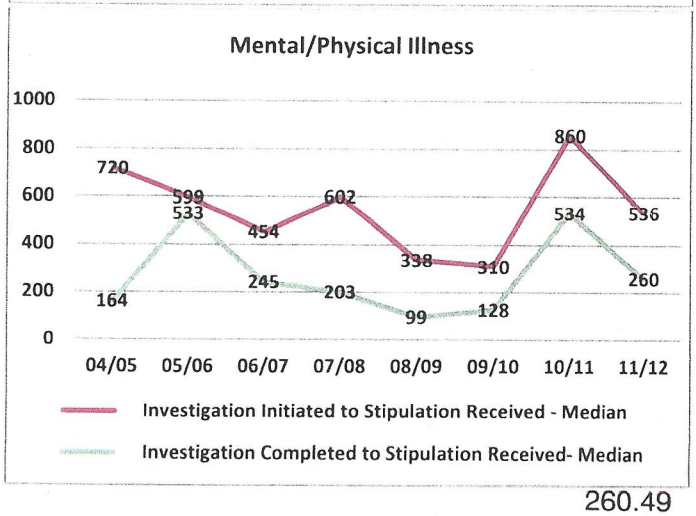

Investigation Initiated/Completed to Stipulated Decision Received Average/Median Calendar Days

The graphs below illustrate the average (left column) and median (right column) calendar days for all case types and then a breakdown by each individual type. These graphs show two measurements. The top lines represent the average/median calendar days from the time the district office initiated the investigation to the time a Stipulated Decision was received. The bottom lines are a subset of the top lines and represent the average/median calendar days from the time the district office completed the investigation to the time a Stipulated Decision was received.

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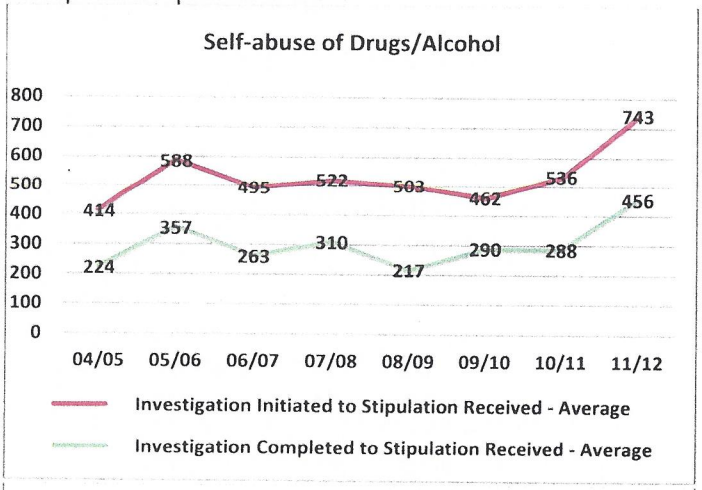

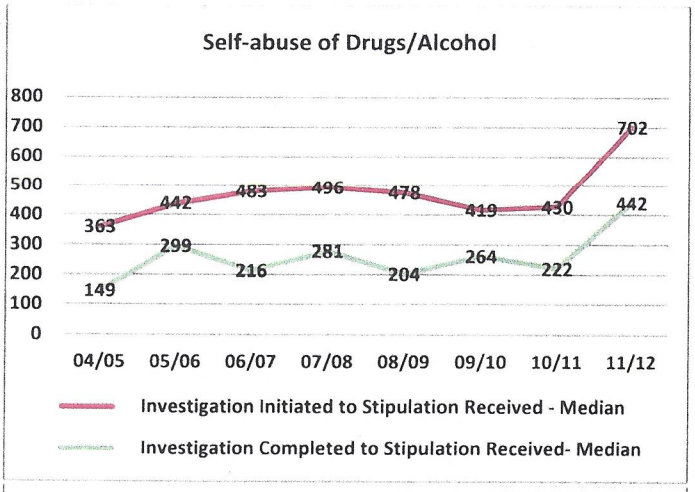

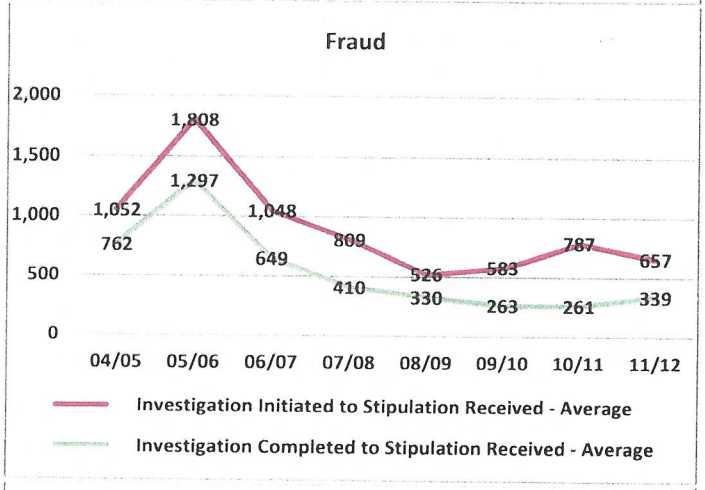

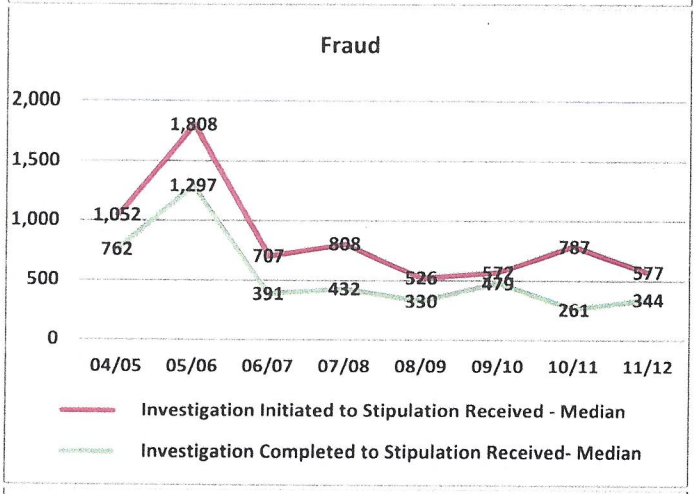

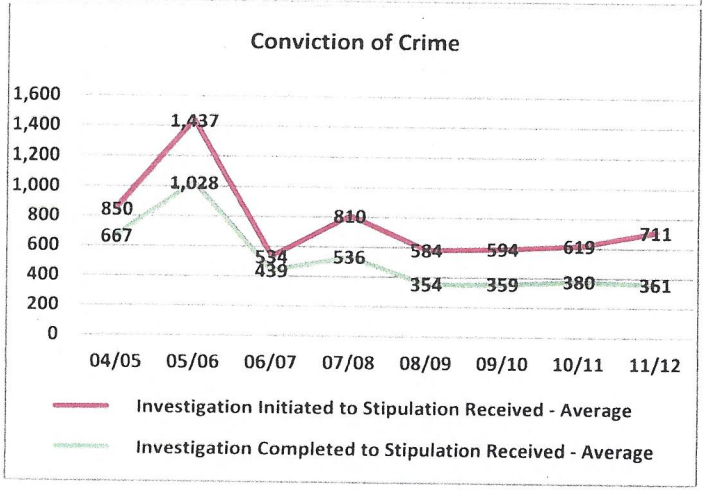

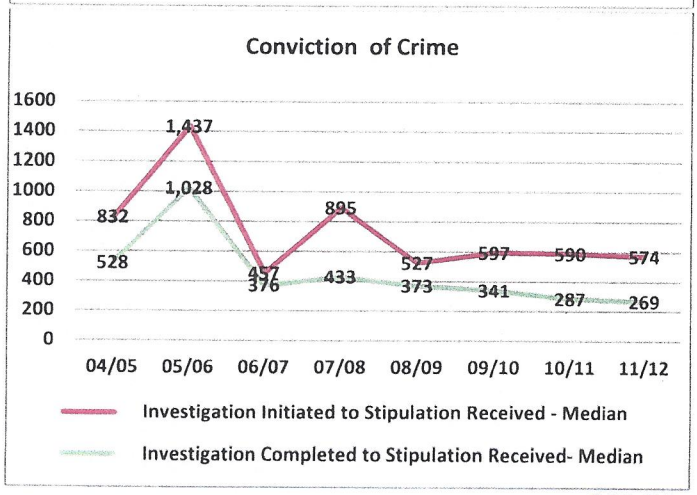

Investigation Initiated/Completed to Stipulated Decision Received Average/Median Calendar Days

The graphs below illustrate the average (left column) and median (right column) calendar days for all case types and then a breakdown by each individual type. These graphs show two measurements. The top lines represent the average/median calendar days from the time the district office initiated the investigation to the time a Stipulated Decision was received. The bottom lines are a subset of the top lines and represent the average/median calendar days from the time the district office completed the investigation to the time a Stipulated Decision was received.

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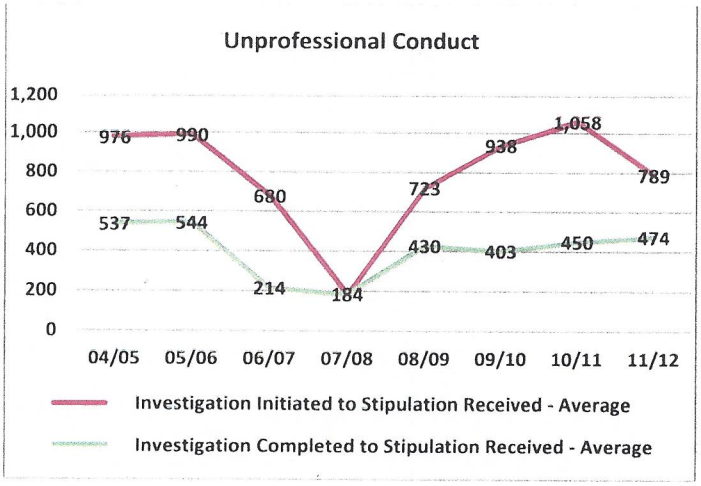

