

State of California
State and Consumer Services Agency

MEDICAL BOARD OF CALIFORNIA

April 5, 2013



Education and Wellness Committee Meeting
and
Executive Committee Meeting

Education and Wellness Committee	10:30 am – 1:00 pm
Executive Committee	1:30 pm – 3:00 pm



MEDICAL BOARD OF CALIFORNIA



EXECUTIVE COMMITTEE MEETING AGENDA

MEMBERS OF THE EXECUTIVE COMMITTEE

Sharon Levine, M.D., President
Gerrie Schipske, R.N.P., J.D., Vice
President
Silvia Diego, M.D., Secretary
Reginald Low, M.D.
Janet Salomonson, M.D.
Barbara Yaroslavsky, Past President

Medical Board of California
Lake Tahoe Room
2005 Evergreen Street, St.
Sacramento, CA 95815

Friday, April 5, 2013

Executive Committee
1:30 pm – 3:00 pm

(or until the 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 of Items Not on the Agenda
Note: The Committee may not discuss or take action on any matter raised during this public comment section that is not included on this agenda, except to decide to place the matter on the agenda of a future meeting. [Government Code §§11125, 11125.7(a)]
3. Approval of Minutes from January 31, 2013 Meeting
4. Consideration of 2013 Legislation – Ms. Simoes
5. Review and Consideration of Revisions to the Board Member Administrative Procedure Manual – Ms. Kirchmeyer
6. Update on Strategic Plan – Ms. Kirchmeyer
7. Update on Sunset Review Hearing – Ms. Kirchmeyer
8. 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 Lisa Toof at (916) 263-2389 or email lisa.toof@mbc.ca.gov or send a written request to Lisa Toof at the Medical Board of California, 2005 Evergreen Street, Ste. 1200, Sacramento, CA 95815. 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 Meeting 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

Executive Office



EXECUTIVE COMMITTEE

Embassy Suites
San Francisco Airport
150 Anza Boulevard
Burlingame, CA 94010

Thursday
January 31, 2013

MEETING MINUTES

Agenda Item 1 - Call to Order/Roll Call

The Executive Committee of the Medical Board of California was called to order by Sharon Levine, M.D. was called to order at 2:45 p.m. on Thursday, January 31, 2013. Due notice was provided to all interested parties.

Members Present:

Sharon Levine, M.D., President
Silvia Diego, M.D., Secretary
Reginald Low, M.D.
Janet Solomonson, M.D.
Barbara Yaroslavsky, Past President

Staff Present:

Armando Melendez, Business Services Staff
Curt Worden, Chief of Licensing
Diane Dobbs, Legal Counsel, Department of Consumer Affairs
Doreathea Johnson, Department of Consumer Affairs
Jennifer Simoes, Chief of Legislation
Kevin Schunke, Outreach Program Manager
Kimberly Kirchmeyer, Deputy Director
Kurt Heppler, Legal Counsel
Laura Sweet, Deputy Chief of Enforcement
Linda Whitney, Executive Director
Lisa Toof, Administrative Assistant II
Natalie Low, Licensing Manager
Regina Rao, Business Services Staff
Renee Threadgill, Chief of Enforcement
Susan Cady, Central Complaint Unit Manager
Tim Einer, Administrative Assistant II
Tracy Tu, Senior Investigator

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Members of the Audience:

Carrie Sparrevohn, Midwifery Advisory Council
GV Ayers, Senate B&P
Hank Dempsey, Senate B&P
Jack French, Consumers Union
Jane Zack Simon
Julie d'Angelo Fellmeth, CPIL
Karen Erlich, Midwifery Advisory Council
Kristin Chambers, California Medical Association
Teresa Anderson, CAPA
Terry Jones, Supervising Deputy Attorney General
Tess Winn, CPIL
Tina Manasian, Consumers Union
William Perry, PhD
Yvonne Chong, California Medical Association
Zennie Coughlin, Kaiser Permanente'

Agenda Item 2 - Public Comments on Items not on the Agenda

There were no public comments.

Agenda Item 3 - Approval of Minutes from the September 19, 2012 Meeting

Dr. Levine made a motion to approve the minutes from the September 19, 2012 meeting; s/Low; motion carried.

Agenda Item 4 - Report on How Consumer Protection Enforcement Initiative Positions are Being Allocated - Ms. Kirkmeyer

Ms. Kirkmeyer provided a detailed update on positions under the Consumer Protection Enforcement Initiative (CPEI) including background. There were several negative articles regarding the Board of Registered Nursing in 2009 regarding the length of time for the enforcement process. As a result of those articles the Department of Consumer Affairs (DCA) submitted a budget change proposal (BCP) for additional positions for all healing arts boards. As a result of that BCP the Medical Board of California (Board) received 22.5 positions in fiscal year 10/11. Two and a half positions were to assist with Board of Psychology and the Osteopathic Medical Board investigations. Those positions were subsequently transferred to those boards leaving the Medical Board with 20 positions. The Board filled two positions in order to assist with the complaint triage and the upfront review. During fiscal year 10/11, the Board had to decrease its positions due to a workforce cap so the Board gave up 2.5 of the CPEI positions resulting in 15.5 positions that still needed to be filled. The staff identified how to implement these positions, but the hiring freeze began. The hiring freeze was lifted in November, 2011 and then in early 2012 the Board was notified that it had to reduce its positions by 18.1 positions due to the salary savings elimination. The Board chose to give up 15.5 vacant CPEI positions rather than eliminating any existing staff positions. In September 2012 the Board was notified that it could fill these positions as long as the board maintains a 5% vacancy rate. Now the Board is in the process of filling those positions and has met and discussed where those positions should be placed.

The Board is going to establish a Northern California Operations Safe Medicine Unit identical to the one in Southern California. The unit will be made up of four Investigators, one clerical staff and one supervising investigator. By establishing this unit the unlicensed cases currently being performed by the investigators in the northern district offices will be transferred to this unit. This will reduce the northern California investigator workloads and allow them to process the case more expeditiously. The Board will also add an investigator to the Tustin and Rancho Cucamonga offices to bring them to six investigators in each office identical to the other district offices. Again this will reduce the caseloads and expedite the investigative process.

Two positions will be added to the Board's expert reviewer program to assist in expert retraining and recruitment. Three positions will be added to the Central Complaint Unit to assist in the quality of care unit, the discipline coordination unit and provide clerical support. One and a half positions will be used to conduct malpractice desk investigations. These 1.5 positions will perform the review and workup on these cases thus eliminating the need for transmission to the district offices. The ultimate goal is to expedite triage review and to reduce the workload in the district offices. All but 4.5 of these positions have been advertised and are pending final approval from the DCA in the recruitment process. The other 4.5 positions should be advertised by the end of February. The overall goal is to reduce the time it takes to investigate a complaint alleging a physician is in violation of the law.

Dr. Salomonson asked whether the Osteopathic Medical Board and the Board of Psychology investigations: have a complete independent investigation staff, and if so what is the interface with the Board.

Ms. Kirchmeyer responded that when these positions were originally proposed, DCA had a broad BCP. The Board of Psychology and Osteopathic Medical Board determined those positions should be housed with them and not part of the Medical Board's staff.

Dr. Levine asked Ms. Kirchmeyer to explain the difference between a sworn investigator and a non-sworn investigator. Ms. Kirchmeyer stated that a sworn investigator is an individual who is a peace officer identified under the Penal Code. These officers have the rights of a peace officer such as making arrests, obtaining search warrants, carrying a weapon, etc. A non-sworn investigator does more of the desk investigation such as obtaining medical records, telephone interviews working in a headquarters' office, and doing more of the paper trail investigation.

Agenda Item 5 - Review and potential revisions to Board Administrative Manual

Ms. Kirchmeyer discussed the edits that had been made in the manual based on comments from the Board Members and items that staff had been requested to include. Since the Board has begun webcasting its meetings, an update was needed to that section.

Ms. Kirchmeyer stated that the major edits were made to the election of officers section and panel members section. Based upon a request from members, a section was added outlining the role of Board officers, Committee chairs and Panel officers. Also added was a section outlining Board

Members' responsibilities. This document is provided during the DCA Board Member orientation and should be added to the Board's manual.

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Mr. Heppler requested that Item 4 on page 77 should read – public shall be requested to complete the speaker request. It has been pointed out that there is no mandatory requirement to complete one. The Board does this to maintain a record for the minutes.

Dr. Levine requested that in the section for the role of the Board President, a statement be added to include other meetings such as the Federation of State Medical Boards, etc.

Ms. Kirchmeyer asked for a motion to accept the edits in the supplied documents as well as the ones recently identified here prior to moving into the next agenda items.

Dr. Low made a motion; s/Yaroslavsky; motion carried.

Agenda Item 5A - Roles of Members Upon Media Inquiry

Ms. Kirchmeyer moved into Agenda Item 5A discussing the roles of the members when contacted by the media.

Several Committee Members expressed concerns about the proper way to address media and the public who ask to speak to a board member about certain issues. Members are not certain which type of questions they should refer back to the Executive Director or the Boards public information office, etc. It was discussed that perhaps the board members who wish to speak to media or the public be sure and state clearly that they are not speaking on behalf of the Board, but on their own behalf. Dr. Levine asked if the Committee Members were comfortable with doing things that way and/or whether there should be any constraints on Board Members from responding to a media inquiry with the understanding of the kinds of communication that should not happen.

After discussion between Board Members and staff about what the Board Members role is upon media inquiry's and how to handle them. However, Dr. Levine requested that this be agendized again with a process to identify how to handle media contacts.

Ms. Kirchmeyer clarified that the current policy is when the members get a call from the press to refer the call to staff and this will be outlined in the manual.

Agenda Item 5B - Meetings with the Public and Interested Parties

Ms. Kirchmeyer stated there have been recent discussions where individuals had wanted to meet with individual Board Members. After discussions among legal staff and Board Members, it was determined that the Board Members are free to speak with members of the public as long as it is clear that comments that are made are personal ones and not as an official position of the Board.

Dr. Levine requested that the staff prepare guidelines for communication with interested parties for more clarification and discuss the guidelines at the next Committee Meeting.

Public Comment was received for this agenda item.

Tina Manasian brought to the Board's attention an incident that took place at a doctor's office. She was not sure how to handle the situation and called the Board. She was told to file a complaint. She

did not understand why she was told to file a complaint. Ms. Whitney responded that a complaint was needed so the Board would have the matter on record, including the doctor's name and issue so it could be reviewed.

Agenda Item 5C - Providing Written Comments to the Board

Mr. Heppler requested that the Board consider establishing a policy on how to handle written comments received on agenda items.

Public Comment was received for this agenda item.

Jack French spoke on behalf of Consumers' Union Safe Patient Project. He expressed his concerns with how members of the public have found barriers to communicate with the Board Members. He offered some recommendations on how the Board might offer more communication options.

He urged the Board to make clear and prominent on its Web site the opportunities and rules for public participation in Board meetings including how to submit written testimony to Board Members.

After discussion, Dr. Levine asked that this be brought back to the next meeting with staff providing options on how to handle these types of comments.

Agenda Item 6 - Update on Strategic Plan

Ms. Kirchmeyer provided a brief update on the status of the Strategic Plan objectives. The objectives that did not have current or past due dates have not been included in this update as they will be included in the update when they are due. The Chiefs of Licensing, Enforcement and Legislation will continue to update their items at their committee meetings or during their program updates. Referring to the report at the September Executive Committee Meeting many deadlines were extended due to the work being performed on the Sunset Review and the Breeze project. Several of the objectives will be dependent upon the issues that have been presented in the sunset review report and whether legislation is drafted. Staff will be monitoring the Sunset Review process in comparison to the Board strategic plan and will see what items need to move forward after the Sunset Review hearings and legislation is drafted. All other objectives are on target for completion or have been completed as indicated in the status column.

Dr. Levine requested that staff lay out a time line of these objectives.

