MEDICAL BOARD OF CALIFORNIA

ENFORCEMENT COMMITTEE MEETING AGENDA

MEMBERS OF THE COMMITTEE
Reginald Low, M.D., Chair
Dev GnanaDev, M.D.
Sharon Levine, M.D.
Gerrie Schipske, R.N.P., J.D.
David Serrano Sewell, J.D.

Embassy Suites – Burlingame
Mendocino & Burlingame Meeting Rooms
150 Anza Blvd
Burlingame, CA 94010
650-342-4600 (directions only)

Thursday, January 31, 2013
1:15 p.m. – 1:45 p.m.
(or until completion of business)

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.

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE.
If a quorum of the Board is present, members of the Board who are not members of the Committee may attend only as observers.

1. 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 §11125 and 11125.7(a)]

3. Approval of Minutes from the July, 2012 Meeting

4. Update on Expert Reviewer Training – Ms. Sweet

5. Central Complaint Unit Progress Report – Ms. Cady

6. SB 1441 Uniform Standards Implementation – Ms. Cady

7. Update on Outreach Proposal to Medical Societies

8. Agenda Items for the April 2013 Meeting in the Los Angeles Area

9. Adjournment

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.

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.

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. For additional information call (916) 263-2389.

MEDICAL BOARD OF CALIFORNIA

ENFORCEMENT COMMITTEE

Courtyard by Marriot
Golden C
1782 Tribute Road
Sacramento, CA 95815

July 19, 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. Low called the Enforcement Committee meeting to order on July 19, 2012, at 2:30 p.m. A quorum was present and notice had been sent to interested parties.

Members Present:

Reginald Low, M.D., Chair
Dev GnanaDev, M.D.
Sharon Levine, M.D.

Members Absent:

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

Staff Present:

Eric Berumen, Enforcement Manager
Susan Cady, Enforcement Manager
Ramona Carrasco, Enforcement Manager
Dianne Dobbs, Department of Consumer Affairs (DCA), Legal Counsel
Teri Hunley, Business Services Manager
Kimberly Kirchmeyer, Deputy Director
Natalie Lowe, Licensing Manager
Armando Melendez, Business Services Assistant
Kelly Montalbano, Enforcement Analyst
Valerie Moore, Enforcement Manager
Sarah Peters, Enforcement Analyst
Cynthia Robinson, Executive Assistant
Letitia Robinson, Research Analyst
Paulette Romero, Enforcement Manager
Teresa Schaffer, Enforcement Analyst
Sharlene Smith, Enforcement Analyst
Laura Sweet, Deputy Chief of Enforcement
Renee Threadgill, Chief of Enforcement

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Danielle Turner, Enforcement Analyst
Anna Vanderveen, Investigator
Terrence Washington, Inspector

Members of the Audience:

Gloria Castro, Supervising Deputy Attorney General, Department of Justice (DOJ)
Yvonne Choong, California Medical Association (CMA)
Zennie Coughlin, Kaiser Permanente
Julie D'Angelo Fellmeth, Center for Public Interest Law (CPIL)
Vern Hines, Internal Audits Office
Mia Perez, Deputy Attorney General
Carlos Ramirez, Senior Assistant Attorney General
Farzana Sheikh
Rehan Sheikh
Ryan Spencer

Agenda Item 2 Public Comments on Items Not on the Agenda

No public comment was offered.

Agenda Item 3 Approval of Minutes from the May 3, 2012 Meeting

Dr. GnanaDev made a motion to approve the minutes from the May 3, 2012 meeting; s/Levine; motion carried.

Agenda Item 4 Discussion of Amended Accusations

Dr. Low introduced Carlos Ramirez, Senior Assistant Attorney General and Gloria Castro, Supervising Deputy Attorney General, both from the Department of Justice, Health Quality Enforcement Section in Los Angeles.