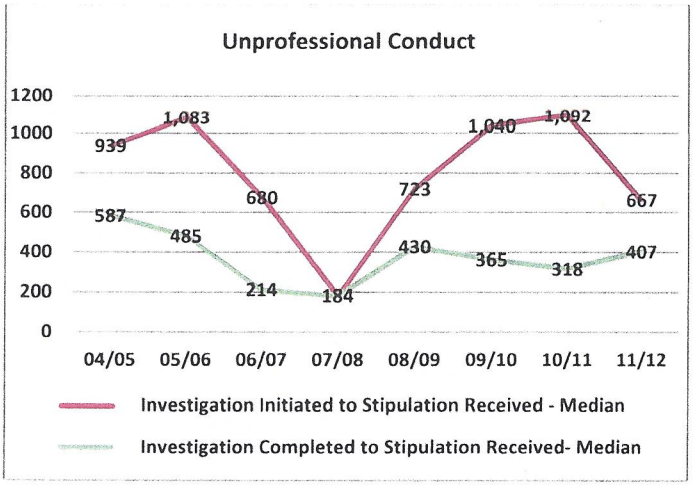

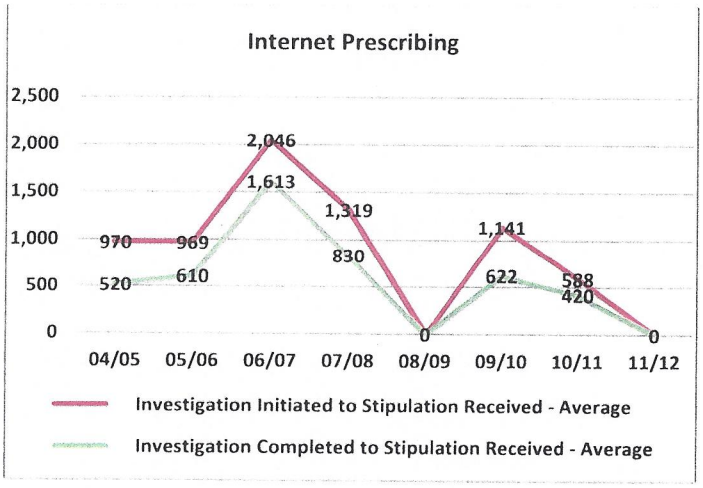

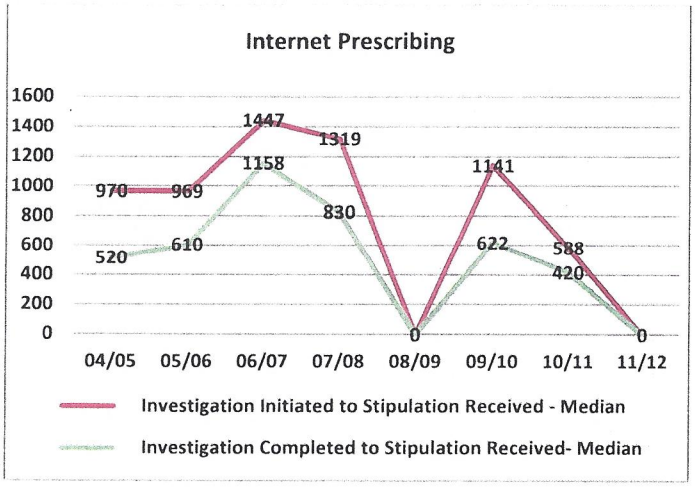

Investigation Initiated/Completed to Submittal of the Matter to an Administrative Law Judge (ALJ) or Proposed Decision Received – Average Calendar Days

The chart below illustrates the average calendar days for all case types and then a breakdown by each individual type. This chart captures the average calendar days from the time the district office initiated the investigation to the time a matter was submitted to an ALJ or a proposed decision was received and the average calendar days from the time the district office completed the investigation to the time a matter was submitted to an ALJ or a proposed decision was received. Note: the date a proposed decision was received was only used in cases where the Board could not identify when the matter was submitted to the ALJ.

This data excludes the following case types: out-of-state, headquarters, Operation Safe Medicine, probation violations, petitions for modification/termination of probation terms, petitions for reinstatement, and subsequent discipline on probationers.

Fiscal Years	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12
All Case Types - (Number of cases)	**42**	**30**	**37**	**39**	**33**	**27**	**37**	**38**
Investigation Initiated to Matter Submitted to ALJ or Proposed Decision Received - Average	**1,115**	**1,161**	**926**	**1,161**	**1,102**	**850**	**973**	**1,038**
Investigation Completed to Matter Submitted to ALJ or Proposed Decision Received - Average	**713**	**747**	**604**	**751**	**700**	**437**	**513**	**565**
Gross Negligence/Incompetence - (Number of cases)	23	18	17	23	20	13	16	19
Investigation Initiated to Matter Submitted to ALJ or Proposed Decision Received - Average	1,233	1,198	1,064	1,212	1,224	1,046	1,095	1,213
Investigation Completed to Matter Submitted to ALJ or Proposed Decision Received - Average	722	727	640	739	762	443	529	604
Inappropriate Prescribing - (Number of cases)	3	1	2	2	2	0	2	3
Investigation Initiated to Matter Submitted to ALJ or Proposed Decision Received - Average	1,360	1,786	774	1,477	680	0	1,106	1,262
Investigation Completed to Matter Submitted to ALJ or Proposed Decision Received - Average	833	1,362	522	965	452	0	673	964
Unlicensed Activity - (Number of cases)	0	0	1	1	0	0	2	0
Investigation Initiated to Matter Submitted to ALJ or Proposed Decision Received - Average	0	0	1,005	1,297	0	0	637	0
Investigation Completed to Matter Submitted to ALJ or Proposed Decision Received - Average	0	0	556	710	0	0	401	0
Sexual Misconduct - (Number of cases)	5	3	4	5	3	5	5	0
Investigation Initiated to Matter Submitted to ALJ or Proposed Decision Received - Average	934	725	747	1,017	1,138	855	1,370	0
Investigation Completed to Matter Submitted to ALJ or Proposed Decision Received - Average	611	547	534	902	668	604	863	0
Mental/Physical Illness - (Number of cases)	1	1	4	2	2	0	3	3
Investigation Initiated to Matter Submitted to ALJ or Proposed Decision Received - Average	611	1,038	643	826	765	0	632	922
Investigation Completed to Matter Submitted to ALJ or Proposed Decision Received - Average	407	639	450	134	570	0	367	483
Self-abuse of Drugs/Alcohol - (Number of cases)	4	2	4	4	3	6	3	5
Investigation Initiated to Matter Submitted to ALJ or Proposed Decision Received - Average	717	503	685	625	434	615	350	844
Investigation Completed to Matter Submitted to ALJ or Proposed Decision Received - Average	643	408	388	365	247	389	231	414
Fraud - (Number of cases)	2	3	0	2	1	1	1	3
Investigation Initiated to Matter Submitted to ALJ or Proposed Decision Received - Average	1,091	1,606	0	1,964	1,666	501	890	809
Investigation Completed to Matter Submitted to ALJ or Proposed Decision Received - Average	777	1,045	0	1,699	1,151	262	342	529
Conviction of Crime - (Number of cases)	2	1	4	0	0	2	3	3
Investigation Initiated to Matter Submitted to ALJ or Proposed Decision Received - Average	1,222	1,079	1,135	0	0	444	650	533
Investigation Completed to Matter Submitted to ALJ or Proposed Decision Received - Average	1,049	775	1,014	0	0	212	353	392
Unprofessional Conduct - (Number of cases)	1	1	1	0	2	0	2	2
Investigation Initiated to Matter Submitted to ALJ or Proposed Decision Received - Average	447	1,342	772	0	1,312	0	1,178	800
Investigation Completed to Matter Submitted to ALJ or Proposed Decision Received - Average	351	951	325	0	950	0	433	417
Internet Prescribing - (Number of cases)	1	0	0	0	0	0	0	0
Investigation Initiated to Matter Submitted to ALJ or Proposed Decision Received - Average	1,181	0	0	0	0	0	0	0
Investigation Completed to Matter Submitted to ALJ or Proposed Decision Received - Average	807	0	0	0	0	0	0	0

Investigation Initiated/Completed to Submittal of the Matter to an Administrative Law Judge (ALJ) or Proposed Decision Received – Median Calendar Days

The chart below illustrates the median calendar days for all case types and then a breakdown by each individual type. This chart captures the median calendar days from the time the district office initiated the investigation to the time a matter was submitted to an ALJ or a proposed decision was received and the median calendar days from the time the district office completed the investigation to the time a matter was submitted to an ALJ or a proposed decision was received. Note: the date a proposed decision was received was only used in cases where the Board could not identify when the matter was submitted to the ALJ.

This data excludes the following case types: out-of-state, headquarters, Operation Safe Medicine, probation violations, petitions for modification/termination of probation terms, petitions for reinstatement, and subsequent discipline on probationers.

Fiscal Years	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12
All Case Types - (Number of cases)	**42**	**30**	**37**	**39**	**33**	**27**	**37**	**38**
Investigation Initiated to Matter Submitted to ALJ or Proposed Decision Received - Median	**1,006**	**1,114**	**833**	**1,123**	**1,146**	**817**	**899**	**1,104**
Investigation Completed to Matter Submitted to ALJ or Proposed Decision Received - Median	**648**	**639**	**513**	**746**	**621**	**352**	**420**	**505**
Gross Negligence/Incompetence - (Number of cases)	23	18	17	23	20	13	16	19
Investigation Initiated to Matter Submitted to ALJ or Proposed Decision Received - Median	1,034	1,142	961	1,273	1,181	1,083	1,114	1,201
Investigation Completed to Matter Submitted to ALJ or Proposed Decision Received - Median	648	615	606	786	738	404	450	534
Inappropriate Prescribing- (Number of cases)	3	1	2	2	2	0	2	3
Investigation Initiated to Matter Submitted to ALJ or Proposed Decision Received - Median	1,208	1,786	774	1,477	680	0	1,106	1,140
Investigation Completed to Matter Submitted to ALJ or Proposed Decision Received - Median	561	1,362	522	965	452	0	673	906
Unlicensed Activity - (Number of cases)	0	0	1	1	0	0	2	0
Investigation Initiated to Matter Submitted to ALJ or Proposed Decision Received - Median	0	0	1,005	1,297	0	0	637	0
Investigation Completed to Matter Submitted to ALJ or Proposed Decision Received - Median	0	0	556	710	0	0	401	0
Sexual Misconduct - (Number of cases)	5	3	4	5	3	5	5	0
Investigation Initiated to Matter Submitted to ALJ or Proposed Decision Received - Median	956	863	727	1,123	1,210	936	1,309	0
Investigation Completed to Matter Submitted to ALJ or Proposed Decision Received - Median	759	537	396	1,003	577	428	762	0
Mental/Physical Illness - (Number of cases)	1	1	4	2	2	0	3	3
Investigation Initiated to Matter Submitted to ALJ or Proposed Decision Received - Median	611	1,038	439	826	765	0	603	1,104
Investigation Completed to Matter Submitted to ALJ or Proposed Decision Received - Median	407	639	434	134	570	0	308	332
Self-abuse of Drugs/Alcohol - (Number of cases)	4	2	4	4	3	6	3	5
Investigation Initiated to Matter Submitted to ALJ or Proposed Decision Received - Median	674	503	726	557	380	588	442	928
Investigation Completed to Matter Submitted to ALJ or Proposed Decision Received - Median	581	408	317	407	278	315	265	437
Fraud - (Number of cases)	2	3	0	2	1	1	1	3
Investigation Initiated to Matter Submitted to ALJ or Proposed Decision Received - Median	1,091	1,671	0	1,964	1,666	501	890	778
Investigation Completed to Matter Submitted to ALJ or Proposed Decision Received - Median	777	978	0	1,699	1,151	262	342	472
Conviction of Crime - (Number of cases)	2	1	4	0	0	2	3	3
Investigation Initiated to Matter Submitted to ALJ or Proposed Decision Received - Median	1,222	1,079	456	0	0	444	707	614
Investigation Completed to Matter Submitted to ALJ or Proposed Decision Received - Median	1,049	775	274	0	0	212	315	430
Unprofessional Conduct - (Number of cases)	1	1	1	0	2	0	2	2
Investigation Initiated to Matter Submitted to ALJ or Proposed Decision Received - Median	447	1,342	772	0	1,312	0	1,178	800
Investigation Completed to Matter Submitted to ALJ or Proposed Decision Received - Median	351	951	325	0	655	0	433	417
Internet Prescribing - (Number of cases)	1	0	0	0	0	0	0	0
Investigation Initiated to Matter Submitted to ALJ or Proposed Decision Received - Median	1,181	0	0	0	0	0	0	0
Investigation Completed to Matter Submitted to ALJ or Proposed Decision Received - Median	807	0	0	0	0	0	0	0

ATTACHMENT E

Investigation Initiated/Completed to Submittal of the Matter to an Administrative Law Judge (ALJ) or Proposed Decision Received - Average/Median Calendar Days

The graphs below illustrate the average (left column) and median (right column) calendar days for all case types and then a breakdown by each individual type. These graphs show two measurements. The top lines represent the average/median calendar days from the time the district office initiated the investigation to the time a matter was submitted to an ALJ or a proposed decision was received. The bottom lines are a subset of the top lines and represent the average/median calendar days from the time the district office completed the investigation to the time a matter was submitted to an ALJ or a proposed decision was received. Note: the date a proposed decision was received was only used in cases where the Board could not identify when the matter was submitted to the ALJ.