Ms. Kirchmeyer agreed to create that time line and present it to Members at the next meeting.

Ms. Kirchmeyer concluded her report and reminded Members that updates will continue to be provided at each Executive Committee meeting.

Agenda Item 7 - Adjournment

Dr. Levine made a motion to adjourn; s/Salomonson; motion carried. The meeting was adjourned at 3:40 pm.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 154
Author: Atkins
Bill Date: March 19, 2013, amended
Subject: Abortion
Sponsor: ACCESS Women's Health Justice
American Civil Liberties Union of California
Black Women for Wellness California
Latinas for Reproductive Justice
NARAL Pro-Choice California
Planned Parenthood Affiliates of California

STATUS OF BILL:

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

DESCRIPTION OF CURRENT LEGISLATION:

This bill would eliminate the distinction in existing law between “surgical” and “nonsurgical” abortions and would allow physician assistants (PAs), nurse practitioners (NPs), and certified nurse-midwives (CNMs) to perform an abortion by medication or aspiration techniques in the first trimester of pregnancy, if specified training is completed and clinical competency is validated.

ANALYSIS:

This bill will codify the Health Workforce Pilot Project (HWPP) #171, coordinated through the Office of Statewide Health Planning and Development (OSHPD) and sponsored by the Advancing New Standards in Reproductive Health (ANSIRH) program at the University of California, San Francisco (UCSF). The purpose of the pilot project was to evaluate the safety, effectiveness and acceptability of NPs, NMs, and PAs in providing aspiration abortions, and to evaluate the implementation of a standardized, competency based curriculum in provision of aspiration abortion care.

As part of the pilot, 40 NPs, CNMs and PAs were trained to be competent in aspiration abortion care. Clinicians participated in a comprehensive didactic and supervised clinical training program, which included a written exam and competency-based evaluation process. Trainee competency was evaluated daily and at the end of training on confidence, procedural performance, patient care, communication /interpersonal skills, professionalism, practice-based learning, and clinical knowledge.

This bill would require PAs, NPs, and CNMs to complete specified training and achieve clinical competency, which was also required as a part of the pilot project, before they are allowed to perform abortions by medication or aspiration techniques.

STATISTICS of the HWPP Pilot Project (#171) (Taken from the Peer Reviewed Study published in the American Journal of Public Health):

Patient sample selection, enrollment and consent:

- 5,675 first-trimester aspiration abortion procedures were completed by NPs/CNMs/PAs and 5,812 procedures were completed by physicians, for a total of 11,487 abortion procedures.

Abortion-related complications summary:

- A complication is identified at the time of the procedure (immediate) or after the procedure (delayed) and classified as either major (defined by the DCSCMC as “complications requiring abortion-related surgeries, transfusion or hospitalization”) or minor.
- Overall abortion-related complication rate: 1.3% of all procedures (152 of 11,487) had abortion-related complication diagnoses.
- Group-specific abortion-related complication rate: 1.8% for NPs, CNMs, and PAs and 0.9% for physicians.
- 96% (146 out of 152) of abortion-related complications were minor; 6 cases have been classified as major complications.
- The most common type of minor abortion-related complication diagnoses reported were incomplete abortion, hematometra, and failed abortion. Major abortion-related complications include hemorrhage, infection, and uterine perforation.
- The peer reviewed study found that abortion complications were clinically equivalent between newly trained NPs, CNMs, and PAs and physicians.

According to the author’s office, this bill is needed to ensure that women in California have access to early abortion. According to the author’s office early abortion access is a critical public health issue as many women in California do not have sufficient access to aspiration abortion because many counties in California lack an abortion provider, which requires women to travel a significant distance for care. The sponsors believe that increasing the number of providers for aspiration abortions will increase the ability of women to receive safe reproductive health care from providers in their community.

FISCAL: None

SUPPORT: ACCESS Women’s Health Justice (sponsor); American Civil Liberties Union of California (Sponsor); Black Women for Wellness California (sponsor); Latinas for Reproductive Justice (sponsor); NARAL Pro-Choice California (sponsor); and Planned Parenthood Affiliates of California (sponsor)

OPPOSITION: None on file

POSITION: Recommendation: Neutral

AMENDED IN ASSEMBLY MARCH 19, 2013

california legislature—2013–14 regular session

ASSEMBLY BILL

No. 154

Introduced by Assembly Member Atkins

January 22, 2013

~~An act relating to reproductive health care.~~ *An act to amend Section 2253 of, and to add Sections 734, 2725.4, and 3502.4 to, the Business and Professions Code, and to amend Section 123468 of the Health and Safety Code, relating to healing arts.*

legislative counsel's digest

AB 154, as amended, Atkins. ~~Healing arts: reproductive health care.~~ *Abortion.*

Existing law makes it a public offense, punishable by a fine not exceeding \$10,000 or imprisonment, or both, for a person to perform or assist in performing a surgical abortion if the person does not have a valid license to practice as a physician and surgeon, or to assist in performing a surgical abortion without a valid license or certificate obtained in accordance with some other law that authorizes him or her to perform the functions necessary to assist in performing a surgical abortion. Existing law also makes it a public offense, punishable by a fine not exceeding \$10,000 or imprisonment, or both, for a person to perform or assist in performing a nonsurgical abortion if the person does not have a valid license to practice as a physician and surgeon or does not have a valid license or certificate obtained in accordance with some other law authorizing him or her to perform or assist in performing the functions necessary for a nonsurgical abortion. Under existing law, nonsurgical abortion includes termination of pregnancy through the use of pharmacological agents.

AB 154

— 2 —

Existing law, the Nursing Practice Act, provides for the licensure and regulation of registered nurses, including nurse practitioners and certified nurse-midwives, by the Board of Registered Nursing. Existing law, the Physician Assistant Practice Act, provides for the licensure and regulation of physician assistants by the Physician Assistant Committee of the Medical Board of California.

~~Existing law authorizes the Office of Statewide Health Planning and Development to designate experimental health workforce projects as approved projects that, among other things, teach new skills to existing categories of health care personnel. The office has designated a pilot project, known as the Access through Primary Care Project, relating to the provision of health care services involving pregnancy.~~

~~This bill would state that it is the intent of the Legislature to enact legislation that would expand access to reproductive health care in California by allowing qualified health care professionals to perform early abortions.~~

This bill would instead make it a public offense, punishable by a fine not exceeding \$10,000 or imprisonment, or both, for a person to perform an abortion if the person does not have a valid license to practice as a physician and surgeon, except that it would not be a public offense for a person to perform an abortion by medication or aspiration techniques in the first trimester of pregnancy if he or she holds a license or certificate authorizing him or her to perform the functions necessary for an abortion by medication or aspiration techniques. The bill would also require a nurse practitioner, certified nurse-midwife, or physician assistant to complete training, as specified, in order to perform an abortion by aspiration techniques, and would indefinitely authorize a nurse practitioner, certified nurse-midwife, or physician assistant who completed a specified training program and achieved clinical competency to continue to perform abortions by aspiration techniques. The bill would delete the references to a nonsurgical abortion and would delete the restrictions on assisting with abortion procedures. The bill would also make technical, nonsubstantive changes.

Because the bill would change the definition of crimes, the bill would impose a state-mandated local program.

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

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AB 154

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

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

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

- 1 *SECTION 1. Section 734 is added to the Business and*
- 2 *Professions Code, to read:*
- 3 *734. It is unprofessional conduct for any nurse practitioner,*
- 4 *certified nurse midwife, or physician assistant to perform an*
- 5 *abortion pursuant to Section 2253, without prior completion of*
- 6 *training and validation of clinical competency.*
- 7 *SEC. 2. Section 2253 of the Business and Professions Code is*
- 8 *amended to read:*
- 9 *2253. (a) Failure to comply with the Reproductive Privacy*
- 10 *Act (Article 2.5 (commencing with Section 123460) of Chapter 2*
- 11 *of Part 2 of Division 106 of the Health and Safety Code) ~~in~~*
- 12 *~~performing, assisting, procuring or aiding, abetting, attempting,~~*
- 13 *~~agreeing, or offering to procure an illegal abortion~~ constitutes*
- 14 *unprofessional conduct.*
- 15 *(b) (1) ~~A~~ Except as provided in paragraph (2), a person is*
- 16 *subject to ~~Sections Section 2052 and 2053~~ if he or she performs*
- 17 *~~or assists in performing a surgical~~ an abortion, and at the time of*

18 so doing, does not have a valid, unrevoked, and unsuspended
19 license to practice as a physician and surgeon as provided in this
20 chapter, or if he or she assists in performing a surgical abortion
21 and does not have a valid, unrevoked, and unsuspended license or
22 certificate obtained in accordance with some other provision of
23 law that authorizes him or her to perform the functions necessary
24 to assist in performing a surgical abortion.

25 (2) A person ~~is shall not be~~ subject to ~~Sections~~ Section 2052
26 and 2053 if he or she performs ~~or assists in performing a~~
27 ~~nonsurgical abortion, an abortion by medication or aspiration~~
28 ~~techniques in the first trimester of pregnancy,~~ and at the time of
29 so doing, ~~does not have a valid, unrevoked, and unsuspended~~
30 ~~license to practice as a physician and surgeon as provided in this~~
31 ~~chapter, or does not have~~ has a valid, unrevoked, and unsuspended
32 license or certificate obtained in accordance with some other
33 provision of law, *including, but not limited to, the Nursing Practice*

AB 154

— 4 —

1 *Act (Chapter 6 (commencing with Section 2700)) or the Physician*
2 *Assistant Practice Act (Chapter 7.7 (commencing with Section*
3 *3500)), that authorizes him or her to perform or assist in performing*
4 *the functions necessary for a nonsurgical abortion. an abortion by*
5 *medication or aspiration techniques.*

6 (e) ~~For purposes of this section, “nonsurgical abortion” includes~~
7 ~~termination of the use of pharmacological agents.~~

8 (c) *In order to perform an abortion by aspiration techniques*
9 *pursuant to paragraph (2) of subdivision (b), a person shall comply*
10 *with Section 2725.4 or 3502.4.*

11 *SEC. 3. Section 2725.4 is added to the Business and Professions*
12 *Code, to read:*

13 2725.4. (a) *In order to perform an abortion by aspiration*
14 *techniques, a person with a license or certificate to practice as a*
15 *nurse practitioner or a certified nurse-midwife shall complete*
16 *training recognized by the Board of Registered Nursing. Beginning*
17 *January 1, 2014, and until January 1, 2016, the competency-based*
18 *training protocols established by Health Workforce Pilot Project*
19 *(HWPP) No. 171 through the Office of Statewide Health Planning*
20 *and Development shall be used.*

21 (b) *A nurse practitioner or certified nurse-midwife who has*
22 *completed training and achieved clinical competency through*
23 *HWPP No. 171 shall be authorized to perform abortions by*
24 *aspiration techniques.*

25 *SEC. 4. Section 3502.4 is added to the Business and Professions*
26 *Code, to read:*

27 3502.4. (a) *In order to receive authority from his or her*
28 *supervising physician and surgeon to perform an abortion by*
29 *aspiration techniques, a physician assistant shall complete training*

30 *either through training programs approved by the Physician*
31 *Assistant Board pursuant to Section 3513 or by training to perform*
32 *medical services which augment his or her current areas of*
33 *competency pursuant to Section 1399.543 of Title 16 of the*
34 *California Code of Regulations. Beginning January 1, 2014, and*
35 *until January 1, 2016, the training and clinical competency*
36 *protocols established by Health Workforce Pilot Project (HWPP)*
37 *No. 171 through the Office of Statewide Health Planning and*
38 *Development shall be used as training and clinical competency*
39 *guidelines to meet this requirement.*

1

(b) *The training protocols established by HWPP No. 171 shall*
2 *be deemed to meet the standards of the Physician Assistant Board.*
3 *A physician assistant who has completed training and achieved*
4 *clinical competency through HWPP No. 171 shall be authorized*
5 *to perform abortions by aspiration techniques.*

6 *SEC. 5. Section 123468 of the Health and Safety Code is*
7 *amended to read:*

8 123468. The performance of an abortion is unauthorized if
9 either of the following is true:

10 (a) ~~The person performing or assisting in performing the~~
11 ~~abortion is not a health care provider authorized to perform or~~
12 ~~assist in performing an abortion pursuant to Section 2253 of the~~
13 ~~Business and Professions Code.~~

14 (b) The abortion is performed on a viable fetus, and both of the
15 following are established:

16 (1) In the good faith medical judgment of the physician, the
17 fetus was viable.