Ms. Castro presented a brief overview of the Administrative Procedure Act (APA) from which the rules relating to administrative law are derived. The APA regulates the conduct of formal administrative hearings by Administrative Law Judges (ALJs) and parties to the matters and it provides procedures by which the Board conducts its adjudicative proceedings. The APA affords licensees due process rights such as notice and opportunity to be heard, opportunity to rebut evidence, discovery rights, adjudicative function separate from the investigative, prosecutorial, and advocacy functions within the agency and written decisions based on the administrative record at hearing. Hearings are initiated by the filing of an Accusation. An Accusation is defined as a written statement of charges which sets forth the acts or omissions for which the respondent is charged, so that the respondent will be able to prepare a defense. It also specifies the statutes and rules which the respondent is alleged to have violated. An Amended Accusation may be filed at any time before the submission of the matter for decision.

Dr. Levine asked who was present at the prehearing conference. Ms. Castro stated, the respondent, his/her counsel, and the deputy attorney general. Additionally, the agency settlement contact is usually available by telephone. The prehearing settlement conference is held in front of an ALJ.

Ms. Castro presented statistics regarding the number of accusations filed and stated that out of 190

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Accusations filed in fiscal year 2009/2010, 29 required a first amended accusation, and 8 of those 29 are still pending. Ms. Castro stated in fiscal year 2010/2011 229 accusations were filed and 25 of those were amended.

Dr. GnanaDev wanted to know if something had been done between 2009 and 2010 to change the number of amended accusations. He stated that in looking at the numbers they seem to have improved in one year. Ms. Castro stated every case is different and therefore the numbers vary from one year to the next.

Ms. Castro then discussed two reasons for amendments, one, the testimony or evidence no longer supports a viable cause for discipline in the existing accusation; or two, the testimony or evidence supports an additional cause for discipline to be added to the existing Accusation. The Accusation is amended to strike out the causes that are no longer viable or it is amended to include the causes with the new information.

Ms. Castro further stated that when new causes for discipline are added, the hearings often get continued and this adds time to the case to allow the respondent to properly defend himself/herself. Sometimes the case settles when an offer is made and accepted. The amendment provisions of the APA allow a respondent to have one accusation heard and settled at the same time by adding the new accusations to an existing Accusation. Ms. Castro also suggested that another reason why amendments at hearing may occur is that discovery provisions in the APA are not generous and are time consuming. The APA does not allow the taking of depositions. Business and Professions Code section 2334 requires a brief and concise statement about the defense expert testimony but not the respondent's expert testimony. Dr. GnanaDev wanted to know why the Board cannot get that information from the respondent's expert. Ms. Castro explained that there is a requirement to produce statements that are relevant to the case but there is no requirement that they must generate the expert report and because of that, the exchange does not happen.

Ms. Castro concluded her presentation explaining that due process allows continuances so that respondents can adequately defend against new charges in an Amended Accusation. Amended Accusations prevent the filing of multiple accusations and multiple hearings against the respondent allowing for more efficient resolution of matters. Lastly, Amended Accusations pare down or add charges where justice requires it.

Dr. Low commented that this process is to make life fair for both sides; it is all in the interest of efficiency. The down side is that it makes the timeline look bad.

Dr. Low asked who could be a settlement arbitrator. Ms. Castro responded that the Office of Administrative Hearings (OAH) has a medical quality panel, consisting of different ALJs who hear the cases at the OAH. Those ALJs manage the prehearing settlement conferences, and on the same day as the prehearing conference there is a mandatory settlement conference, if it is a longer scheduled hearing. Any ALJ from the OAH can preside. Each side speaks with the judge separately and then both sides and the judge meet together and discuss the settlement and how the case can be resolved promptly.

Dr. GnanaDev wanted to know how the Board could shorten the process and at the same time respect the due process of the respondent. Mr. Ramirez responded the biggest obstacle in getting cases to hearing is the calendar of the opposing counsel.

Agenda Item 5 Update on Expert Reviewer Training

Laura Sweet presented an update on the Expert Reviewer training that was held at the UC Davis Medical Center, May 19, 2012. She stated the training was a huge success, with over 100 doctors attending. The

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surveys of the training were overwhelmingly positive. Ms. Sweet commented that there are a few modifications to make to the training for the next session, which is targeted to take place in February 2013 in San Diego or Irvine.