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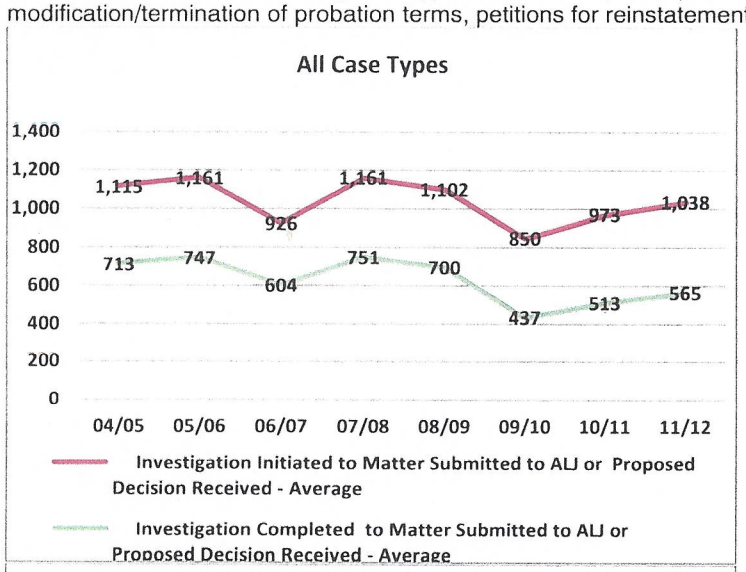

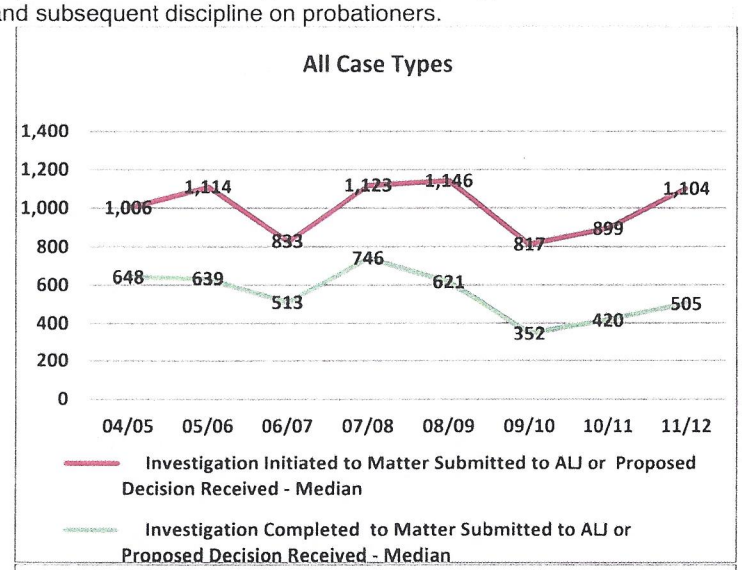

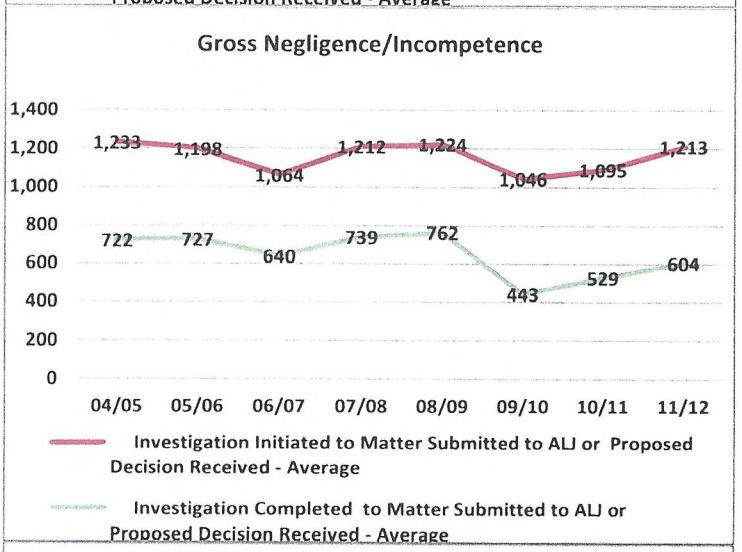

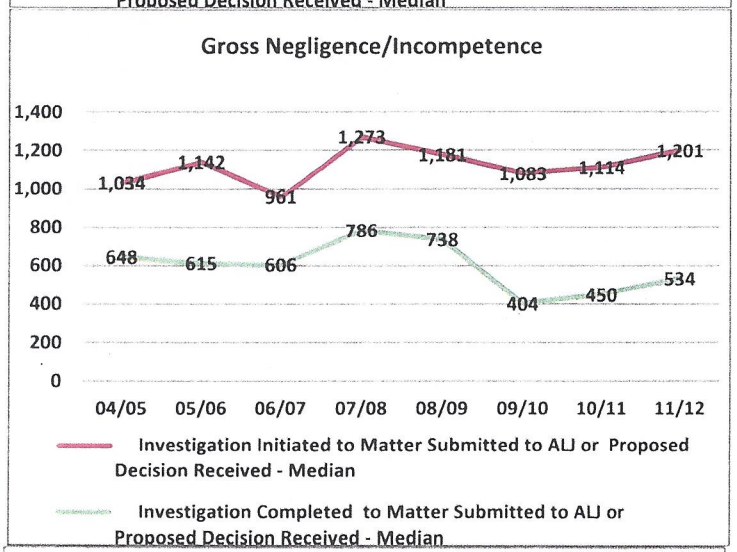

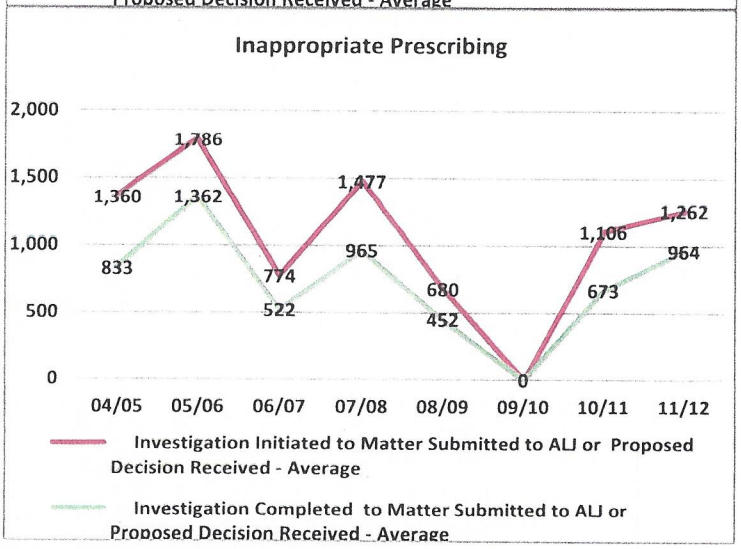

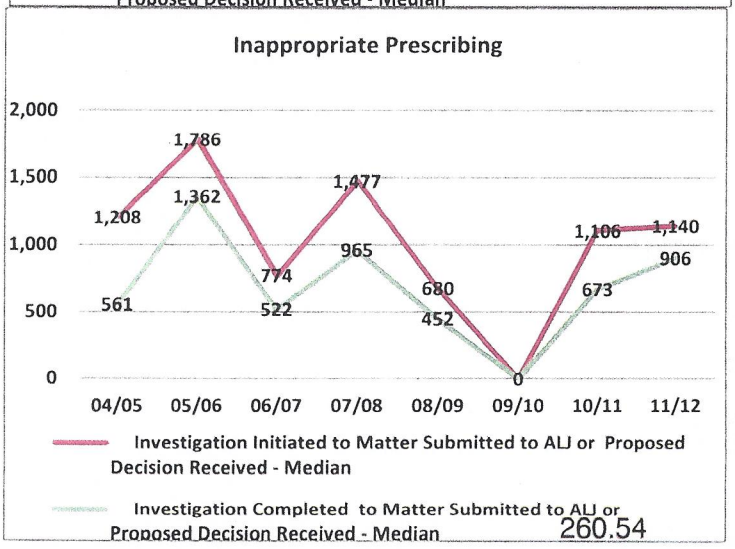

ATTACHMENT E

Investigation Initiated/Completed to Submittal of the Matter to an Administrative Law Judge (ALJ) or Proposed Decision Received - Average/Median Calendar Days

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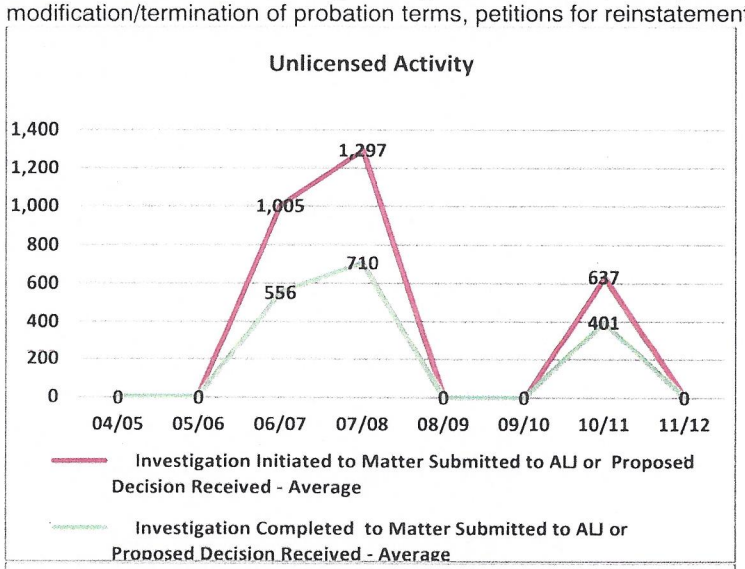