18 (2) In the good faith medical judgment of the physician,
19 continuation of the pregnancy posed no risk to life or health of the
20 pregnant woman.

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

30 ~~SECTION 1. It is the intent of the Legislature to enact~~
31 ~~legislation that would expand access to reproductive health care~~
32 ~~in California by allowing qualified health care professionals to~~
33 ~~perform early abortions, provided that the functions are within the~~
34 ~~scope of their licenses.~~

<http://blog.ansirh.org/2013/01/roe-v-wade-california-abortion-law-hwpp-171-and-the-future-of-access/>

***Roe v Wade*, California abortion law, HWPP #171, and the future of access**

Posted January 17, 2013 By [Tracy Weitz](#)

A newly published landmark study by ANSIRH demonstrates that trained nurse practitioners, certified nurse midwives, and physician assistants match physicians in the safety of aspiration abortions they provide. We hope that these results will give policymakers the evidence they need to move beyond physician-only restrictions in order to enable more women to have their reproductive health care needs met in their local communities by health care providers they know and trust.

January 22, 2013 marks the 40th anniversary of the *Roe v. Wade* Supreme Court decision that legalized abortion nationwide. While abortion in California had been legal under more limited circumstances since 1967, *Roe* did have an effect on our law. It eliminated the need for a psychiatrist to approve a woman's abortion, negated the requirement that abortions be performed in hospitals, and extended when a woman could have an abortion. But the law on the books didn't change.

It wasn't until 2000, when the FDA was poised to approve mifepristone (the "abortion pill"), that advocates considered asking the legislature to modernize the abortion law. Legal research in California confirmed that the state's physician-only law would prohibit nurse practitioners (NPs), certified nurse midwives (CNMs), and physician assistants (PAs) from being able to offer women the abortion pill, thereby limiting the benefit of this new abortion option. Although they knew it wouldn't be easy, advocates took on the challenge of reforming California's abortion law. A lot of hard work paid off, and on January 1, 2003, California enacted a contemporary abortion law. Known as the Reproductive Privacy Act, SB1301 codified the *Roe v. Wade* standards and affirmed the legal right of NPs, CNMs, and PAs to perform abortions using medications.

One of the unsettled parts of the discussion over SB1301 was whether non-physician clinicians should be allowed to offer other types of low-risk abortion procedures. At the time, there were two published studies on the provision of aspiration abortion by PAs in Vermont and New Hampshire. While the authors found no difference in safety, the studies included both a small number of patients and only a few clinicians. For many stakeholders, the evidence was insufficient to give them comfort opening up California's law in this way. What was needed was a more comprehensive study of the safety of aspiration abortion provision by NPs, CNMs, and PAs.

This is where UCSF entered the picture

After a few years of research design and fundraising, ANSIRH researchers were prepared to study the safety and competency of NPs, CNMs, and PAs performing aspiration abortions. In order to conduct the study, we utilized the Health Workforce Pilot Project (HWPP) mechanism within the Office of Statewide Health Planning and Development (OSHPD), which provides legal waivers for demonstration projects to test and evaluate new or expanded roles for health care professionals to improve access to health care and encourage workforce development. In 2007, UCSF obtained a legal waiver from the State and the HWPP #171 study began.

HWPP #171 was designed to answer two questions:

1. Can NPs, CNMs, and PAs be trained to competence in aspiration abortion?
2. Can they perform those procedures with outcomes comparable to those of their physician colleagues?

There were three principal investigators on the application to the state: Tracy A. Weitz, PhD, MPA; Diana Taylor, PhD, FNP, and Philip Darney, MD, MSc. There is also a principal investigator for each of the five partner organizations where clinicians were trained and offered services (four Planned Parenthood affiliates and Kaiser Permanente of Northern California).

Today, the results of our study were released in the American Journal of Public Health, one of the nation's most prestigious peer-reviewed journals.

The study results are relatively simple. A total of 5,675 women had their abortions performed by an NP, CNM, or PA and 5,812 by a licensed physician. The first major conclusion is that abortion is incredibly safe no matter who performed it. Fewer than 2% of all patients required any additional care after the initial abortion; only 6 patients (less than .05%) needed any hospital-based care (3 of those patients were seen by physicians and 3 by an NP, CNM, or PA); and all of those women recovered without any long-term physical harm.

The study was designed to assess the equivalence between the two groups of providers. The goal of the study was not to show that one group was better than the other, rather to see if they are the same. To do this, we set a margin of difference of 2%. In the physician group, 0.9% of women had a complication, compared to 1.8% of women in the NP/CNM/PA group. This slightly higher number among newly trained providers was expected and is not clinically significant. The risk difference for complications between the two groups fell within the predetermined margin of non-inferiority. As a result, we conclude that NPs, CNMs, and PAs can perform aspiration abortions as safely as their physician colleagues.

So why does all this matter?

Nationally, 92% of abortions take place in the first trimester—but black, uninsured, rural, and low-income women continue to have less access to this care. In California, 13% of women using state Medicaid insurance obtain abortions after the first trimester. Because the average cost of a second-trimester abortion is substantially higher than a first-trimester procedure and abortion complications increase as the pregnancy advances, shifting the population distribution of abortions to earlier gestations would result in safer, less costly care.

In addition, NPs, CNMs, and PAs provide the majority of well-woman care in primary care settings and are key health access points for low-income and rural women. Allowing a larger group of health care professionals to offer early aspiration abortion care is one way to reduce this health care disparity and increase continuity of care. The evidence to support this policy option is now in hand.

In 2013, policy advocates in Sacramento will once again work with the California legislature to modernize California's abortion law and allow NPs, CNMs, and PAs to perform early aspiration abortions. By utilizing these skilled health care professionals, perhaps many more California women will have their reproductive health care needs met in their local communities by health care providers they know and trust.

Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver

Tracy A. Weitz, PhD, Diana Taylor, PhD, Sheila Desai, MPH, Ushma D. Upadhyay, PhD, Jeff Waldman, MD, Molly F. Battistelli, BA, and Eleanor A. Drey, MD

Increased access to early abortion is a pressing public health need. By 2005, the number of abortion care facilities in the United States had decreased 38% from its peak in 1982.¹ Although the number has since remained stable, the proportion of US counties with no facility remains high at 87%; more than one third of women aged 15 to 44 years live in these counties.² Additionally, a large proportion of US facilities are hospitals that perform abortions only in cases of serious medical and fetal indications or facilities that offer medical abortions only up to 9 weeks of pregnancy.²

Many women face difficulties finding a facility, resulting in delayed care.³ Increasing access is critical because abortions at later gestations are associated with a higher risk of complications⁴ and higher costs.² Research has also found that many women would prefer to obtain their abortions earlier.⁵ Finally, traditionally underserved populations experience the greatest barriers to abortion care, resulting in higher rates of procedures after the first trimester.^{6,7}

In California, more than half of the 58 counties lack a facility that provides 400 or more abortions (R. K. Jones, personal communication). Low-income and minority women are most likely to be served by public health departments or community health centers,⁸ most of which do not provide abortions. These women are also more likely to be cared for by nurse practitioners (NPs) and physician assistants (PAs) than by obstetricians and gynecologists.⁹

One potential solution to improve access is to increase the number and types of health care professionals who offer early abortion care.¹⁰⁻¹² Increased emphasis has been placed on task sharing to better meet women's health needs in the context of health care workforce shortages.¹³ In the United States, health professions are regulated through a patchwork of state regulations^{14,15}

Objectives. We examined the impact on patient safety if nurse practitioners (NPs), certified nurse midwives (CNMs), and physician assistants (PAs) were permitted to provide aspiration abortions in California.

Methods. In a prospective, observational study, we evaluated the outcomes of 11 487 early aspiration abortions completed by physicians (n = 5812) and newly trained NPs, CNMs, and PAs (n = 5675) from 4 Planned Parenthood affiliates and Kaiser Permanente of Northern California, by using a noninferiority design with a predetermined acceptable risk difference of 2%. All complications up to 4 weeks after the abortion were included.

Results. Of the 11 487 aspiration abortions analyzed, 1.3% (n = 152) resulted in a complication: 1.8% for NP-, CNM-, and PA-performed aspirations and 0.9% for physician-performed aspirations. The unadjusted risk difference for total complications between NP-CNM-PA and physician groups was 0.87 (95% confidence interval [CI] = 0.45, 1.29) and 0.83 (95% CI = 0.33, 1.33) in a propensity score-matched sample.

Conclusions. Abortion complications were clinically equivalent between newly trained NPs, CNMs, and PAs and physicians, supporting the adoption of policies to allow these providers to perform early aspirations to expand access to abortion care. (*Am J Public Health*. Published online ahead of print January 17, 2013; e1-e8. doi:10.2105/AJPH.2012.301159)

that determine who can perform abortions, a power reaffirmed by several US Supreme Court decisions.¹⁶⁻¹⁸ Currently, nonphysician clinicians can perform aspiration abortions legally in only 4 states—Montana, Oregon, New Hampshire, and Vermont. Two additional states (Kansas and West Virginia) do not limit the performance of abortions to physicians, but nonphysician clinicians have never tried to provide abortion care. Of the remaining 44 states (Figure 1), some allow nonphysician clinicians to perform medical (but not aspiration) abortions under decisions by attorneys general or health departments, and 1 state—California—passed statutory authority for that care. As part of a larger effort to limit abortion access, several states have recently promulgated laws that specifically prohibit nonphysician clinicians from performing abortions.¹⁹ For example, a 2009 Arizona law (HB 2564 and SB 1175) that precluded NPs from providing abortions resulted in the discontinuation

of abortion care at several facilities that had previously been staffed exclusively by NPs.²⁰

Limited clinical evidence is available to inform policymakers about whether physician-only legal restrictions on abortion are evidence-based.²¹⁻²⁴ Our study was designed to provide this evidence to policymakers; it answers the question “What would be the impact on patient safety if NPs, PAs, and certified nurse midwives (CNMs) were permitted to provide aspiration abortions in California?” (We use the term *aspiration abortion* to refer to what is commonly called *surgical abortion* because the technique does not meet the technical definition of surgery.²⁵) We used a noninferiority design to compare the incidence of abortion-related complications between groups because we anticipated a slightly higher number of complications among newly trained NPs, CNMs, and PAs than among the experienced physicians.

captured. For all outcomes other than an uncomplicated recovery, an incident report was generated and reviewed by the site medical director, study investigators, and the study's Data and Clinical Safety Monitoring Committee. Additional monitoring of outcomes and study procedures included annual Office of Statewide Health Planning and Development–sponsored site visits; quarterly reviews of participant recruitment, patient experience, and clinical outcomes; and routine communication between facility and UCSF study staff.