Ms. Sweet suggested that a possible solution to the experts' concern regarding lack of feedback was to incorporate into the training time for the reviewers to prepare an expert opinion of a sample case provided to them and have a panel consisting of a Supervising Investigator, medical consultant and Supervising Deputy Attorney General provide individualized feedback regarding their written opinions. This can be accomplished by paring the course down to six hours, and then giving the experts additional hours of credit for preparing the opinion. Additionally, the enforcement program is looking for other ways to augment the one individual who is currently handling the expert program in order to systematically provide feedback to our experts, including the status of cases that have resulted in Accusations being filed.

Agenda Item 6 Presentation on CCU Process and Goals

Susan Cady presented an overview on the Central Complaint Unit (CCU) process and goals. Ms. Cady explained the steps from receipt of the complaint through referral of the complaint to investigation.

When a complaint is received, it is entered into the computer and an acknowledgement letter is sent to the complainant. The complaint is then referred to an analyst who reviews the case to make sure the Board has jurisdiction. If it is a quality of care case the analyst requests an authorization for release of medical records from the patient and obtains medical records and a summary from the physician. The case is then sent out to an expert reviewer in the same specialty to determine if the treatment was within the standard of practice. If there is insufficient information to establish a violation the case is closed. If there may be a deviation from the standard of care, the case is referred to a district office for investigation. For non-quality of care cases, which include sexual misconduct, the unlicensed practice of medicine, and physician impairment, these cases are sent straight to a district office for investigation.

Ms. Cady stated staff have identified where improvements can be made by excluding the upfront specialty review for certain case types and sending those cases directly to the district office. Ms. Cady will provide specific recommendations at the next committee meeting.

Agenda Item 7 Presentation on DCA – Risk Assessment Results

Dr. Low introduced Vern Hines of the DCA Internal Audits Office who provided the results of a risk assessment survey of the CCU.

The DCA commissioned Mr. Hines to determine if the Medical Board CCU is prioritizing and processing complaints in an efficient and effective manner. Mr. Hines identified potential auditable risks in the CCU. One of the auditable risks is delay in processing approximately 12% of the cases. Part of the audit scope included steps and procedures to ascertain the cause for the delay and provide recommendations to reduce the delay. One of the delays identified was the implementation of Senate Bill 1950 that requires quality of care cases to be reviewed by a medical expert before referral to the field. Other areas of risk were complaint cases may not be adequately prioritized; cases may not be assigned in a timely fashion to a medical specialist; medical specialists may have the cases too long and CCU tracking reports are missing prioritization information. Some of the recommendations suggested by Mr. Hines regarding those areas of risk were: create a better prioritization system; explore the need for more medical specialists, revise the medical specialist; due dates or increase follow ups to reduce medical specialist delay; and, show the

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urgency level of each case on the overdue report.

Julie D'Angelo Fellmeth of the CPIL posed a question regarding the timelines and wanted to clarify that the timeframe Mr. Hines spoke of was focused on CCU only and did not include time spent in the field. Mr. Hines explained that he did not go into the field or assess the investigation side; much of the data that he looked at incorporated the CCU timeframe and also how much time it was in the field. However, he focused only on improvements in the CCU. Ms. Fellmeth again questioned one of the presentation slides that said CCU + field investigation, saying that Mr. Hines must have meant just CCU. Mr. Hines clarified that he meant the field too. He finished by saying that he had looked at all the cases that closed, even some that never went out to the field and that the 4.3 months was an average of all 3,599 cases that were closed for that 6 month period. He noted that there were 416 cases that took a year or longer to process, and his focus was on the 416, where the medical consultant issue was identified.

Dr. GnanaDev asked if the medical consultant reviewers reviewed the file with or without medical records.