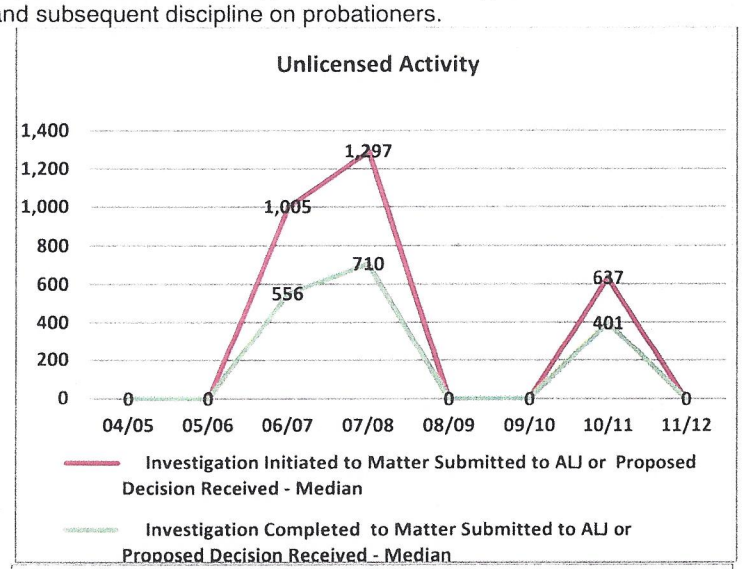

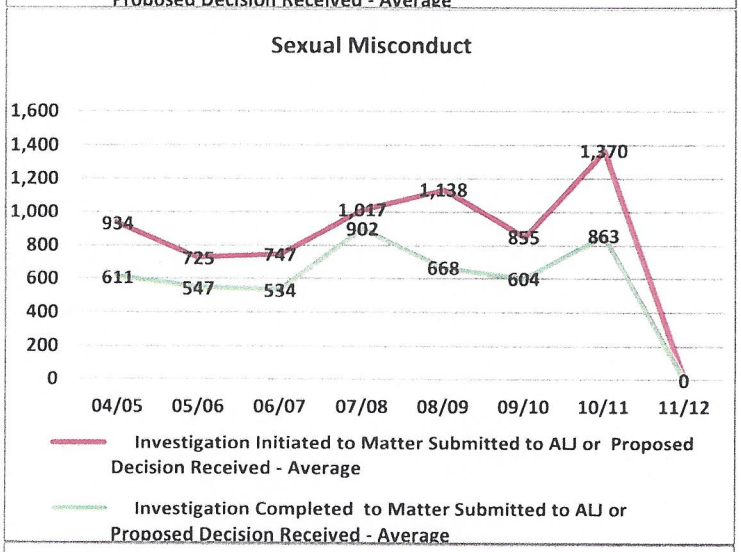

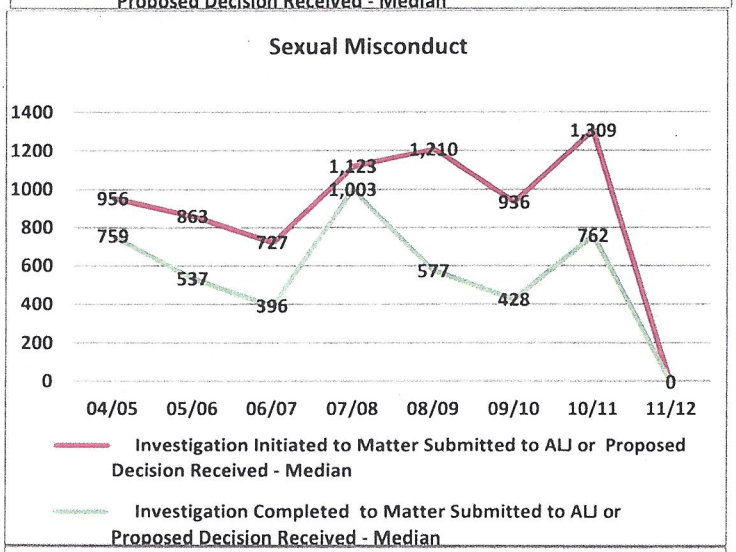

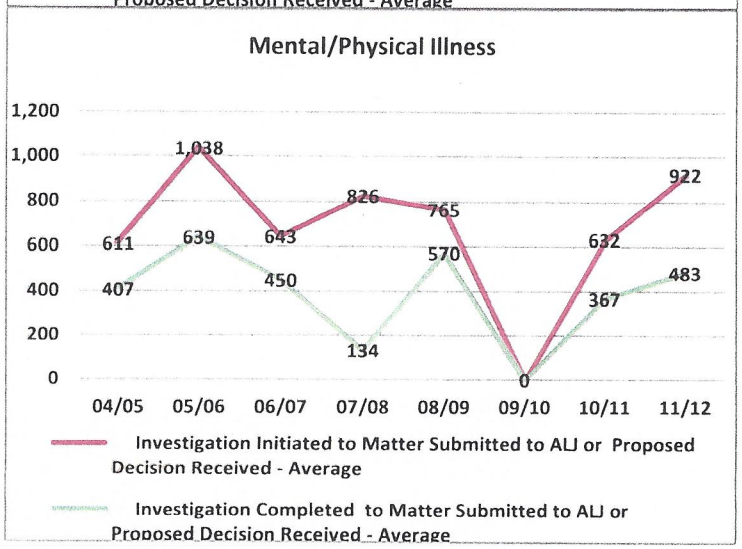

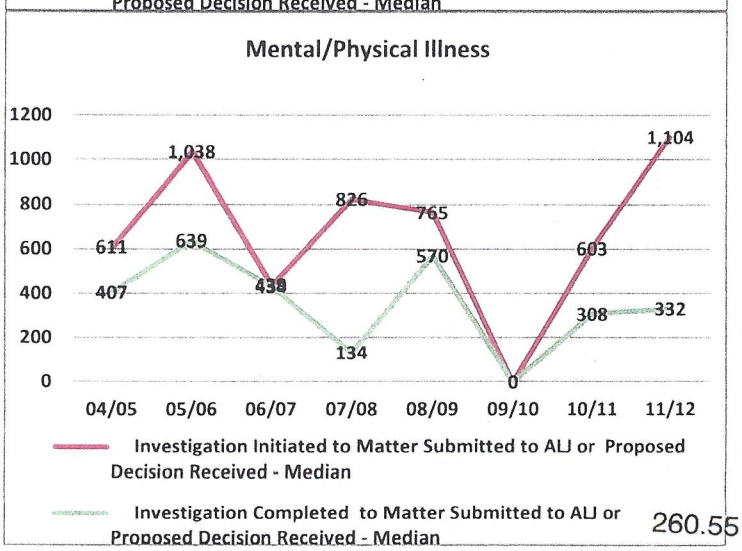

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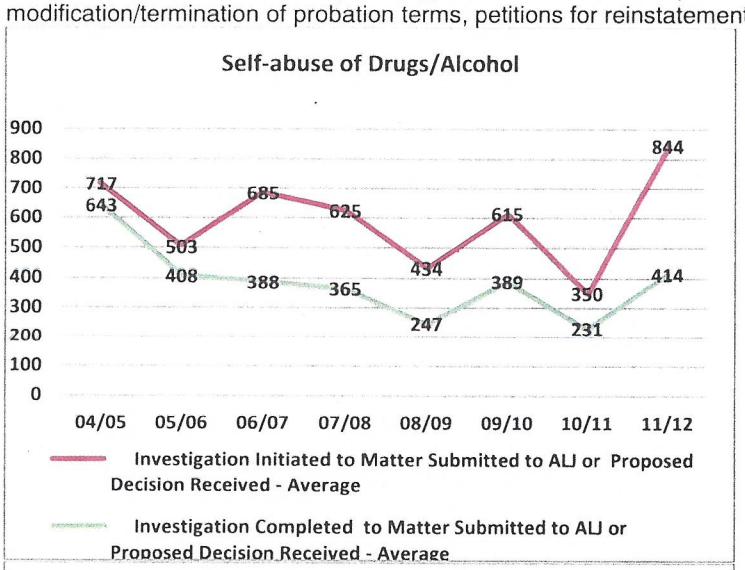