Study Outcomes

Unlike a superiority analysis, a noninferiority study design determines whether the effect of a new treatment is not worse than that of an active control by more than a specified clinically acceptable margin.^{29–32} We selected a noninferiority design because we were seeking not to replace physicians as abortion providers or to determine whether NPs, CNMs, and PAs were better than current providers of care but to identify additional, comparably safe providers to supplement the provider pool. Because NPs, CNMs, and PAs who are newly trained in aspiration abortion have less experience, we expected to find a statistically significant higher rate of complications among this group than among more experienced physicians. However, we also anticipated a low overall incidence of complications from procedures across both groups. Therefore, a noninferiority design provided a more clinically relevant analysis. Given a low expected complication rate in both provider groups, we prespecified the margin of noninferiority as a change of 2%, which was determined before the start of the study by a panel of researchers and clinicians and approved by the Data and Clinical Safety Monitoring Committee, who considered ethical and clinical issues and previous US-based studies, which showed abortion-related complication rates ranging from 1.3% to 4.4%.^{21,22,33–38}

The primary outcome was the difference in incidence of complications within 4 weeks of the aspiration abortion between NPs, CNMs, and PAs and physicians. Complications were categorized as immediate (occurring before leaving the facility) and delayed (occurring ≤ 4 weeks after the procedure). Additionally,

complications were classified as major if the patient required hospital admission, surgery, or a blood transfusion and minor if they were treated at home or in an outpatient setting. This classification schema is consistent with that used in other studies of abortion-related morbidity.^{34–37}

Statistical Analysis

We based sample size calculations for this study on an expected complication rate of 2.5%, which was based on mean complication rates cited in the published literature^{21,22,33–38} and powered at 90% to detect a 1.0% or greater difference in complication incidence between groups ($\alpha = .025$, 1-tailed test). The study was powered specifically for a noninferiority analysis. Although we set a clinically acceptable margin of difference at 2.0%, we took a conservative approach and powered the study to detect an even smaller difference. We then further increased the sample size per group by 15% to adjust for clustering effects at the provider and clinic levels.

We compared sociodemographic characteristics of patients seen by NPs, CNMs, and PAs and those seen by physicians using mixed-effects logistic regression for dichotomous variables, mixed-effects multinomial logistic regression for categorical variables, and mixed-effects linear regression for continuous variables, all of which included random effects for facility. Incidence of a complication was coded as a dichotomous variable. Complication incidence was calculated by provider group. We fit a mixed-effects logistic regression model with crossed random effects to obtain odds ratios that account for the lack of independence between abortions performed by the same clinician and within the same facility and cross-classification of providers across facilities. We included variables associated with complications in bivariate analyses at $P < .05$ in the multivariate model in addition to other clinically relevant covariates to adjust for potential confounders.

To mitigate selection bias resulting from the lack of randomization, we replicated the analysis in a propensity score–matched sample, a method used to achieve balance between study groups in observational or nonrandomized studies using the predicted probability

of group membership (NP, CNM, or PA vs physician group) on the basis of observed predictors.^{39–41} We used the Stata module *pscore* to develop the propensity scores based on a logistic regression model that included patient characteristics that potentially influenced to which provider type the patient was assigned (age, race/ethnicity, insurance type, gestational age, parity, history of cesarean delivery, history of miscarriages, history of abortions, screening for sexually transmitted infections, positive test for a sexually transmitted infection, selection of a clinical contraceptive method, and presence of risk factors). Patients with similar propensity scores in the 2 provider groups were matched using nearest neighbor matching. After testing that the balancing property of the propensity score was satisfied, we selected a matched sample composed of 78.3% of the original sample, among which we replicated our mixed-effects analysis. We used predictive probabilities to calculate risk differences and 95% confidence intervals (CIs) for all models. We used STATA version 12 (StataCorp LP, College Station, TX) for all analyses.

RESULTS

A total of 21 095 women were screened for eligibility. Of these, 3837 did not meet the eligibility criteria, most commonly because of patient age and gestational age. Among the 17 258 eligible women, 13 807 agreed to participate in the study. Of these, 2320 had procedures performed by NPs, CNMs, and PAs during their training phase and were therefore not included in this analysis. As a result of a protocol violation at 1 site, 79 patients in the physician group were excluded. Follow-up data were available for 69.5% of patients, and follow-up rates were nondifferential between provider groups. Patients who did not return the follow-up survey were retained in the analytic sample because we found that they contacted the facility when they did experience a complication ($n = 41$), which we also discovered via medical chart abstraction, suggesting a low likelihood of missing complications among this group. Additionally, in a sensitivity analysis, complication incidence and risk differences were similar when we excluded patients who did not return the

TABLE 1—Baseline Characteristics of Patient Study Participants by Provider Type at 22 California Clinical Facilities: August 2007–August 2011

Patient Characteristic	Physicians (n = 5812), % or Mean ±SD	NPs–CNMs–PAs (n = 5675), % or Mean ±SD	P ^a
Age, y	25.7 ±6.1	25.6 ±5.9	.01
16–19	12.9	13.5	.73
20–24 (Ref)	39.0	39.0	
25–34	36.9	37.4	.83
≥ 35	11.2	10.1	.06
Race/ethnicity ^b			
White, non-Hispanic (Ref)	29.3	29.5	
Black, non-Hispanic	12.1	13.8	.03
Hispanic	40.6	40.4	.87
Asian, non-Hispanic	8.3	6.6	.01
Other, non-Hispanic	8.7	8.5	.83
Insurance type			
No coverage (Ref)	24.7	26.5	
Medi-Cal ^c	56.3	54.1	.68
Private	11.9	14.1	.67
Other	7.1	5.3	<.001
Gestational age, d			
< 36 (Ref)	2.5	2.7	
36–49	31.5	33.3	.26
50–63	32.1	33.1	.36
≥ 64	33.9	30.9	.93
Gravidity			
≤ 1 (Ref)	27.2	26.9	
2	20.6	21.5	.25
3	18.3	17.4	.55
≥ 4	33.9	34.1	.59
Parity ^d			
0 (Ref)	44.2	44.9	
1	24.8	24.1	.63
≥ 2	30.8	30.7	.97
Previous cesarean deliveries			
0 (Ref)	86.5	86.7	
≥ 1	13.5	13.3	.21
Previous miscarriages ^e			
0 (Ref)	82.3	82.7	
1	13.9	13.2	.2
≥ 2	3.5	3.6	.99
Previous induced abortions ^f			
0 (Ref)	52.3	51.5	
1	28.0	28.6	.46
≥ 2	19.5	19.6	.7
Tested positive for an STI	3.6	3.4	.77

Continued

follow-up survey. Patients without follow-up data were more likely to have no insurance, have fewer risk factors, be multigravida, and be at less than 5 weeks gestation than were those with follow-up data ($P < .05$; not shown).

The final analytic sample size was 11 487; of these procedures, 5812 were performed by physicians and 5675 were performed by NPs, CNMs, or PAs.

Patient Characteristics

The majority of women in both groups had had 3 or more pregnancies; no previous cesarean deliveries, miscarriages, or induced abortions; and no history of medical risk factors (Table 1). Women in the NP–CNM–PA group were more likely to be younger ($P < .01$), less likely to be Asian than White ($P < .01$), and more likely to be non-Hispanic Black than White ($P < .03$). Women were similar on all other sociodemographic characteristics across provider groups.

Outcomes

Overall, complications were rare (Table 2). Out of 11 487 aspiration abortions, 1.3% ($n = 152$; 95% CI = 1.11, 1.53) resulted in a complication; 1.8% of NP-, CNM-, and PA-performed aspirations and 0.9% of physician-performed aspirations resulted in a complication. The majority of complications (146/152, or 96%) were minor (1.3% of all abortions) and included cases of incomplete abortion ($n = 9$ among physicians, $n = 24$ among NPs, CNMs, and PAs), failed abortion ($n = 7$ among physicians, $n = 11$ among NPs, CNMs, and PAs), bleeding not requiring transfusion ($n = 2$ among NPs, CNMs, and PAs), hematometra ($n = 3$ among physicians, $n = 16$ among NPs, CNMs, and PAs), infection ($n = 7$ among physicians, $n = 7$ among NPs, CNMs, and PAs), endocervical injury ($n = 2$ among physicians, $n = 2$ among NPs, CNMs, and PAs), anesthesia-related reactions ($n = 1$ among physicians, $n = 1$ among NPs, CNMs, and PAs), and uncomplicated uterine perforation ($n = 3$ among NPs, CNMs, and PAs). We classified complications without clear etiology but accompanied by patient symptoms as symptomatic intrauterine material ($n = 16$ among physicians, $n = 24$ among NPs, CNMs, and PAs). We classified 11 minor complications as “other”; 4 were from physician-performed procedures

TABLE 1—Continued

Risk factors ^d			
Extreme obesity (BMI > 40 kg/m ²)	2.3	2.2	.33
Existing chronic illness	5.0	4.9	.72
Placenta previa (16–18 wk)	0.0	0.0	.32
Psychiatric condition	3.3	3.2	.61

Note. BMI = body mass index; CNM = certified nurse midwife; NP = nurse practitioner; PA = physician assistant; STI = sexually transmitted infection. Physicians had completed a residency in either obstetrics and gynecology or family medicine. Missing data on age (n = 18), patient insurance (n = 35), cesarean delivery history (n = 82), and gravidity (n = 7) were recoded to mean age, no insurance, no history of cesarean delivery, and median gravidity, respectively. Missing data on gestational age by ultrasound (n = 85) were recoded to gestational age by last menstrual period; where those data were also missing, they were recoded to the mean gestational age by ultrasound. For other missing variables, we created a new variable for missing.

^aP values are based on a significance level of .05 and were calculated using mixed-effects logistic regression for dichotomous variables, mixed-effects multinomial logistic regression for categorical variables, and mixed-effects linear regression models for continuous variables, all of which included random effects for facility.

^bData missing for 70 women in the NP-CNM-PA group and 56 in the physician group.

^cCalifornia's Medicaid program.

^dData missing for 11 women in each provider group.

^eData missing for 25 women in the NP-CNM-PA group and 20 in the physician group.

^fData missing for 17 women in the NP-CNM-PA group and 18 in the physician group.

^gAll risk factor variables are dichotomous (no-yes). "No" is the reference category (not shown in table).

(1 urinary tract infection, 1 possible false passage, 1 probable gastroenteritis, 1 unspecified allergic reaction), and 7 were from NP-, CNM-, or PA-performed procedures (1 fever of unknown origin, 1 intrauterine device-related bleeding, 3 sedation drug errors, 1 inability to urinate, 1 vaginitis).

Only 6 major complications occurred (3 in each provider group), which included 2 uterine perforations, 3 infections, and 1 hemorrhage. We found no difference in risk of major complications between provider groups: 0.001% (95% CI = -0.08, 0.09).

The overall unadjusted risk difference for total complications between NPs, CNMs, and PAs and physicians was 0.87% (95% CI = 0.45, 1.29). The risk difference in immediate complications (n = 9 for physicians; n = 20 for NPs, CNMs, and PAs) was 0.20%

(95% CI = 0.01, 0.38); for delayed complications (n = 43 for physicians; n = 80 for clinicians), it was 0.67% (95% CI = 0.29, 1.10).

Abortions by NPs, CNMs, and PAs were 1.92 (95% CI = 1.36, 2.72) times as likely to result in a complication as those performed by physicians after adjusting for potential confounders (see table available as a supplement to the online version of this article at <http://www.ajph.org>). Among the propensity score-matched sample, complications were 2.12 (95% CI = 1.33, 3.37) times as likely to result from abortions by NPs, CNMs, and PAs as by physicians. The corresponding risk differences were 0.70% (95% CI = 0.29, 1.10) in overall complications between provider groups in the adjusted model and 0.83% (95% CI = 0.33, 1.33) in the propensity score-matched sample.

The estimated 95% CIs for risk differences in unadjusted, adjusted, and propensity score-matched analyses all fell well within the predetermined margin of noninferiority, and therefore complication rates from aspiration abortions performed by recently trained NPs, CNMs, and PAs were statistically no worse than those from those performed by the more experienced physician group (Figure 2).