Ms. Threadgill responded that sometimes the case has records and sometimes it does not. Sometimes the case may just have a statement from the physician. She also noted that sexual misconduct cases would not go to a specialty reviewer but go straight to the field.

Agenda Item 8 Update on Training for Administrative Law Judges (ALJ)

Dr. Low presented an update on the June 22, 2012 ALJ training that the Board coordinated for ALJs who hear Board cases. Dr. Low stated the training topics included pain management/appropriate medication standards, chronic pain issues, new developments in medicine, and other subjects. Dr. Low commented that the training was particularly cost effective because it was accomplished through video conference and presenters were located throughout the state with the ALJ in their respective offices. Dr. Low stated that additional training opportunities are being developed, including training that would take place during lunch time, which will allow judges more time to attend hearings.

Agenda Item 9 Update on Reconciliation of MBC and HQES Data

Dr. Low stated that he met with the Board and Health Quality Enforcement (HQE) staff on June 29, 2012 to discuss the reconciliation of data and statistics. The group has been working hard to reconcile data. The Supervising Investigators and Supervising Deputy Attorneys General have been exchanging information monthly so the data comports. Ms. Cady and Ms. Castro have been working reconciling cases at the AG's office that remain unfiled. Lastly, the AG's office is working gathering data regarding elements of the vertical enforcement model to compare across the four regions of the state.

Agenda Item 10 Discussion and Consideration of Enforcement Annual Report Format

Kimberly Kirchmeyer presented background on the Enforcement Annual Report format, where it came from and where it is now. Ms. Kirchmeyer explained that the enforcement section of the annual report is mainly driven by the information required to be reported pursuant to Business and Professions Code section 2313. The Board will make a change this year to the report by adding a column to the enforcement processing time frames, where the days will be converted to years in order for the public to have another way of examining the information. Ms. Kirchmeyer pointed out that the enforcement program report always begins with a narrative, usually written by the Chief of Enforcement, regarding what has happened in the last year and outlines any improvements or accomplishments that are noteworthy. Ms.

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Kirchmeyer then briefed everyone on the entire report and solicited edits or changes that the Board might like to see made in the report. The Board will get back to Ms. Kirchmeyer by August 15 with comments or edits that could potentially be incorporated into the annual report. The annual report is available on the MBC Web site.

Agenda Item 11 Overview of Investigative Process After Vertical Enforcement

Ms. Threadgill and Mr. Ramirez presented a process overview of the Vertical Enforcement and Prosecution Model (VEP). The principal element of the VEP includes an Investigator and a Deputy Attorney General (DAG) assigned to each case from investigation through the duration of the disciplinary matter. Mr. Ramirez explained the various roles of the team members and the law from which VEP is derived. Improved policies and procedures have had a significant effect on the VEP team, such as: strict deadlines on investigators and deputies; joint training of investigators and deputies; expedited review of subpoenas for medical record procurement; and, ongoing medical expert reviewer training. Since the inception of vertical enforcement, the time it takes to obtain an Interim Suspension Order decreased from an average of 51 days in 2005 to an average of 30 days in the current year. Also, the number of Penal Code section 23 orders has increased during each of the past three years to a total of 36. Both the Board and the AG's office have improved operational efficiencies that resulted in decreasing the number of days it takes to complete a complainant and subject physician interview, obtaining medical records with an authorization to release records, and obtaining medical records with a subpoena. The percentage of cases settled without hearing has increased and the number of Accusations withdrawn or dismissed has decreased. In conclusion, the consequence is improved public protection and improvements within both the investigation and prosecution stages.

Dr. GnanaDev raised the question regarding the cost of VEP and whether or not it was appropriate for all cases. Ms Threadgill said this question is being addressed as part of an objective of the strategic plan and will be reported back to the committee at a later date.

Dr. GnanaDev wanted to know how things could be improved and still cut costs. Mr. Ramirez answered that the sooner an Accusation can be evaluated through the medical consultant, the investigator and the attorney and the sooner a determination of that case is made, the more efficient the process will be.