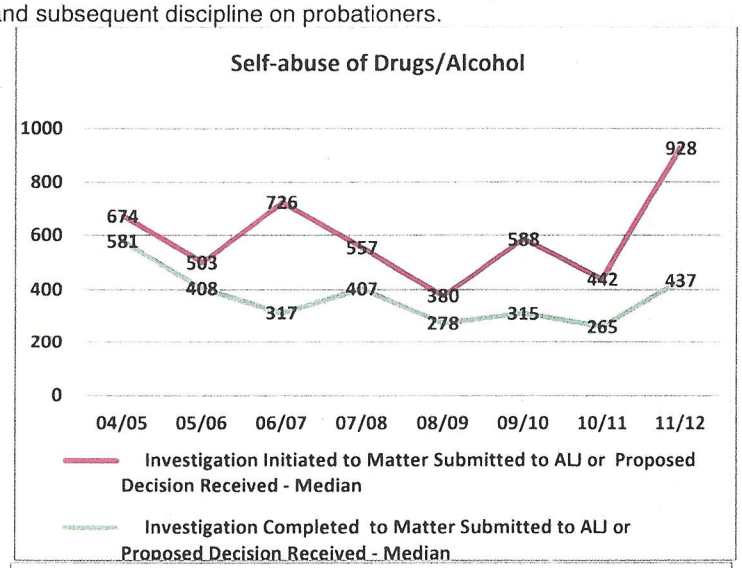

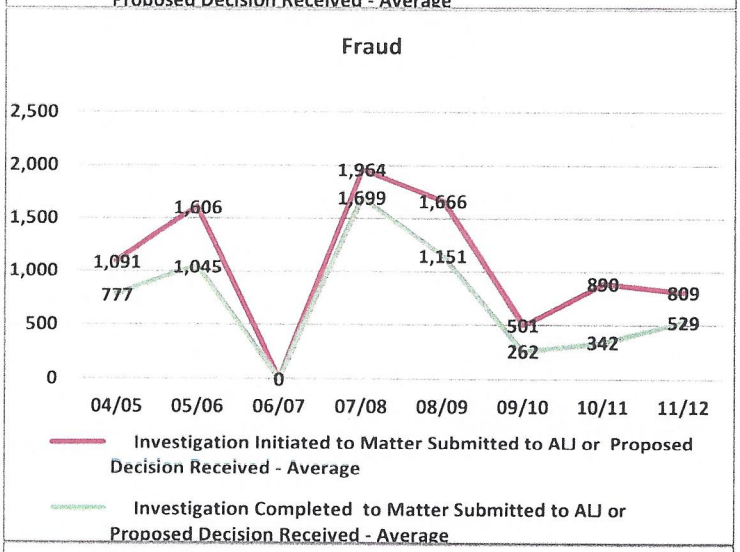

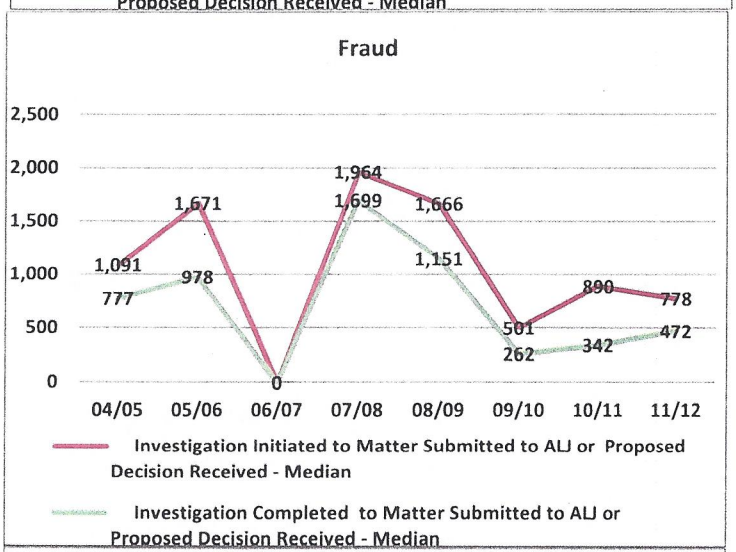

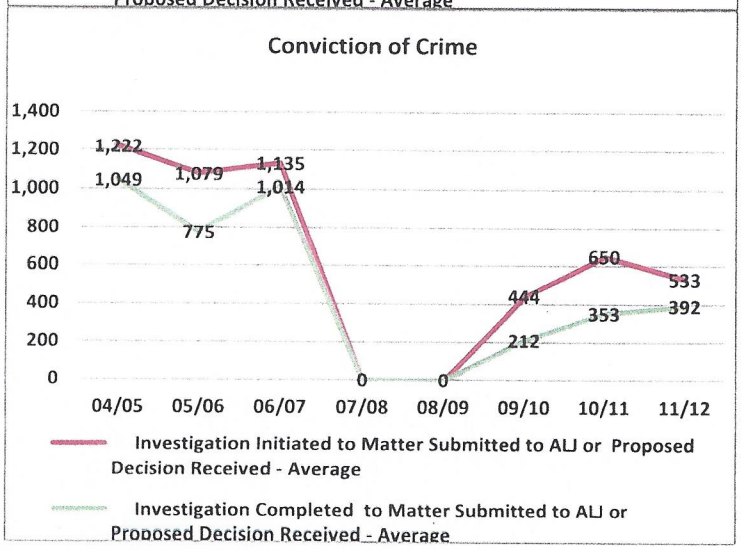

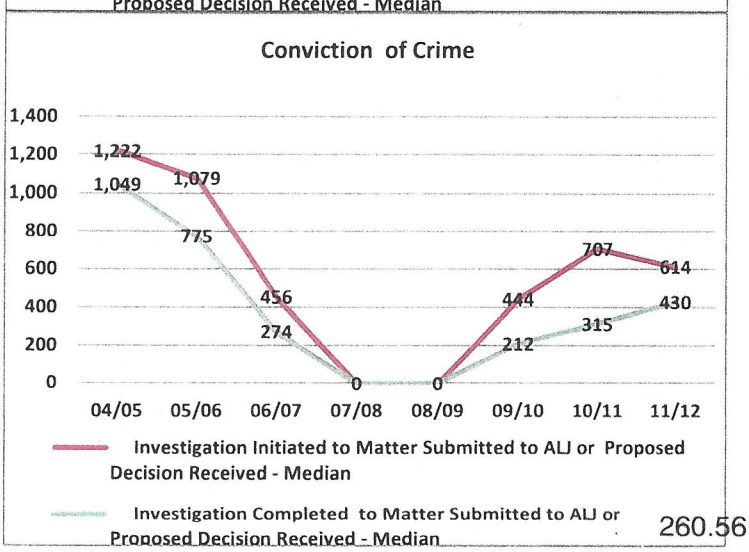

Investigation Initiated/Completed to Submittal of the Matter to an Administrative Law Judge (ALJ) or Proposed Decision Received - Average/Median Calendar Days

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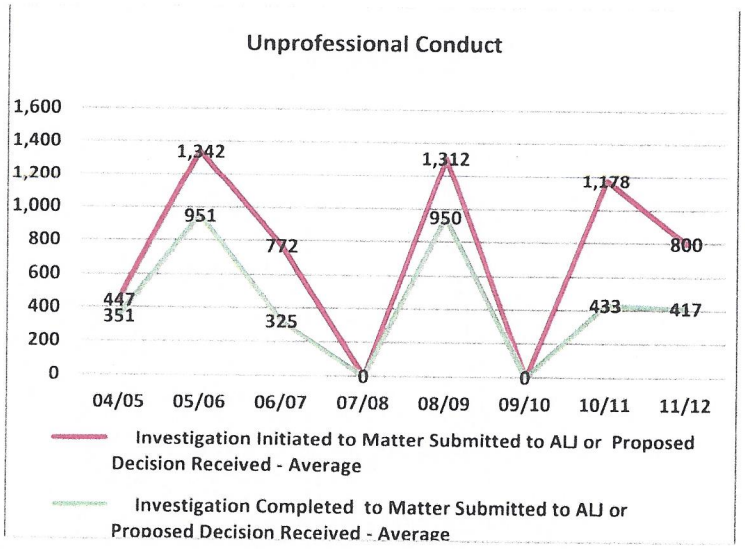

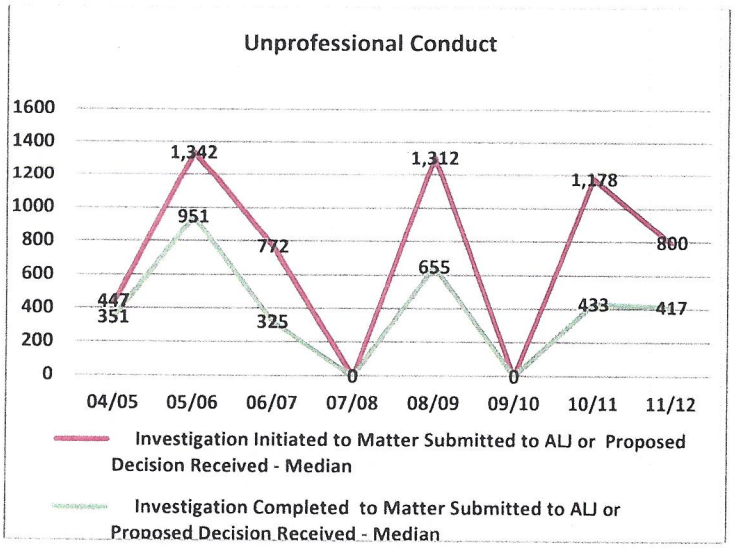

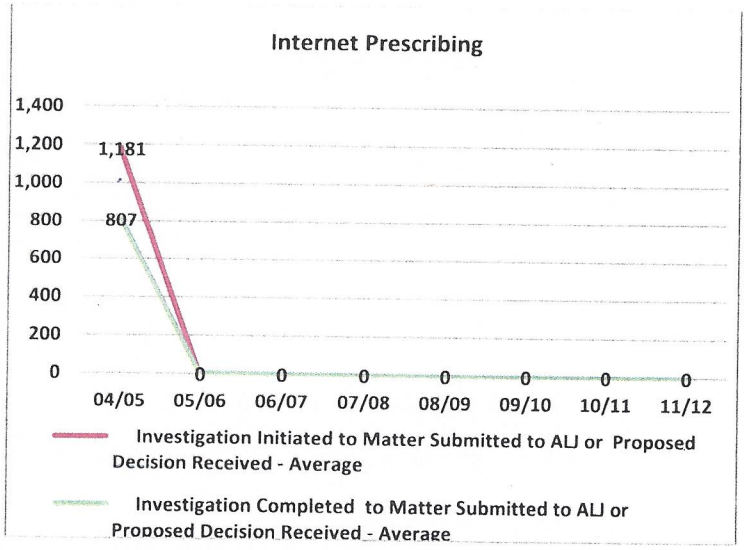

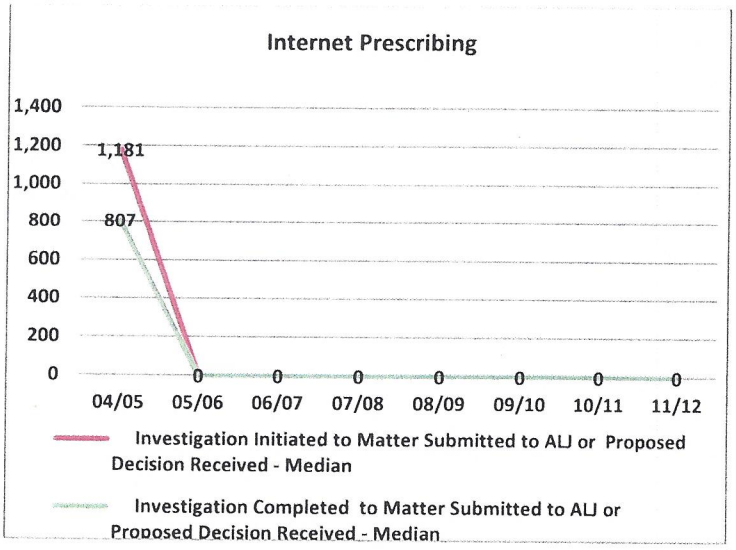

Investigation Initiated/Completed to Default Decision Received – Average Calendar Days

The chart below illustrates the average calendar days for all case types and then a breakdown by each individual type. This graph captures the average calendar days from the time the district office initiated the investigation to the time a default decision was received and the average calendar days from the time the district office completed the investigation to the time a default decision was received.

This data excludes the following case types: out-of-state, headquarters, Operation Safe Medicine, probation violations, petitions for modification/termination of probation terms, petitions for reinstatement, and subsequent discipline on probationers.

Fiscal Year	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12
All Case Types - (Number of cases)	**12**	**7**	**11**	**8**	**12**	**7**	**11**	**8**
Investigation Initiated to Default Decision Received - Average	**477**	**554**	**673**	**591**	**732**	**771**	**690**	**678**
Investigation Completed to Default Decision Received - Average	**190**	**211**	**411**	**304**	**441**	**374**	**322**	**282**
Gross Negligence/Incompetence - (Number of cases)	3	3	3	1	3	1	3	2
Investigation Initiated to Default Decision Received - Average	731	636	1,087	781	1,215	1,605	894	710
Investigation Completed to Default Decision Received - Average	270	185	719	190	871	1,301	115	218
Inappropriate Prescribing - (Number of cases)	1	0	0	0	2	0	0	0
Investigation Initiated to Default Decision Received - Average	195	0	0	0	400	0	0	0
Investigation Completed to Default Decision Received - Average	83	0	0	0	162	0	0	0
Sexual Misconduct - (Number of cases)	0	0	1	0	0	1	0	0
Investigation Initiated to Default Decision Received - Average	0	0	279	0	0	1,121	0	0
Investigation Completed to Default Decision Received - Average	0	0	219	0	0	73	0	0
Mental/Physical Illness - (Number of cases)	4	0	1	3	3	3	2	3
Investigation Initiated to Default Decision Received - Average	338	0	692	723	563	585	668	633
Investigation Completed to Default Decision Received - Average	157	0	525	417	371	287	214	215
Self-abuse of Drugs/Alcohol - (Number of cases)	4	0	3	1	2	2	1	1
Investigation Initiated to Default Decision Received - Average	497	0	690	276	680	460	309	376
Investigation Completed to Default Decision Received - Average	191	0	384	121	207	191	132	151
Fraud - (Number of cases)	0	0	0	2	1	0	0	1
Investigation Initiated to Default Decision Received - Average	0	0	0	565	965	0	0	1,009
Investigation Completed to Default Decision Received - Average	0	0	0	352	660	0	0	640
Conviction of Crime - (Number of cases)	0	1	2	1	1	0	5	1
Investigation Initiated to Default Decision Received - Average	0	351	409	373	328	0	653	716
Investigation Completed to Default Decision Received - Average	0	237	138	168	173	0	526	384
Unprofessional Conduct - (Number of cases)	0	3	1	0	0	0	0	0
Investigation Initiated to Default Decision Received - Average	0	540	277	0	0	0	0	0
Investigation Completed to Default Decision Received - Average	0	228	199	0	0	0	0	0

Investigation Initiated/Completed to Default Decision Received – Median Calendar Days

The chart below illustrates the median calendar days for all case types and then a breakdown by each individual type. This graph captures the median calendar days from the time the district office initiated the investigation to the time a default decision was received and the median calendar days from the time the district office completed the investigation to the time a default decision was received.

This data excludes the following case types: out-of-state, headquarters, Operation Safe Medicine, probation violations, petitions for modification/termination of probation terms, petitions for reinstatement, and subsequent discipline on probationers.