DISCUSSION

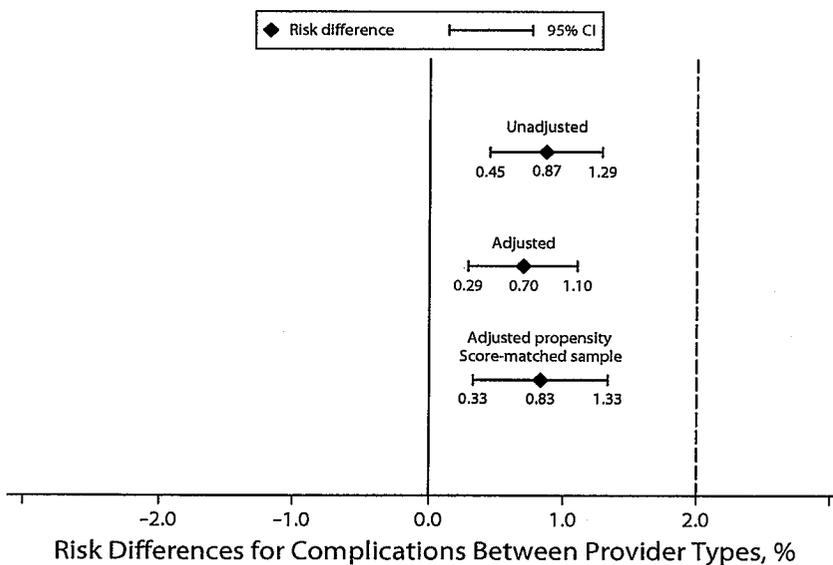
In 2008, 1.21 million abortions took place in the United States, with more 200 000 (18%) in the State of California.² Nationally, 92% of abortions take place in the first trimester,⁷ but Black, uninsured, and low-income women have less access to this care.⁶ In California, only 87% of women using state Medicaid insurance obtain abortions in the first trimester.⁴² Because the average cost of a second-trimester abortion is substantially higher than that of a first-trimester procedure, shifting the population distribution of abortions to earlier gestations would result in safer, less costly care. Increasing the types of health care professionals involved in abortion care is one way to reduce this health care disparity.

Our study was designed to examine the effect of removing the physician-only requirement for aspiration abortion provision in California. We found that the care provided by newly trained NPs, CNMs, and PAs was not inferior to that provided by experienced physicians. We estimate that only 1 additional complication would occur for every 120 procedures as a consequence of having an NP, CNM, or PA as the abortion provider. Additionally, the 0.83% risk difference was mainly

TABLE 2—Overall and Major and Minor Complication Rates by Provider Type at 22 California Clinical Facilities: August 2007–August 2011

Complication Type	Physicians (n = 5812)		NPs-CNMs-PAs (n = 5675)		Total (n = 11 487)		Risk Difference Between Provider Groups (n = 11 487) Difference in Rate/100 (95% CI)
	Rate/100 (95% CI)	No.	Rate/100 (95% CI)	No.	Rate/100 (95% CI)	No.	
Major	0.05 (-0.01, 0.11)	3	0.05 (-0.01, 0.11)	3	0.05 (0.01, 0.09)	6	0.001 (-0.08, 0.09)
Minor	0.84 (0.61, 1.08)	49	1.71 (1.37, 2.05)	97	1.27 (1.07, 1.48)	146	0.87 (0.46, 1.28)
Total	0.89 (0.65, 1.14)	52	1.76 (1.42, 2.10)	100	1.32 (1.11, 1.53)	152	0.87 (0.45, 1.29)

Note. CI = confidence interval; CNM = certified nurse midwife; NP = nurse practitioner; PA = physician assistant. Physicians had completed a residency in either obstetrics and gynecology or family medicine.



Note. CI = confidence interval. Both adjusted models included patient age, race/ethnicity, insurance type, gestational age, gravidity, history of cesarean section, positive test for a sexually transmitted infection, an indicator for extreme obesity, an indicator for chronic illness, and an indicator for psychiatric conditions. 2.0 is also the delta.

FIGURE 2—Unadjusted, adjusted, and adjusted propensity score-matched risk differences in overall complication rates of first-trimester aspiration abortion by nurse practitioner, certified nurse midwife, and physician assistant providers compared with physician providers in California.

the result of higher incidence of minor complications, the majority of which were from diagnoses easily treated and without consequential sequelae. Moreover, on the basis of findings in other studies, we expect this risk difference to narrow further over time.^{43–45} The comparison of newly trained NPs, CNMs, and PAs with more experienced physician abortion providers suggests that the small difference found would represent the maximum variation in outcomes that might be expected immediately after a policy change.

Both provider groups had extremely low numbers of complications, less than 2% overall—well below published rates—and only 6 complications out of 11 487 procedures required hospital-based care. Because the effect size is minimal compared with the published data and within the prespecified margin of noninferiority, we conclude that the difference between the 2 groups of providers is not clinically significant.

While the reported odds ratios comparing complication rates from procedures performed by NPs, CNMs, and PAs with those from procedures performed by physicians were statistically significant, these results should be interpreted cautiously. The study was powered specifically for a noninferiority analysis, which necessitated a larger sample size than a superiority analysis would. Therefore the significance we see may be a result of the study being overpowered.

These findings support the adoption of policies that increase access to abortion by expanding the number and type of health care professionals who can perform early aspiration abortions. The benefits of expanding access to abortion for California's women outweigh the small initial difference in risk, particularly because it would likely move many second-trimester abortions into the first trimester, significantly decreasing the overall risk of complications, which increases with gestational age.⁴ Expanded access is also likely to afford more women

the opportunity to obtain care without the additional indirect costs associated with traveling to a geographically distant abortion provider.

The strengths of this study are its statistical power, the large number of providers, and its setting in multiple facilities. A limitation of the study is its nonrandomized design, although the use of propensity score matching allowed for statistical adjustments to address this limitation. Additionally, this study had a low follow-up rate (70%), but this was not unexpected because of the sensitive nature of abortion, which may have deterred women from continuing participation in the study after the procedure. This follow-up rate is also similar to those in other US abortion-related studies with comparable follow-up periods (14–28 days).^{22,37,46} Although postprocedure complications may have been missed among patients for whom we did not have follow-up data, given the nondifferential follow-up rates between provider groups, we would expect unidentified complications to be equally distributed between groups, leaving the risk difference unaffected. A further limitation of the study is that the health care provider who initially identified a complication was not blinded to the type of provider who performed the abortion. However, we hypothesize that complaints from patients cared for by newly trained NPs, CNMs, and PAs would be more aggressively evaluated if the provider type was known to the health care provider evaluating the patient. Therefore, any bias caused by lack of blinding would have resulted in an overestimate of the risk difference.

Our results confirm existing evidence from smaller studies that the provision of abortion by NPs, CNMs, and PAs is safe^{21,22} and from larger international¹³ and national⁴⁷ reviews that have found these clinicians to be safe and qualified health care providers. The value of this study extends beyond the question of who can safely perform aspiration abortion services in California because it provides an example of how research can be used to answer relevant health workforce policy issues. As the demand for health care providers increases under US health care reform,⁴⁸ one part of the solution for all health care, including abortion care, is to allow all

qualified professionals to perform clinical care to the fullest extent of their education and competency.^{49,50} ■

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Contributors

T. A. Weitz and D. Taylor developed the study concept and design. T. A. Weitz, D. Taylor, and E. A. Drey supervised the overall study and analyzed the interpretation of results. S. Desai oversaw the acquisition of data. U. D. Upadhyay and S. Desai analyzed the data and provided statistical expertise. T. A. Weitz, U. D. Upadhyay, S. Desai, and E. A. Drey drafted the article, and J. Waldman advised on critical revision of the article for intellectual content. M. F. Battistelli provided administrative, technical, and material support.

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Human Participant Protection

Study protocol and procedures received institutional review board approvals from the University of California, San Francisco; Ethical and Independent Review Services; and Kaiser Permanente of Northern California.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 635
Author: Ammiano
Bill Date: February 20, 2013, Introduced
Subject: Drug Overdose Treatment: Liability
Sponsor: Harm Reduction Coalition
California Society of Addiction Medicine

STATUS OF BILL:

This bill is in the Assembly Judiciary Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would amend the civil code to allow a licensed health care provider that is authorized by law to prescribe an opioid antagonist, to prescribe and subsequently dispense or distribute an opioid antagonist to a person at risk of an opioid-related overdose or a family member, friend, or other person in a position to assist a person at risk of an opioid-related overdose. This bill would allow the licensed health care provider to issue standing orders for the administration of the opioid antagonist. This bill would specify that if health care provider or person who possesses, distributes, or administers an opioid antagonist pursuant to a prescription or order acts with reasonable care, they shall not be subject to professional review, be found liable in a civil action, or be subject to criminal prosecution for issuing a prescription or order or possessing, distributing, or administering the opioid antagonist.

BACKGROUND (taken from the fact sheet)

Naloxone is used in opioid overdoses to counteract life-threatening depression of the central nervous system and respiratory system, allowing an overdosing person to breathe normally. Naloxone is a non-scheduled, inexpensive prescription medication with the same level of regulation as ibuprofen. Naloxone only works if a person has opioids in their system, and has no effect if opioids are absent.

In 2008, SB 797 (Ridley-Thomas, Chapter 477, Statutes of 2007) established a three-year overdose prevention pilot project. This bill granted immunity from civil and criminal penalties to licensed health care providers in seven counties (Alameda, Fresno, Humboldt, Los Angeles, Mendocino, San Francisco, and Santa Cruz) who worked with opioid overdose prevention and treatment training programs, if the provider acted with reasonable care when prescribing, dispensing, or distributing naloxone. The pilot was extended in 2010 and extended liability protection to third party administrators of naloxone. This pilot is now scheduled to sunset on January 1, 2016.

California's longest running naloxone prescription program in San Francisco has

provided over 3,600 take-home naloxone prescriptions since 2003 through collaboration with the San Francisco Department of Public Health. To date, 916 lives have been saved by laypersons trained by this program who administered the take-home naloxone during an overdose. According to the most recent data released by the Centers for Disease Control and Prevention (CDC), in 2008 there were 36,450 drug overdose deaths in the United States. According to CDC, overdose prevention programs in the United States distributing naloxone have trained over 50,000 lay persons to revive someone during an overdose, resulting in over 10,000 overdose reversals using naloxone

ANALYSIS

This bill will allow health care providers to prescribe, dispense, and issue standing orders for an opioid antagonist to persons at risk of overdose, or their family member, friend, or other person in a position to assist persons at risk, without making them professionally, civilly or criminally liable, if acting within reasonable care. It would also extend this same liability protection to individuals assisting in dispensing, distributing, or administering the opioid antagonist during an overdose.

Language in existing law for the pilot project only provides civil and criminal liability, it does not exclude health care providers from “professional review”. Board staff is unsure of what the reasoning behind including professional review is, and would like to work with the author’s office on this point and bring this bill back to the Board at the April Board Meeting.

Drug overdoses are now the leading cause of injury death in the United States, surpassing motor vehicle crash deaths. According to the author’s office, this bill will protect licensed health care providers and encourage them to begin prescribing naloxone to patients on chronic opioid pain medications in order to help address the prescription drug overdose epidemic, as well as make it easier for providers to participate in comprehensive drug overdose prevention programs that prescribe opioid antagonists. This is one element of many to address the issue of drug related overdose deaths in California.

This bill will help to further the Board’s mission of consumer protection, staff is suggesting that the Board support this bill in concept, but continue to work with the author’s office.

FISCAL: None

SUPPORT: Harm Reduction Coalition (sponsor)
California Society of Addiction Medicine (sponsor)

OPPOSITION: None on file

POSITION: Recommendation: Support in Concept

ASSEMBLY BILL

No. 635

Introduced by Assembly Member Ammiano

February 20, 2013

An act to amend Section 1714.22 of the Civil Code, relating to drug overdose treatment.

legislative counsel's digest

AB 635, as introduced, Ammiano. Drug overdose treatment: liability.

Existing law authorizes a physician and surgeon to prescribe, dispense, or administer prescription drugs, including prescription-controlled substances, to an addict under his or her treatment, as specified. Existing law prohibits, except in the regular practice of his or her profession, any person from knowingly prescribing, administering, dispensing, or furnishing a controlled substance to or for any person who is not under his or her treatment for a pathology or condition other than an addiction to a controlled substance, except as specified.