Dr. Low commented on the timeline inconsistency regarding the time allowed to fill record requests, as hospitals are allowed 30 days, and doctor's offices are allowed 15 days. Most hospitals have electronic records. Ms. Threadgill responded the law sets forth the timeframes allowed however, the Board will look at the laws to identify where there are opportunities to recommend changes in order to improve efficiency.

Agenda Item 12 Update on SB 100 Implementation – Outpatient Surgery Center Requirements

Ms. Cady presented an update on the implementation of Senate Bill (SB) 100, regarding outpatient surgery settings. SB 100 requires the Board to maintain and publish a list of all accredited outpatient settings and provide information regarding the status of the setting's accreditation. These portions of the bill are being implemented by the Licensing Program. Ms. Cady provided a flow chart which explained how the Board will respond to complaints received regarding an outpatient surgery setting. The complaint will initially be reviewed by the Licensing Program to determine whether the setting is accredited. If the setting is accredited, the complaint will be referred to the accrediting agency for inspection. Once the inspection report is received in Licensing, the findings will be reviewed to determine if any deficiencies were identified in categories that relate to patient safety. Patient safety deficiencies will be referred to the CCU

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to be initiated, and if necessary, referred for formal investigation.

SB 100 also calls for the accrediting agency to inspect the setting no less often than once every three years. The inspection reports are to be provided to the Board and posted on the Web site for public viewing. When an accrediting agency identifies deficiencies during regular inspections or takes action against the setting to revoke, suspend or place the setting on probation, staff proposes that written notification be sent, by the accrediting agency, to any physician known to have privileges at the setting to advise them of the change in accreditation status. The physician can continue to perform procedures at the setting but cannot use a level of anesthesia which places the patient at risk for loss of life preserving protective reflexes.

Finally, SB 100 also made outpatient surgery settings subject to the same adverse event report requirements that are currently in place for hospitals and other licensed health care facilities. Board staff met with representatives from the Department of Public Health (DPH) to discuss this new reporting requirement, as the law requires that the adverse event reports be filed with that department. Ms. Cady developed a reporting form to be used specifically by the surgery centers and is waiting for input from DPH before finalizing the reporting form.

Dr. GnanaDev asked if the DPH and the Board were going to follow the same guidelines for accrediting outpatient centers. Ms. Cady explained that the agency regulating the surgery center depends on who owns the center. The Board's responsibility is to approve the accrediting agency and the accrediting agency will inspect and accredit the facility.

Dr. GnanaDev also wanted to know if the accrediting agency had enough staff to evaluate within 24 hours of a complaint. Ms. Cady explained that part of the Board's responsibility is to evaluate the performance of the accrediting agency in responding to issues. There are two designations, either an immediate jeopardy which requires an 24 hour response or a more routine issue which requires a 30-day response. Therefore, Licensing will be monitoring the response periods as it has the authority for agency review.

Natalie Lowe provided an update from the licensing standpoint and stated that the database has been released to the public and is on the Board Web site. The Web site will contain inspection reports soon. The Board's internal database is going to be tracking timeframes regarding the receipt of reports. The reports will cover the initial inspection, the follow up of corrective action plans and also the follow-up to determine that the corrective action plans have been completed. Licensing will be working closely with Enforcement to ensure that any reports received are shared by both units. Licensing will be tracking the timeframes internally.

Agenda Item 13 Agenda Items for the October 25-26, 2012 Meeting in the San Diego Area

No items were discussed.

Agenda Item 14 Adjournment

The meeting was adjourned at 4:10 p.m.

The full meeting can be viewed at www.mbc.ca.gov/board/meetings/Index.html

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CENTRAL COMPLAINT UNIT

MEDICAL BOARD OF CALIFORNIA

GOALS FOR IMPROVING CASE AGING

- Reduce the time required for complaint initiation from 10 days to 5 days
- Reduce length of time required for medical consultant review on quality of care cases
- Continue specialized training for consumer services analysts to improve efficiency and effectiveness in managing complaint caseloads

Strategic Plan Objective 5.2: Reduce disciplinary timelines, complaint processing and investigations by 10-20%; Complaint processing averaging under 70 days with 50-60% under 50 days.