Fiscal Years	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12
All Case Types - (Number of cases)	**12**	**7**	**11**	**8**	**12**	**7**	**11**	**8**
From Investigation Initiated to Default Decision - Median	**370**	**539**	**692**	**629**	**681**	**758**	**654**	**660**
From Investigation Completed to Default Decision - Median	**211**	**185**	**237**	**296**	**282**	**269**	**175**	**190**
Gross Negligence/Incompetence - (Number of cases)	3	3	3	1	3	1	3	2
From Investigation Initiated to Default Decision - Median	745	640	1,059	781	681	1,605	866	710
From Investigation Completed to Default Decision - Median	269	185	533	190	395	1,301	100	218
Inappropriate Prescribing - (Number of cases)	1	0	0	0	2	0	0	0
From Investigation Initiated to Default Decision - Median	195	0	0	0	400	0	0	0
From Investigation Completed to Default Decision - Median	83	0	0	0	162	0	0	0
Sexual Misconduct - (Number of cases)	0	0	1	0	0	1	0	0
From Investigation Initiated to Default Decision - Median	0	0	279	0	0	1,121	0	0
From Investigation Completed to Default Decision - Median	0	0	219	0	0	73	0	0
Mental/Physical Illness - (Number of cases)	4	0	1	3	3	3	2	3
From Investigation Initiated to Default Decision - Median	316	0	692	834	783	648	668	610
From Investigation Completed to Default Decision - Median	163	0	525	358	527	299	214	161
Self-abuse of Drugs/Alcohol - (Number of cases)	4	0	3	1	2	2	1	1
From Investigation Initiated to Default Decision - Median	390	0	773	276	680	460	309	376
From Investigation Completed to Default Decision - Median	200	0	254	121	207	191	132	151
Fraud - (Number of cases)	0	0	0	2	1	0	0	1
From Investigation Initiated to Default Decision - Median	0	0	0	565	965	0	0	1,009
From Investigation Completed to Default Decision - Median	0	0	0	352	660	0	0	640
Conviction of Crime - (Number of cases)	0	1	2	1	1	0	5	1
From Investigation Initiated to Default Decision - Median	0	351	409	373	328	0	450	716
From Investigation Completed to Default Decision - Median	0	237	138	168	173	0	290	384
Unprofessional Conduct - (Number of cases)	0	3	1	0	0	0	0	0
From Investigation Initiated to Default Decision - Median	0	409	277	0	0	0	0	0
From Investigation Completed to Default Decision - Median	0	184	199	0	0	0	0	0

Investigation Initiated/Completed to Default Decision Received – Average/Median Calendar Days

The graphs below illustrate the average (left column) and median (right column) calendar days for all case types and then a breakdown by each individual type. These graphs show two measurements. The top lines represent the average/median calendar days from the time the district office initiated the investigation to the time a default decision was received. The bottom lines are a subset of the top lines and represent the average/median calendar days from the time the district office completed the investigation to the time a default decision was received.

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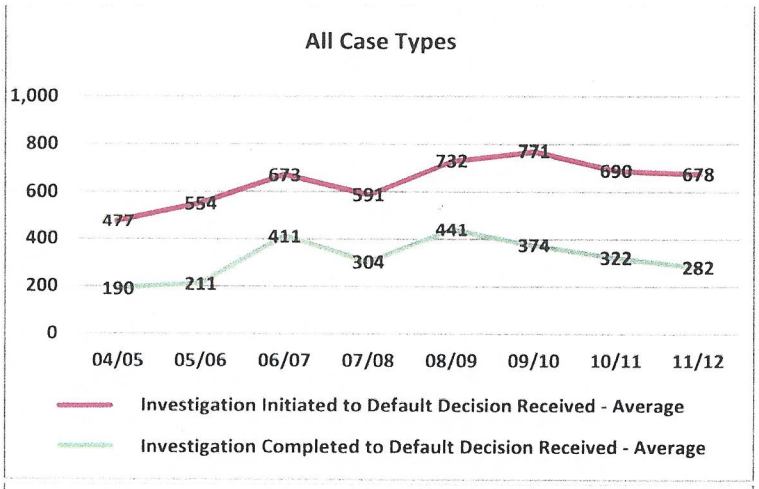

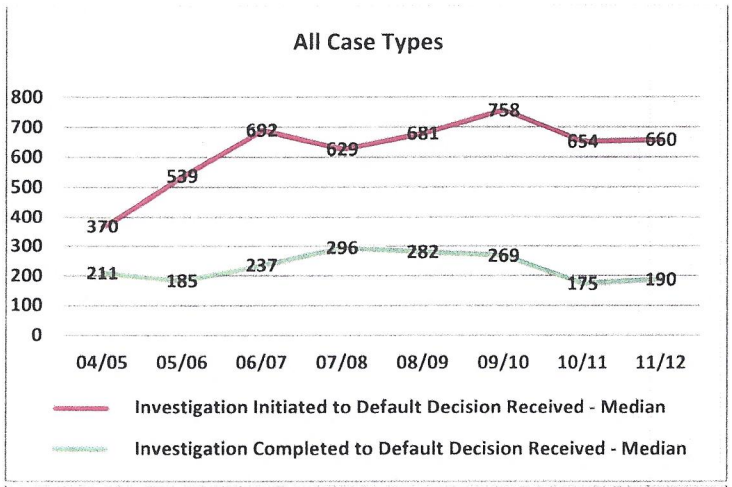

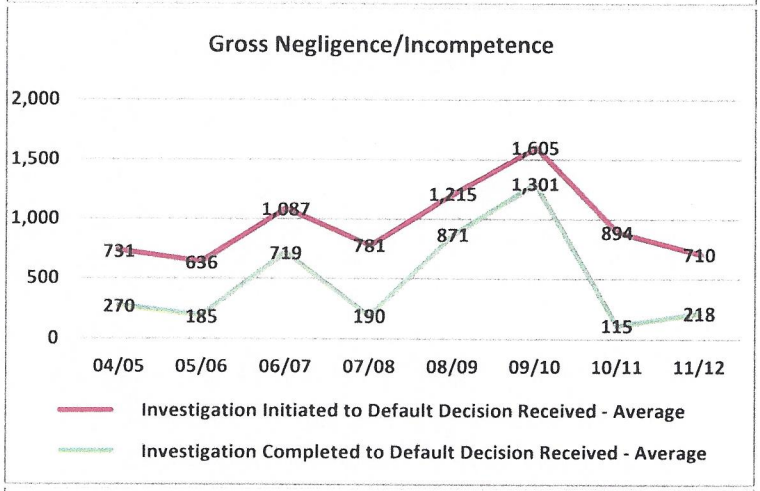

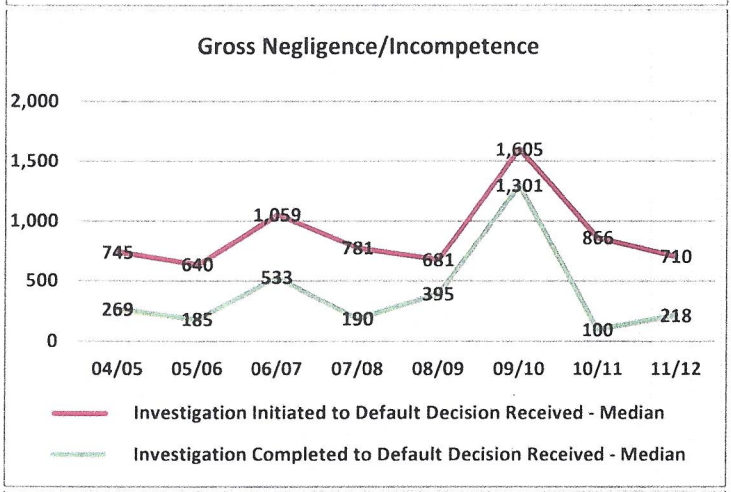

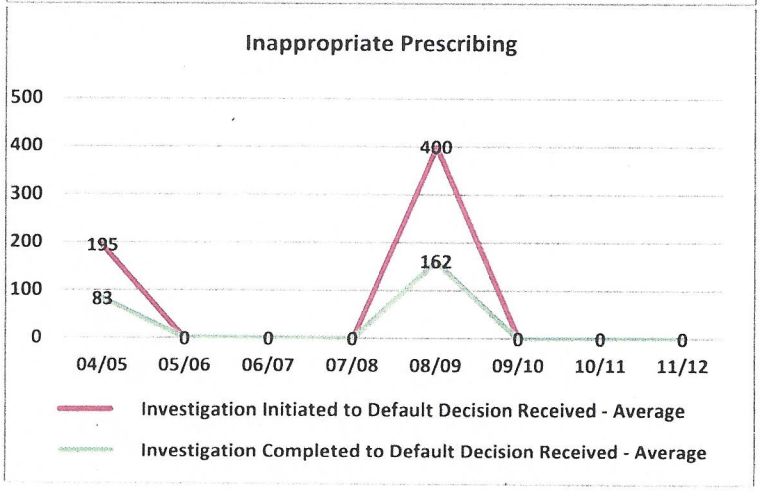

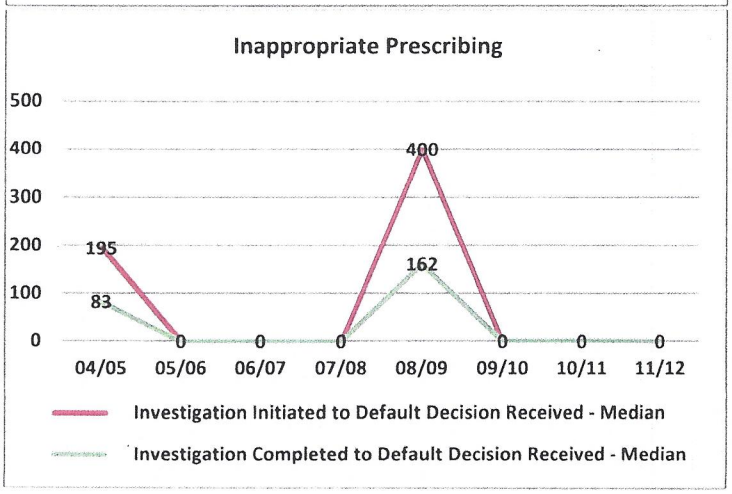

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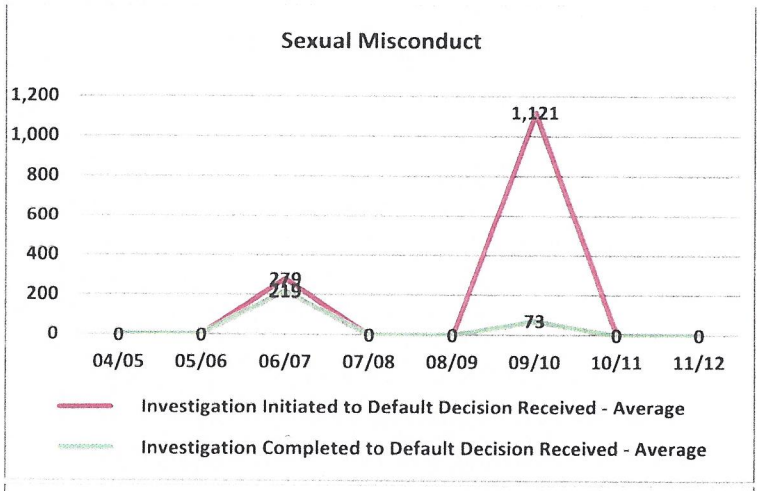