Existing law authorizes, until January 1, 2016, and only in specified counties, a licensed health care provider, who is already permitted pursuant to existing law to prescribe an opioid antagonist, as defined, and who is acting with reasonable care, to prescribe and subsequently dispense or distribute an opioid antagonist in conjunction with an opioid overdose prevention and treatment training program, as defined, without being subject to civil liability or criminal prosecution. Existing law requires a local health jurisdiction that operates or registers an opioid overdose prevention and treatment training program to collect prescribed data and report it to the Senate and Assembly Committees on Judiciary by January 1, 2015.

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— 2 —

Existing law authorizes, until January 1, 2016, and only in specified counties, a person who is not licensed to administer an opioid antagonist to do so in an emergency without fee if the person has received specified training information and believes in good faith that the other person is experiencing a drug overdose. Existing law prohibits that person, as a result of his or her acts or omissions, from being liable for any violation of any professional licensing statute, or subject to any criminal prosecution arising from or related to the unauthorized practice of medicine or the possession of an opioid antagonist.

This bill would revise and recast these provisions to instead authorize a licensed health care provider who is permitted by law to prescribe an opioid antagonist and is acting with reasonable care to prescribe and subsequently dispense or distribute an opioid antagonist for the treatment of an opioid overdose to a person at risk of an opioid-related overdose or a family member, friend, or other person in a position to assist a person at risk of an opioid-related overdose. The bill would authorize these licensed health care providers to issue standing orders for the

distribution of an opioid antagonist to a person at risk of an opioid-related overdose or to a family member, friend, or other person in a position to assist the person at risk. The bill would authorize these licensed health care providers to issue standing orders for the administration of an opioid antagonist by a family member, friend, or other person in a position to assist a person experiencing or suspected of experiencing an opioid overdose. The bill would provide that a person who acts with reasonable care and issues a prescription for, or an order for the administration of, an opioid antagonist to a person experiencing or suspected of experiencing an opioid overdose is not subject to professional review, liable in a civil action, or subject to criminal prosecution for issuing the prescription or order. The bill would also delete the repeal date and reporting requirements and expand the applicability of these provisions statewide.

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

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

1 SECTION 1. Section 1714.22 of the Civil Code is amended
2 to read:
3 1714.22. (a) For purposes of this section:

— 3 —

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1 ~~(1) “Opioid section, “opioid antagonist” means naloxone~~
2 ~~hydrochloride that is approved by the federal Food and Drug~~
3 ~~Administration for the treatment of a drug an opioid overdose.~~
4 ~~(2) “Opioid overdose prevention and treatment training~~
5 ~~program” or “program” means any program operated by a local~~
6 ~~health jurisdiction or that is registered by a local health jurisdiction~~
7 ~~to train individuals to prevent, recognize, and respond to an opiate~~
8 ~~overdose, and that provides, at a minimum, training in all of the~~
9 ~~following:~~
10 ~~(A) The causes of an opiate overdose.~~
11 ~~(B) Mouth to mouth resuscitation.~~
12 ~~(C) How to contact appropriate emergency medical services.~~
13 ~~(D) How to administer an opioid antagonist.~~
14 (b) A licensed health care provider who is ~~permitted~~ *authorized*
15 by law to prescribe an opioid antagonist may, if acting with
16 reasonable care, prescribe and subsequently dispense or distribute
17 an opioid antagonist ~~in conjunction with an opioid overdose~~
18 ~~prevention and treatment training program, without being subject~~
19 ~~to civil liability or criminal prosecution. This immunity shall apply~~
20 ~~to the licensed health care provider even when the opioid antagonist~~
21 ~~is administered by and to someone other than the person to whom~~
22 ~~it is prescribed to a person at risk of an opioid-related overdose~~

23 or a family member, friend, or other person in a position to assist
24 a person at risk of an opioid-related overdose.

25 (c) (1) A licensed health care provider who is authorized by
26 law to prescribe an opioid antagonist may issue standing orders
27 for the distribution of an opioid antagonist to a person at risk of
28 an opioid-related overdose or to a family member, friend, or other
29 person in a position to assist a person at risk of an opioid-related
30 overdose.

31 (2) A licensed health care provider who is authorized by law to
32 prescribe an opioid antagonist may issue standing orders for the
33 administration of an opioid antagonist to a person at risk of an
34 opioid-related overdose by a family member, friend, or other
35 person in a position to assist a person experiencing or reasonably
36 suspected of experiencing an opioid overdose.

37 (d) A licensed health care provider who acts with reasonable
38 care shall not be subject to professional review, be found liable
39 in a civil action, or be subject to criminal prosecution for issuing
40 a prescription or order pursuant to subdivision (b) or (c).

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— 4 —

1 ~~(c) A person who is not otherwise licensed to administer an~~
2 ~~opioid antagonist may administer an opioid antagonist in an~~
3 ~~emergency without fee if the person has received the training~~
4 ~~information specified in paragraph (2) of subdivision (a) and~~
5 ~~believes in good faith that the other person is experiencing a drug~~
6 ~~overdose. The person shall not, as a result of his or her acts or~~
7 ~~omissions, be liable for any violation of any professional licensing~~
8 ~~statute, or subject to any criminal prosecution arising from or~~
9 ~~related to the unauthorized practice of medicine or the possession~~
10 ~~of an opioid antagonist.~~

11 ~~(d) Each local health jurisdiction that operates or registers an~~
12 ~~opioid overdose prevention and treatment training program shall,~~
13 ~~by January 1, 2015, collect, and report to the Senate and Assembly~~
14 ~~Committees on Judiciary, all of the following data on programs~~
15 ~~within the jurisdiction:~~

16 ~~(1) Number of training programs operating in the local health~~
17 ~~jurisdiction.~~

18 ~~(2) Number of individuals who have received a prescription for,~~
19 ~~and training to administer, an opioid antagonist.~~

20 ~~(3) Number of opioid antagonist doses prescribed.~~

21 ~~(4) Number of opioid antagonist doses administered.~~

22 ~~(5) Number of individuals who received opioid antagonist~~
23 ~~injections who were properly revived.~~

24 ~~(6) Number of individuals who received opioid antagonist~~
25 ~~injections who were not revived.~~

26 ~~(7) Number of adverse events associated with an opioid~~
27 ~~antagonist dose that was distributed as part of an opioid overdose~~

28 prevention and treatment training program, including a description
29 of the adverse events.

30 ~~(e) This section shall apply only to the Counties of Alameda,
31 Fresno, Humboldt, Los Angeles, Mendocino, San Francisco, and
32 Santa Cruz.~~

33 ~~(f) This section shall remain in effect only until January 1, 2016,
34 and as of that date is repealed, unless a later enacted statute, that
35 is enacted before January 1, 2016, deletes or extends that date.~~

36 *(e) Notwithstanding any other law, a person who possesses or
37 distributes an opioid antagonist pursuant to a prescription or
38 standing order shall not be subject to professional review, be found
39 liable in a civil action, or be subject to criminal prosecution for
40 this possession or distribution. Notwithstanding any other law, a*

99

1 *person who acts with reasonable care and administers an opioid*
2 *antagonist to a person who is experiencing or is suspected of*
3 *experiencing an overdose shall not be subject to professional*
4 *review, be liable in a civil action, or be subject to criminal*
5 *prosecution for this administration.*

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— 5 —

AB 635



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Morbidity and Mortality Weekly Report (MMWR)

Community-Based Opioid Overdose Prevention Programs Providing Naloxone – United States, 2010

Weekly

February 17, 2012 / 61(06);101-105

Drug overdose death rates have increased steadily in the United States since 1979. In 2008, a total of 36,450 drug overdose deaths (i.e., unintentional, intentional [suicide or homicide], or undetermined intent) were reported, with prescription opioid analgesics (e.g., oxycodone, hydrocodone, and methadone), cocaine, and heroin the drugs most commonly involved (1). Since the mid-1990s, community-based programs have offered opioid overdose prevention services to persons who use drugs, their families and friends, and service providers. Since 1996, an increasing number of these programs have provided the opioid antagonist naloxone hydrochloride, the treatment of choice to reverse the potentially fatal respiratory depression caused by overdose of heroin and other opioids (2). Naloxone has no effect on non-opioid overdoses (e.g., cocaine, benzodiazepines, or alcohol) (3). In October 2010, the Harm Reduction Coalition, a national advocacy and capacity-building organization, surveyed 50 programs known to distribute naloxone in the United States, to collect data on local program locations, naloxone distribution, and overdose reversals. This report summarizes the findings for the 48 programs that completed the survey and the 188 local programs represented by the responses. Since the first opioid overdose prevention program began distributing naloxone in 1996, the respondent programs reported training and distributing naloxone to 53,032 persons and receiving reports of 10,171 overdose reversals. Providing opioid overdose education and naloxone to persons who use drugs and to persons who might be present at an opioid overdose can help reduce opioid overdose mortality, a rapidly growing public health concern.

Overdose is common among persons who use opioids, including heroin users. In a 2002–2004 study of 329 drug users, 82% said they had used heroin, 64.6% had witnessed a drug overdose, and 34.6% had experienced an unintentional drug overdose (4). In 1996, community-based programs began offering naloxone and other opioid overdose prevention services to persons who use drugs, their families and friends, and service providers (e.g., health-care providers, homeless shelters, and substance abuse treatment programs). These services include education regarding overdose risk factors, recognition of signs of opioid overdose, appropriate responses to an overdose, and administration of naloxone.

To identify local program locations and assess the extent of naloxone distribution, in October 2010 the Harm Reduction Coalition e-mailed an online survey to staff members at the 50 programs then known to distribute naloxone. Follow-up e-mails and telephone calls were used to encourage participation, clarify responses, and obtain information on local, community-based programs. The survey included questions about the year the program began distributing naloxone, the number of persons trained in overdose prevention and naloxone administration, the number of overdose reversals reported, and whether the totals were estimates or based on program data. The survey also asked questions regarding the naloxone formulations currently distributed, any recent difficulties in obtaining naloxone, and the program's experience with naloxone distribution.

EXEC 4-23

Staff members at 48 (96%) of the 50 programs completed the online survey. Since the first program began distributing naloxone in 1996, through June 2010, the 48 responding programs reported providing training and distributing naloxone to an estimated 53,032 persons (program range: zero to 16,220; median: 102.5; mean: 1,104.8).^{*} From the first naloxone distribution in 1996 through June 2010, the programs received reports of 10,171 overdose reversals using naloxone (range: zero to 2,385; median: 32; mean: 211.9).[†] During a recent 12-month period, respondents distributed an estimated 38,860 naloxone vials ([Table](#)).[§] Using data from the survey, the number of programs beginning naloxone distribution each year during 1996–2010 was compared with the annual crude rates of unintentional drug overdose deaths per 100,000 population from 1979 to 2008 ([Figure 1](#)) (*1*).

The 48 responding programs were located in 15 states and the District of Columbia. Four responding programs provided consolidated data for multiple local, community-based programs. Three state health departments, in New York, New Mexico, and Massachusetts, provided data for 129 local programs (65, 56, and eight, respectively); a nongovernmental organization in Wisconsin provided data on a statewide operation with 16 local programs. In all, the 48 responding programs provided data for 188 local opioid overdose prevention programs that distributed naloxone ([Figure 2](#)). Nineteen (76.0%) of the 25 states with 2008 drug overdose death rates higher than the median and nine (69.2%) of the 13 states in the highest quartile (*1*) did not have a community-based opioid overdose prevention program that distributed naloxone ([Figure 2](#)).

For a recent 12-month period, the 48 responding programs reported distributing 38,860 naloxone vials, including refills (range: zero to 12,070; median: 97; mean: 809.6).[¶] Overdose prevention programs were characterized as small, medium, large, or very large, based on the number of naloxone vials distributed during that period. The six responding programs in the large and very large categories distributed 32,812 (84.4%) of the naloxone vials ([Table](#)).