Month	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13
July	57	73	79	73	71	71
August	54	76	78	69	77	70
September	54	75	76	71	79	67
October	54	75	76	70	79	67
November	55	76	75	72	82	66
December	55	75	76	73	83	65
January	57	75	76	74	83	
February	58	76	76	72	84	
March	59	76	76	73	85	
April	60	75	76	73	84	
May	62	75	75	72	84	
June	61	75	75	74	83	

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)**

SB 1441 - Uniform Standards Implementation

DCA #	Requirement	MBC DisciplinaryTerm/Condition
1	If license on probation due to substance abuse problem, licensee must undergo a clinical diagnosis evaluation. The report should contain recommendations for treatment, practice restrictions, etc.	The existing guidelines recommend that a medical and psychiatric evaluation be obtained and allow the Board to designate the evaluator and provide all relevant information. The guidelines also allow the board to require the clinical evaluation for substance abuse issues and also require that the licensee comply with any treatment recommendations made.
2	Requires Board to order cease practice pending results of clinical diagnostic evaluation and review by Board staff. Licensee must be drug tested at least two times per week during evaluation period and must have 30 days of negative tests before resuming practice	The existing guidelines include the optional condition of requiring that the licensee not practice medicine until the evaluation has been completed and the licensee is deemed safe to practice.
3	Requires probationer who has an employer to provide the board with names, addresses, phone numbers of all employers/supervisors and sign a consent authorizing the board to communicate with the employer regarding work status, performance and monitoring.	Board policy is to collect information from licensee on current practice location information(s) and staff at the intake interview and to update the practice location(s) information and contact information on Medical Director/Chief of Staff each quarter. Board Policy will be updated to add release for employer
4	Contains drug testing standards which includes frequency (recommends 104 for the first year), random scheduling, lab standards, observed collections, etc.	The existing guidelines are consistent with standards with the exception of the testing frequency specified in DCA's standards. Given the continued discussion/debate regarding the minimum Biological Fuel Testings (BFT) required, MBC's guidelines moved f number of tests identified so the testing frequency can be adjusted depending on circumstances to be consistent with the uniform standard. MBC incorporated DCA's testing frequency schedule into the procedure for setting BFT schedules.
5	Provides guidelines for group support meetings	Not Applicable
6	Provides guidelines for treatment programs (inpatient, outpatient, etc.)	Not applicable
7	Provides guidelines for qualifications, methods of monitoring and reporting for worksite monitors	Not applicable

8	Requires that licensee be ordered to cease practice immediately when a test for a banned substance is positive. Requires board to notify licensee and employer	2011 Disciplinary Guidelines authorize the board to issue an immediate cease practice order.
9	Identifies that when a licensee tests positive for a prohibited substance, he/she has committed a major violation and subject to penalties from #10	2011 Disciplinary Guidelines authorize the board to issue an immediate cease practice order.
10	Identifies consequences for a major violation to be 1) licensee must cease practice and obtain another clinical evaluation and test negative for at least one month before returning to work; 2) referral for disciplinary action	2011 Disciplinary Guidelines authorize the board to issue an immediate cease practice order. MBC's current policy is to refer any "major" violations to the AG for disciplinary action vs. requiring another evaluation and extended time with no positive BFT.
11	Identifies criteria licensee must meet in order to return to practice full-time	N/A - Appears to relate to licensees in a diversion program
12	Identifies criteria licensee must meet in order to reinstate to a full/unrestricted license	N/A - Appears to relate to licensees in a diversion program
13	Identifies standards for vendors providing diversion services	Not applicable
14	Identifies public information to be provided when licensees are in a diversion program	Not applicable
15	Identifies an audit schedule for diversion programs	Not applicable
16	Identifies reporting information that must be provided to DCA regarding physicians on probation for substance abuse issues	No impact on Disciplinary Guidelines