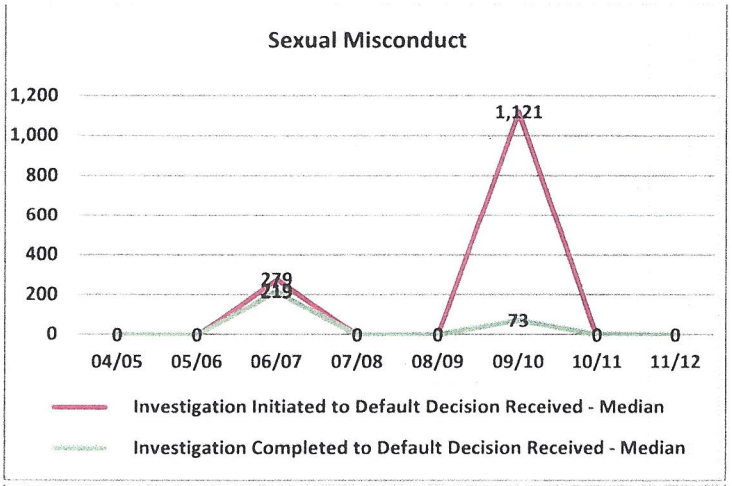

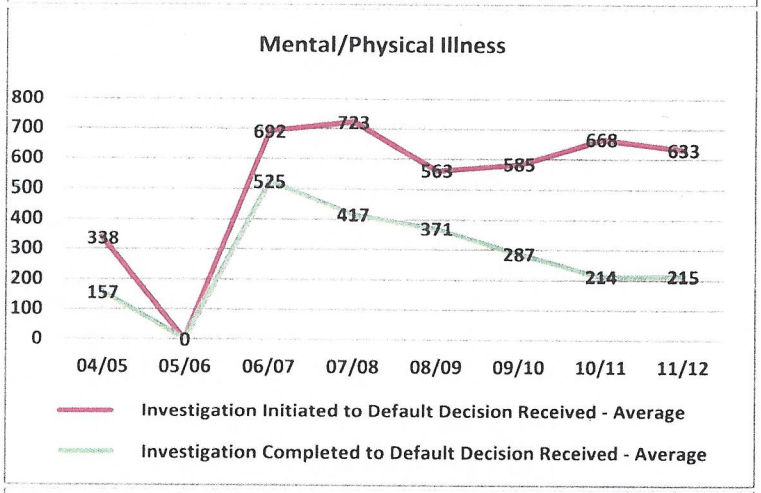

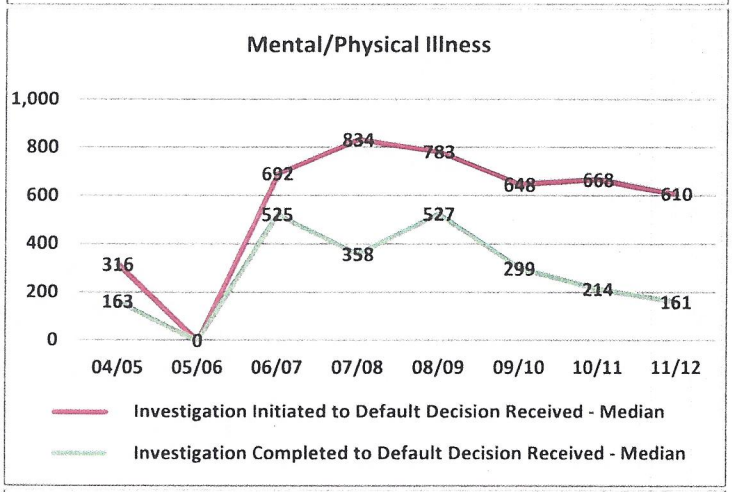

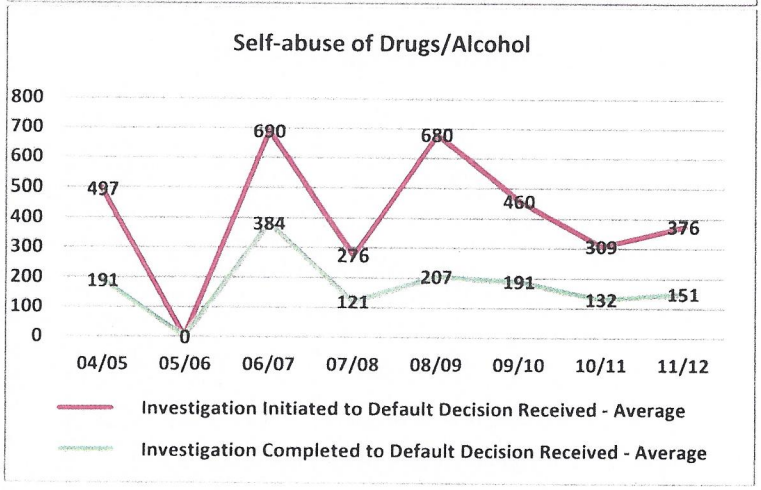

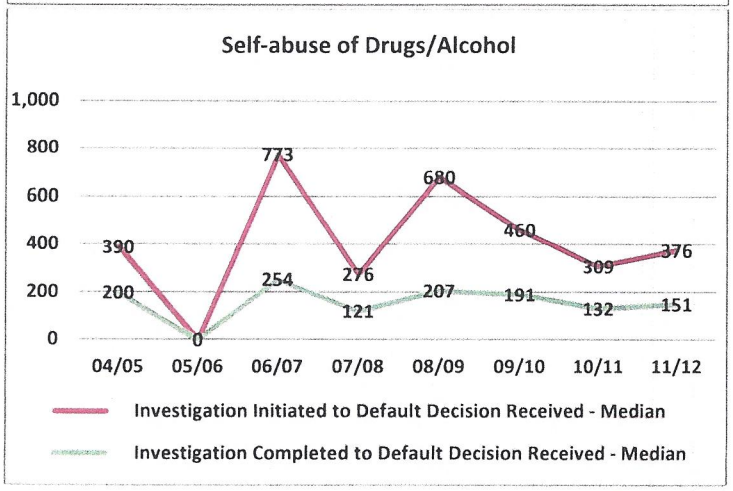

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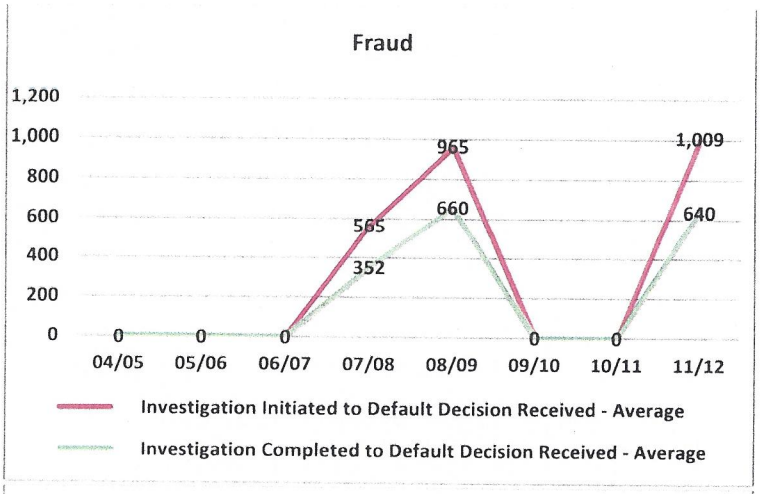