Twenty-one (43.7%) responding programs reported problems obtaining naloxone in the "past few months" before the survey. The most frequently reported reasons for difficulties obtaining naloxone were the cost of naloxone relative to available funding and the inability of suppliers to fill orders.^{**}

Reported by

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Editorial Note

The findings in this report suggest that distribution of naloxone and training in its administration might have prevented numerous deaths from opioid overdoses. Syringe exchange and harm reduction programs for injection-drug users were early adopters of opioid overdose prevention interventions, including providing naloxone (*5,6*). More noninjection opioid users might be reached by opioid overdose prevention training and (where feasible) provision of naloxone in jails and prisons, substance abuse treatment programs, parent support groups, and physician offices (Maya Doe-Simkins, MPH, Boston Medical Center, personal communication, 2011). Reaching users of prescription opioid analgesics is important because a large proportion of drug overdose deaths have been associated with these drugs (*1,7*).

Widespread concern about the substantial increases in opioid drug overdose deaths has prompted adoption of various other prevention measures, including 1) education of patients, clinicians, pharmacists, and emergency department staff members; 2) issuing opioid prescribing guidelines; 3) prescription drug monitoring programs; 4) legal and administrative efforts to reduce illegal

prescribing; 5) prescription drug take-back programs; and 6) improved access to substance abuse treatment (8,9). Programs such as Project Lazarus and Operation OpioidSAFE in North Carolina include clinicians prescribing naloxone to patients receiving opioid analgesic prescriptions who meet criteria for higher overdose risk (8) (Anthony Dragovich, MD, Womack Army Medical Center, Fort Bragg, North Carolina, personal communication, 2011).

In the United States, naloxone is provided to participants in different ways, including through onsite medical professionals and the use of standing orders. Recognizing the potential value of providing naloxone to laypersons, some states (e.g., California, Illinois, New Mexico, New York, and Washington) have passed laws and changed regulations to provide limited liability for prescribers who work with programs providing naloxone to laypersons. In addition, Washington, Connecticut, New Mexico, and New York have enacted Good Samaritan laws providing protection from arrest in an effort to encourage bystanders at a drug overdose to call 911 and use naloxone when available (9). Because of high overdose mortality among persons who use drugs, the Global Fund to Fight AIDS, Tuberculosis, and Malaria recommends naloxone distribution as a component of comprehensive services for drug users (10).

In this analysis, the majority (76.0%) of the 25 states with 2008 age-adjusted drug overdose death rates higher than the median did not have a community-based opioid overdose prevention program that distributed naloxone. High death rates provide one measure of the extent of drug overdoses; however, the number of deaths also should be considered. For example, in 2008, West Virginia had the highest drug overdose death rate (25.8) in the United States, and Texas (8.6) had one of the lowest. However, the West Virginia rate was based on 459 deaths, whereas the Texas rate was based on 2,053 deaths. States might consider both death rates and number of deaths in their intervention planning.

The findings in this report are subject to at least three limitations. First, other naloxone distribution programs might exist that were unknown to the Harm Reduction Coalition. Second, all data are based on unconfirmed self-reports from the 48 responding programs. Finally, the numbers of persons trained in naloxone administration and the number of overdose reversals involving naloxone likely were underreported because of incomplete data collection and unreported overdose reversals. However, because not all untreated opioid overdoses are fatal, some of the persons with reported overdose reversals likely would have survived without naloxone administration (2).

In this report, nearly half (43.7%) of the responding opioid overdose programs reported problems obtaining naloxone related to cost and the supply chain. Price increases of some formulations of naloxone appear to restrict current program activities and the possibility of new programs. Economic pressures on state and local budgets could decrease funding of opioid overdose prevention activities (Daniel Bigg, Chicago Recovery Alliance, personal communication, 2011). To address the substantial increases in opioid-related drug overdose deaths, public health agencies could consider comprehensive measures that include teaching laypersons how to respond to overdoses and administer naloxone to those in need.

Acknowledgments

Participating opioid overdose programs. Naloxone Overdose Prevention Education Working Group.

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* The number of participants to whom naloxone was distributed was estimated by 29 responding programs (26.5% of total) and based on program data for 19 respondents (73.5%).

† The number of opioid overdose reversals was estimated by 26 responding programs (25.4% of total) and based on program data for 22 respondents (74.6%).

§ The number of vials distributed to participants during 2009 or July 2009–June 2010 was estimated by 21 program respondents (6.5% of total) and based on program data for 27 respondents (93.5%).

¶ Responding programs provide naloxone for injection in multidose (10 mL) and single-dose (1 mL) vials with concentrations of 0.4 mg/mL. Vials that are adapted for intranasal use (using a mucosal atomization device) are single-dose 2 mL vials with concentration of 1 mg/mL. Typically, respondents provide 1 multidose or 2 single-dose vials in an overdose rescue kit. Forty-two (87.5%) of 48 reported providing only injectable naloxone (63.0% of total vials), four (8.3%) provided only intranasal naloxone (33.1%), and four (8.3%) provided both injectable and intranasal naloxone (3.9%).

** The two most commonly reported reasons for difficulties obtaining naloxone were the cost of naloxone relative to available funding (seven responding programs) and inability of suppliers to fill orders (13 respondents). Four respondents reported interruptions because they did not have a qualified medical provider to either order naloxone from suppliers or prescribe naloxone to users. Five reported two of the three reasons for interruptions.

What is already known on this topic?

From 1990 to 2008, drug overdose death rates increased threefold in the United States, and the number of annual deaths increased to 36,450. Opioids (including prescription opioid medications and heroin) are major causes of drug overdose deaths. Naloxone is the standard of care for treatment of potentially fatal respiratory depression caused by opioid overdose.

What is added by this report?

In October 2010, at least 188 local opioid overdose prevention programs that distributed naloxone existed. During 1996–2010, these programs in 15 states and the District of Columbia reported training and providing naloxone to 53,032 persons, resulting in 10,171 drug overdose reversals using naloxone. However, many states with high drug overdose death rates have no opioid overdose prevention programs that distribute naloxone.

What are the implications for public health practice?

To address the high rates of opioid drug overdose deaths, public health agencies could, as part of a comprehensive prevention program, implement community-based opioid drug overdose prevention programs, including training and providing naloxone to potential overdose witnesses, and systematically assess the impact of these programs.

TABLE. Number of opioid overdose programs/local programs, naloxone vials provided in a recent 12-month period, program participants overall, and overdose reversals, by program size — United States, 1996–2010

Program size (by no. of vials of naloxone provided during a recent 12-month period)	No. of program respondents	No. of local programs	No. of naloxone vials provided to participants during a recent 12-month period*		No. of program participants from beginning of program through June 2010†		Reported opioid overdose reversals from beginning of program through June 2010§	
			No.	(%)	No.	(%)	No.	(%)
Small <100	24	24	754	(1.9)	1,646	(3.1)	371	(3.6)
Medium 101–1,000	18	18	5,294	(13.6)	13,214	(24.9)	3,241	(31.9)
Large 1,001–10,000	4	74	9,792	(25.3)	26,213	(49.4)	5,648	(55.5)
Very large >10,000	2	72	23,020	(59.2)	11,959	(22.6)	1,091	(10.7)
Total	48	188	38,860	(100.0)	53,032	(100.0)	10,171	(100.0)

* Units of naloxone (including number of vials or intranasal doses and refills) distributed to participants during 2009 or July 2009–June 2010. Estimated by 21 program respondents (2,524 units, 6.5% of total) and based on program data for 27 respondents (36,336 units, 93.5%).

† Number of participants to whom naloxone was distributed from the start of program through June 2010. Estimated by 29 respondents (14,066 participants, 26.5% of total) and based on program data for 19 respondents (38,966 participants, 73.5%).

§ Number of opioid overdose reversals reported using the naloxone provided by the program from the start of the program through June 2010. Estimated by 26 respondents (2,582 reversals, 25.4% of total) and based on program data for 22 respondents (7,589 reversals, 74.6%).

FIGURE 1. Annual crude rates* of unintentional drug overdose deaths and number of overdose prevention programs distributing naloxone — United States, 1979–2010

* Per 100,000 population.

Alternate Text: The figure above shows the annual crude rates of unintentional drug overdose deaths per 100,000 population and the number of overdose prevention programs distributing naloxone in the United States during 1979–2010.

FIGURE 2. Number (N = 188) and location* of local drug overdose prevention programs providing naloxone in 2010 and age-adjusted rates† of drug overdose deaths§ in 2008 — United States

* Not shown in states with fewer than three local programs.

† Per 100,000 population.

§ **Source:** National Vital Statistics System. Available at <http://www.cdc.gov/nchs/nvss.htm>. Includes intentional, unintentional, and undetermined.

Alternate Text: The figure above shows the number (N = 188) and location of local overdose prevention programs providing naloxone in 2010 and age-adjusted rates of drug overdose deaths, by state, in the United States during 2008. In all, the 48 responding programs provided data for 188 local opioid overdose prevention programs that distributed naloxone. Nineteen (76.0%) of the 25 states with 2008 drug overdose death rates higher than the median and nine (69.2%) of the 13 states in the highest quartile did not have a community-based opioid overdose prevention program that distributed naloxone.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 831
Author: Bloom
Bill Date: March 18, 2013, Amended
Subject: Drug Overdoses
Sponsor: Drug Policy Alliance

STATUS OF BILL:

This bill is in the Assembly Health Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require the California Health and Human Services Agency (CHHS) to convene a temporary working group to develop a state plan to reduce the rate of fatal drug overdose in California. This bill would also appropriate \$500,000 from the General Fund to fund a grants program to local governments and community based organizations to implement overdose prevention efforts suited to local needs.

ANALYSIS

This would require CHHS to convene a temporary working group to develop a plan to reduce the rate of fatal drug overdoses in California. The bill would allow experts and staff from the Office of Emergency Services, State Department of Alcohol and Drug Programs, State Department of Public Health, Office of AIDS, and any other staff that the Secretary of CHHS designates may participate in the working group. This bill would also allow staff from the Medical Board of California (Board) and the Board of Pharmacy to participate for the purpose of identifying promising practices to reduce accidental drug overdose among patients and other at-risk groups. This bill would require the working group to make recommendations to the Chair of the Senate Committee on Health and the Chair of the Assembly Committee on Health on or before January 1, 2015. This bill would sunset the working group on January 1, 2016.

This bill would appropriate \$500,000 from the General Fund for fiscal year 2014/15 and in later years if included in CHHS' budget. This bill would require CHHS to make grants to local agencies from the \$500,000 appropriation for the following purposes:

- Drug overdose prevention, recognition, and response education projects in jails, prisons, drug treatment centers, syringe exchange programs, clinics, and other organizations that work with or have access to drug users, their families, and communities.
- Drug overdose prevention, recognition, and response training for patients and their families when the patient is prescribed opiate-based medications for which there is a

significant risk of overdose.

- Naloxone hydrochloride prescription or distribution projects.
- Development and implementation of policies and projects to encourage people, including drug users, to call the 911 emergency response system when they witness potentially fatal drug overdoses.
- Programs to educate Californians over 65 years of age about the risks associated with using opiate-based medications, ways to prevent overdose, or how to respond if they witness an overdose.
- The production and distribution of targeted or mass media materials on drug overdose prevention and response.
- Education and training projects on drug overdose response and treatment for emergency services and law enforcement personnel, including, but not limited to, volunteer fire and emergency services.
- Parent, family, and survivor education and mutual support groups, distributing, or administering the opioid antagonist during an overdose.

This bill would allow CHHS to set guidelines regarding the prioritization of applications and the types of organizations or entities that may apply in a given year. This bill would allow CHHS to adopt emergency regulations needed to implement this bill.