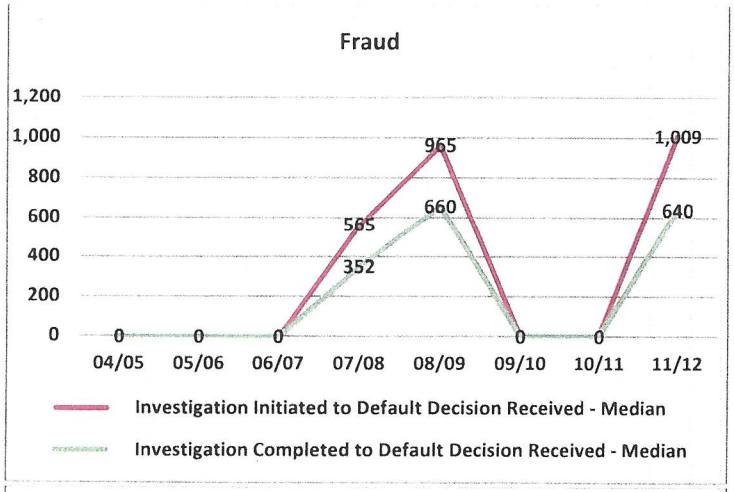

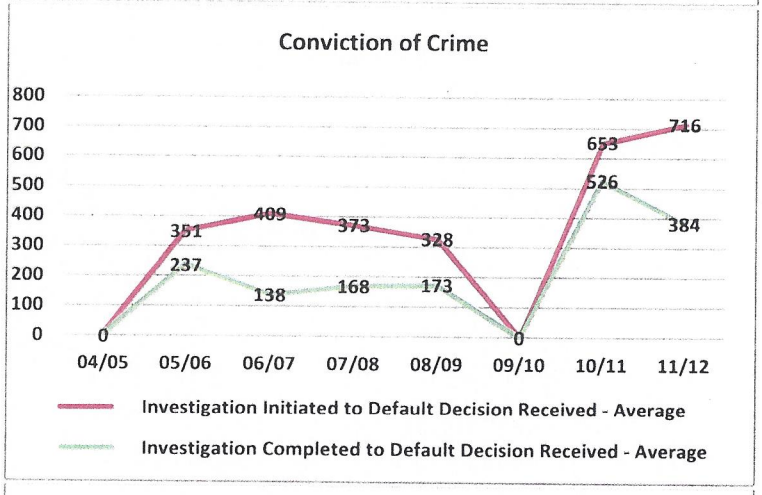

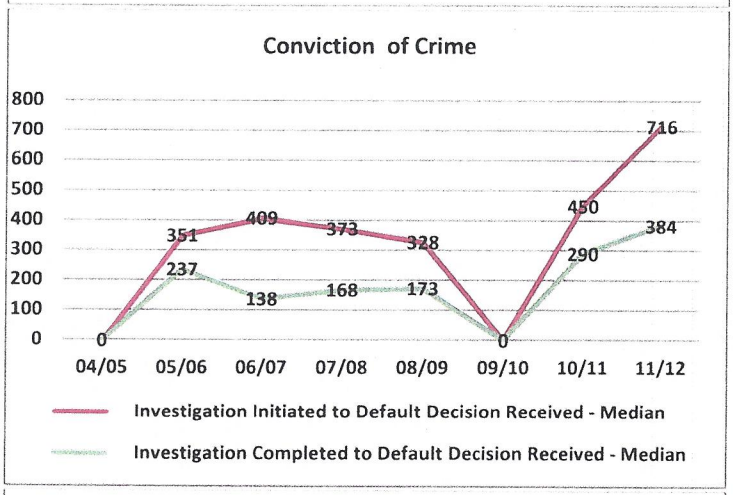

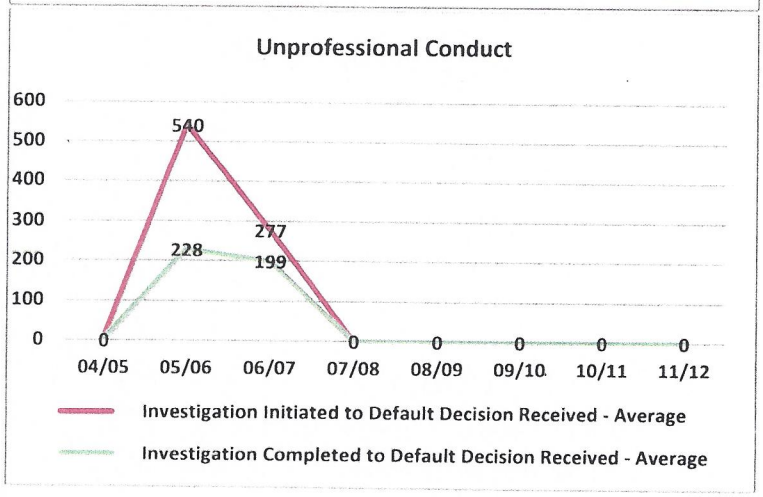

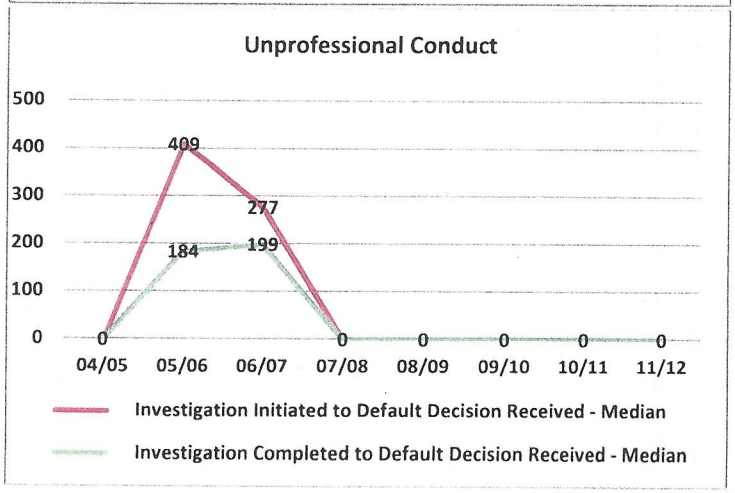

Cases Declined by the Attorney General's Office

The Chart represents the number of cases, which after the investigation was completed through VE/P, were declined to be prosecuted by the Attorney General's Office.

	04-05	05-06	06-07	07-08	08-09	09-10	10-11	11-12
San Jose	1	1	2	1	5	2	7	4
Pleasant Hill	4	1	2	1	2	0	4	0
Sacramento	0	1	0	1	2	1	0	1
Fresno	2	1	5	1	2	1	2	0
Tustin	1	0	2	1	1	1	2	1
San Bernardino	1	1	2	0	0	0	2	0
San Diego	3	0	2	0	8	0	2	0
Rancho Cucamonga	1	0	0	0	0	0	0	1
Valencia	0	2	3	3	0	0	0	3
Cerritos	0	9	5	3	2	0	2	1
San Dimas	0	1	3	3	2	5	2	1
Glendale	7	3	3	2	2	1	7	3
Probation	0	0	0	0	0	0	0	0
Total Cases	**20**	**20**	**29**	**16**	**26**	**11**	**30**	**15**

Cases Requesting Supplemental Investigation After Transmittal

The Chart below represents the number of cases, which after the investigation was completed through VE/P, were deemed to need additional investigation.

	04-05	05-06	06-07	07-08	08-09	09-10	10-11	11-12
San Jose	4	0	0	3	0	1	3	9
Pleasant Hill	4	2	0	0	1	0	2	1
Sacramento	0	0	0	0	1	1	3	4
Fresno	0	0	0	0	0	0	2	0
Tustin	6	1	0	1	0	0	0	0
San Bernardino	0	1	0	0	0	0	1	0
San Diego	0	0	0	0	1	0	1	1
Rancho Cucamonga	1	0	0	0	0	0	1	1
Valencia	1	3	2	0	1	5	2	0
Cerritos	2	9	0	1	0	0	0	2
San Dimas	0	3	4	5	5	6	5	5
Glendale	1	1	2	1	0	0	1	0
Probation	0	0	0	0	0	0	0	0
Total Cases	**19**	**20**	**8**	**11**	**9**	**13**	**21**	**23**

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: January 11, 2013
ATTENTION: Board Members
SUBJECT: Teleconferencing of Board Meetings
STAFF CONTACT: Kimberly Kirchmeyer, Deputy Director

RECOMMENDED ACTION:

Review the information provided and determine the feasibility of providing teleconferencing for statewide public participation.

BACKGROUND AND ANALYSIS:

At previous Board meetings, and at the October Board meeting, the Board was asked to teleconference its future Board meetings to provide public participation from individuals not in attendance at the Board meetings. Specifically, the request was to allow individuals from any location to be able to call in, listen to the Board meeting, and provide public comment throughout the meeting. The Board Members requested staff research the feasibility of this request and provide the information back to the Members for their consideration.

Board staff has determined that there are several ways in which this request could be fulfilled. Although the options are discussed below, further research and paperwork would need to be completed to design, develop, and test the options as they are described below. Additionally, some of the options would require authorization and processing by the Department of Consumer Affairs (DCA).

Options for Teleconferencing:

1) Provide an 800 number for anyone to call in and listen to the Board meeting and provide comments. Individuals, no matter where they are calling from, would be able to call in on the 800 line and provide comment at the appropriate times. A moderator from the telephone company would assist callers in the process. Individuals on the line would remain in a "mute" mode until the Board President (or Chair at Committee Meetings) would ask for public comment. The individuals at the beginning of the call would be provided with a method of informing the moderator that they would like to make a comment (for example by pushing #1). The moderator would then notify the staff monitoring the call that a comment is pending. At the appropriate time, the callers would provide their comments. The callers would need to be limited to specified minutes per comment per agenda item (example two minutes).

   The cost for the moderator is $.287/minute and the cost for the callers is $.021/minute/person. The system can have up to 4,000 participants on the line at one time. The Board would also need to request a telephone line from the hotel and would need one additional staff at each meeting in order to coordinate the call with the moderator and notify the Board President if there is someone who wants to make a comment. If a Board meeting was approximately 6 hours long and there were 200 people on the call, the cost would be **$1,765.32** for the call at each meeting ($103.32 for the moderator + $1,512.00 for the individuals on the phone call + $150.00 for the telephone line) plus one staff member's time and attendance at a Board meeting (and therefore not performing his/her normal duties in the office).

Note: In contacting the DCA to gather information on this option, the Board was notified that no other DCA board or bureau has made a request for such a system that would provide the public input as described. Additionally, if this option were chosen, the Board would need to complete paperwork to obtain a system and would need to test the system. It would be recommended that if this option were chosen, that this would be tested at the Sacramento Board meeting in July in order to have appropriate staff available.

There have been other State agencies who have offered this type of service, however, these entities are not regulatory agencies who have both licensing and disciplinary responsibilities. In most instances, these agencies would not have disgruntled licensees or consumers calling in to comment.

Pros:

- The public would not have to travel to the meeting location to make comments on items not on the agenda or items on the agenda.
- More information can be gathered by the Members when making decisions.

Cons:

- The loss of work from the additional staff needed to attend the meeting.
- The length of the meeting could be extensive. If there are 200 callers and if only half wanted to make a comment on items not on the agenda, the meeting time would increase by over three hours. In addition, depending on the number of individuals who wanted to comment on agenda items, the length of the meeting could increase just for the time comments are being made on agenda items, plus the administrative time for this function. If only 20 people made two minute comments throughout the meeting, this would add close to an hour per meeting.
- The Board President would be required to stop individuals at the end of their specified time (two minutes), which could be perceived as harsh if the comment was not completed.
- There is no method to stop individuals from using several phones to call in and identify themselves as someone else in order to make it appear as if there is more support or opposition on an item than there actually is.
- It would be difficult to ensure the callers do not discuss a specific case during their comment period. The attorneys would have to jump in quickly and this could appear harsh.

2) Provide an email Web account where an individual could listen to the meeting and provide written questions that would then be provided via staff for the Board's consideration. This type of communication is similar to a chat room. The cost for this service is $8.50 per month ($102/year) and it would require a staff member to attend the meeting for the sole purpose of monitoring and reading the comments or questions provided via the Web. There would not be a limit to the individuals who could provide comments. The comments could be long and over the specified time limit, requiring interpretation by the staffer if comments need to be abbreviated.

Pros:

- The public would not have to travel to the meeting location to make comments on items not on the agenda or items on the agenda.
- More information can be gathered by the Members when making decisions.
- These could be screened to ensure cases were not discussed.

Cons:

- The loss of work from the additional staff needed to attend the meeting.
- The length of the meeting could be extensive. If there are 100 individuals who wanted to make a comment on items not on the agenda, the meeting time would increase by over three hours. In addition, depending on the number of individuals who wanted to comment on agenda items, the length of the meeting could increase just for comments on agenda items.
- There is no method to stop an individual from using multiple email accounts to provide comments in order to make it appear as if there is more support or opposition on an item than there actually is.
- Staff would need to respond to those who did not have a comment read to explain it was due to a case.

3) Hold all meetings in Sacramento at the Evergreen Hearing Room and video conference to the three other locations throughout California where the Board has video conferencing equipment (San Jose, San Diego, and Cerritos). Although the main meeting would take place in Sacramento, individuals would be able to go to the three district offices and attend the meeting via video conferencing equipment. A staff member would have to be available at each of the off-site locations to monitor the meeting and equipment, as well as be the point of contact for moderating the public comment. There would be no additional cost to the Board other than the three staff who would not be performing their normal work duties, as long as the Board meets in the limited space of the Evergreen Hearing Room (seats 12 Members comfortably).

Note: Staff is also looking into the possibility of the main location being at a hotel and video conferencing from the hotel to the three district offices, but the ability to do so and the quality of such a system is unknown.

Pros:

- The public would not have to travel to the meeting location to make comments on items not on the agenda or items on the agenda, but would have to travel to one of three locations.
- More information can be gathered by the Members when making decisions.

Cons:

- The public would still need to travel to provide comments, though the travel would not be as extensive. (Although this is the same or similar travel requirements to attend <u>one</u> meeting in the regional location.)
- The loss of work from the additional staff needed to attend the meeting. Also, these individuals are in the field and if clerical staff is not available, it would require a supervising investigator or an investigator to moderate the video conference.
- The sites cannot hold a large number of people, therefore limiting those who could attend at these locations (most will hold 20 individuals).
- The Evergreen Hearing Room cannot hold the Board's full complement of Members and therefore could not be used when all members are on the Board.
- It will add some time to the Board meetings due to the additional comments.

4) Teleconference the Board meeting to locations throughout California where the Board has the most space available (San Jose and Cerritos). The Board's main meeting would take place in its normal locations, and individuals would also be able to go to the two district offices and attend the meeting

via teleconferencing equipment. A staff member would have to be available at each of the off-site locations to monitor the meeting and equipment as well as be the point of contact for moderating the public comment. The Board would have to request a telephone line from the hotel and would have to have a staff member there to run the telephone. There would be an additional cost of $150 for the phone line and the three staff who would not be performing their normal work duties.

Pros:

- The public would not have to travel to the meeting location to make comments on items not on the agenda or items on the agenda, but would have to travel to one of two locations.
- More information can be gathered by the Members when making decisions.

Cons:

- The public would still need to travel to provide comments, though the travel would not be as extensive.
- The loss of work from the additional staff needed to attend the meeting. Also, these individuals are in the field and if clerical staff is not available, it would require a supervising investigator or an investigator to moderate the video conference.
- The sites cannot hold a large number of people, therefore limiting those who could attend at these locations.
- It will add some time to the Board meetings due to the additional comments.

These are the options available at this time. Any of the options, as previously stated, would require implementation time, including development and testing. Additionally, there may be issues that may arise in any of the options above that are currently unknown to staff. It is important to note that State law provides the opportunity for written comments in the regulatory process. These comments must be considered as if a person is testifying in person before the Board. Please note that these options would not be applicable to closed session proceedings.