Drug overdoses are now the leading cause of injury death in the United States, surpassing motor vehicle crash deaths. According to the author's office, California should implement evidence-based interventions to reduce the rate of fatal drug overdoses. This bill would make a small investment in reducing the suffering of California families, and the Author's office believes this bill will significantly reduce hospitalization and emergency room costs.

This bill will help to protect consumers and save lives in California, which will further the Board's mission of consumer protection; staff is suggesting that the Board support this bill.

FISCAL: None

SUPPORT: Drug Policy Alliance (Sponsor)

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY MARCH 18, 2013

california legislature—2013–14 regular session

ASSEMBLY BILL

No. 831

Introduced by Assembly Member Bloom

February 21, 2013

~~An act to amend Section 1797.5 of the Health and Safety Code, relating to emergency medical services. An act to add Section 11758.08 to, and to add and repeal Section 11758.07 of, the Health and Safety Code, relating to drugs, and making an appropriation therefor.~~

legislative counsel's digest

AB 831, as amended, Bloom. ~~Emergency medical services. Drug overdoses.~~

Existing law establishes various programs for the control of illegal drugs in California and requires the State Department of Alcohol and Drug Programs to place on its Internet Web site specified information on drug overdose trends in California, including county and state death rates, from existing data, in order to ascertain changes in the causes or rates of fatal and nonfatal drug overdoses for the preceding 5 years.

This bill, until January 1, 2016, would establish within the California Health and Human Services Agency, a temporary working group, as specified, to develop a plan to reduce the rate of fatal drug overdoses in the state. The bill would require the temporary working group to make recommendations to the Chair of the Senate Committee on Health and the Chair of Assembly Committee on Health on or before January 1, 2015.

This bill would establish a grant program within the California Health and Human Services Agency to provide funds for programs related to drug overdose prevention, recognition, and response education, as

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specified. The bill would appropriate \$500,000 from the General Fund for this purpose in the 2014–15 fiscal year.

~~Existing law declares the intent of the Legislature to promote the development, accessibility, and provision of emergency medical services, and the policy of this state that people shall be encouraged and trained to assist others at the scene of a medical emergency.~~

~~This bill would make technical, nonsubstantive changes to these provisions.~~

Vote: ~~majority~~^{2/3}. Appropriation: ~~no~~ yes. Fiscal committee: ~~no~~ yes. State-mandated local program: no.

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

- 1 *SECTION 1. Section 11758.07 is added to the Health and*
- 2 *Safety Code, to read:*
- 3 *11758.07. (a) The California Health and Human Services*

4 Agency shall convene a temporary working group within the
5 agency to develop a plan to reduce the rate of fatal drug overdoses
6 in the state. Experts and staff from the Office of Emergency
7 Services, State Department of Alcohol and Drug Programs, State
8 Department of Public Health, Office of AIDS, and any other staff
9 that the Secretary of California Health and Human Services
10 designates may participate in the temporary working group.
11 Additionally, staff from the Medical Board of California and
12 California State Board of Pharmacy may also participate for the
13 purpose of identifying promising practices to reduce accidental
14 drug overdose among patients and other at-risk groups.

15 (b) The secretary may invite other experts to participate in the
16 temporary working group. Their participation shall be
17 uncompensated.

18 (c) The temporary working group shall make recommendations
19 to the Chair of the Senate Committee on Health and the Chair of
20 the Assembly Committee on Health on or before January 1, 2015.

21 (d) This section shall remain in effect only until January 1, 2016,
22 and as of that date is repealed, unless a later enacted statute, that
23 is enacted before January 1, 2016, deletes or extends that date.

24 SEC. 2. Section 11758.08 is added to the Health and Safety
25 Code, to read:

26 11758.08. (a) The California Health and Human Services
27 Agency shall make grants to local agencies from funds

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1 appropriated pursuant to this section for any of the following
2 purposes:

3 (1) Drug overdose prevention, recognition, and response
4 education projects in jails, prisons, drug treatment centers, syringe
5 exchange programs, clinics, and other organizations that work
6 with or have access to drug users, their families, and communities.

7 (2) Drug overdose prevention, recognition, and response
8 training for patients and their families when the patient is
9 prescribed opiate-based medications for which there is a significant
10 risk of overdose.

11 (3) Naloxone hydrochloride prescription or distribution projects.

12 (4) Development and implementation of policies and projects
13 to encourage people, including drug users, to call the 911
14 emergency response system when they witness potentially fatal
15 drug overdoses.

16 (5) Programs to educate Californians over 65 years of age about
17 the risks associated with using opiate-based medications, ways to
18 prevent overdose, or how to respond if they witness an overdose.

19 (6) The production and distribution of targeted or mass media
20 materials on drug overdose prevention and response.

21 (7) Education and training projects on drug overdose response

22 and treatment for emergency services and law enforcement
23 personnel, including, but not limited to, volunteer fire and
24 emergency services.

25 (8) Parent, family, and survivor education and mutual support
26 groups.

27 (b) In order to control budgets and appropriately limit the
28 number of possible applications, the agency may set guidelines
29 regarding the prioritization of applications and the types of
30 organizations or entities that may apply in a given year.

31 (c) The adoption and one readoption of regulations to implement
32 this section shall be deemed to be an emergency necessary for the
33 immediate preservation of public peace, health, and safety, or the
34 general welfare for purposes of Sections 11346.1 and 11349.6 of
35 the Government Code, and the agency is hereby exempted from
36 the requirement that it describe specific facts showing the need
37 for immediate action and from review by the Office of
38 Administrative Law.

39 (d) There is hereby appropriated from the General Fund, in the
40 2014–15 fiscal year, five hundred thousand dollars (\$500,000) for

1 the purpose of funding the grants provided in subdivision (a).
2 Additional funds necessary for the implementation of this section
3 in the 2014–15 fiscal year and in later fiscal years may be included
4 in the budget appropriation for the California Health and Human
5 Services Agency.

6 ~~SECTION 1. Section 1797.5 of the Health and Safety Code is~~
7 ~~amended to read:~~

8 ~~1797.5. (a) It is the intent of the Legislature to promote the~~
9 ~~development, accessibility, and provision of emergency medical~~
10 ~~services to the people of this state.~~

11 ~~(b) Further, it is the policy of this state that people shall be~~
12 ~~encouraged and trained to assist others at the scene of a medical~~
13 ~~emergency. Local governments, agencies, and other organizations~~
14 ~~shall be encouraged to offer training in cardiopulmonary~~
15 ~~resuscitation and lifesaving first aid techniques so that people may~~
16 ~~be adequately trained, prepared, and encouraged to assist others~~
17 ~~immediately.~~

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 916
Author: Eggman
Bill Date: February 22, 2013, Introduced
Subject: Healing Arts: False or Misleading Advertising
Sponsor: California Society of Plastic Surgeons

STATUS OF BILL:

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

DESCRIPTION OF CURRENT LEGISLATION:

This bill would prohibit physicians from using the terms “board”, “certified” or “certification” when advertising unless the terms are used in connection to a specific certifying board and that board has been approved by the American Board of Medical Specialties (ABMS), is a board or association with equivalent requirements approved by the Medical Board of California (Board), or is a board or association with an Accreditation Council for Graduate Medical Education (ACGME)-approved postgraduate training program that provides complete training in that specialty or subspecialty.

ANALYSIS

Existing law prohibits physicians from advertising in public communications that they are “board certified” unless the board advertised is a member of ABMS, or the board or association with equivalent requirements is approved by the Board, or a board or association with an Accreditation Council for Graduate Medical Education (ACGME)-approved postgraduate training program that provides complete training in that specialty or subspecialty.

According to the author’s office, there are some physicians misrepresenting themselves and their qualifications by providing misleading statements in public communications. Physicians can imply that they are “board certified”, by using the terms “board”, “certified”, or “certification” in their advertising. When these terms are used, it circumvents the prohibition in existing law, because they aren’t using the term “board certified”.

This bill would prohibit physicians from using the terms “board”, “certified” or “certification” when advertising unless the terms are used in connection to a specific certifying board and that board has been approved by the American Board of Medical Specialties (ABMS), is a board or association with equivalent requirements approved by the Medical Board of California (Board), or is a board or association with an Accreditation Council for Graduate Medical Education (ACGME)-approved postgraduate training program that provides

complete training in that specialty or subspecialty.

According to the author's office, some patients may choose a physician based on misleading terms, believing that the physician is "board certified" when that is not the case. This bill clarifies existing law to further protect the public and to ensure that patients better understand the training and qualifications of physicians from whom they are seeking care. This bill does not address the proposal included in the Board's sunset report that would remove the provision in existing law that requires the Board to recognize equivalent boards or associations.

This bill will allow patients to make informed decisions when choosing a health care provider and tighten existing law related to advertising, which will help to ensure consumer protection. Staff suggests that the Board support this bill.

FISCAL: None

SUPPORT: California Society of Plastic Surgeons (Sponsor)

OPPOSITION: None on file

POSITION: Recommendation: Support

ASSEMBLY BILL

No. 916

Introduced by Assembly Member Eggman

February 22, 2013

An act to amend Section 651 of the Business and Professions Code, relating to healing arts.

legislative counsel's digest

AB 916, as introduced, Eggman. Healing arts: false or misleading advertising.

Existing law provides for the licensure and regulation of the practice of various healing arts practitioners by boards within the Department of Consumer Affairs. Existing law makes it unlawful for those practitioners to disseminate a false, fraudulent, misleading, or deceptive statement and defines those terms for its purposes. Existing law prohibits a physician and surgeon from making a statement in public communications that he or she is board certified unless that board meets certain requirements.

This bill would further prohibit the use of additional terms by a physician or surgeon with respect to board of certification, except as provided. The bill would also make findings and declarations regarding the need for legislation pertaining to misleading advertisements and statements by physicians and surgeons.

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

AB 916

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

- 1 SECTION 1. The Legislature finds and declares all of the
- 2 following:
- 3 (a) Existing law prohibits a physician and surgeon from
- 4 advertising in public communications that he or she is board
- 5 certified unless that board is a member of the American Board of
- 6 Medical Specialties, a board or association with equivalent
- 7 requirements approved by the Medical Board of California, or a
- 8 board or association with an Accreditation Council for Graduate
- 9 Medical Education-approved postgraduate training program that
- 10 provides complete training in that specialty or subspecialty.
- 11 (b) The intent of these laws is to protect the public from being
- 12 misled or endangered as a result of false or misleading
- 13 advertisements by practitioners who claim board certification by
- 14 boards not meeting the above requirements, and to enhance the
- 15 quality of care and safety afforded to patients.
- 16 (c) Unfortunately, these laws have been widely circumvented

17 by the dissemination of public communications by physicians and
18 surgeons, or on their behalf by boards that do not meet the above
19 requirements, that do not include the exact phrase “board certified”
20 but contain similar terms that strongly imply board certification.

21 (d) Further clarification of existing law is needed to further
22 protect the public and to ensure that patients better understand the
23 training and qualifications possessed by physicians and surgeons
24 from whom they are seeking care.

25 SEC. 2. Section 651 of the Business and Professions Code is
26 amended to read:

27 651. (a) It is unlawful for any person licensed under this
28 division or under any initiative act referred to in this division to
29 disseminate or cause to be disseminated any form of public
30 communication containing a false, fraudulent, misleading, or
31 deceptive statement, claim, or image for the purpose of or likely
32 to induce, directly or indirectly, the rendering of professional
33 services or furnishing of products in connection with the
34 professional practice or business for which he or she is licensed.
35 A “public communication” as used in this section includes, but is
36 not limited to, communication by means of mail, television, radio,
37 motion picture, newspaper, book, list or directory of healing arts
38 practitioners, Internet, or other electronic communication.

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1 (b) A false, fraudulent, misleading, or deceptive statement,
2 claim, or image includes a statement or claim that does any of the
3 following:

4 (1) Contains a misrepresentation of fact.

5 (2) Is likely to mislead or deceive because of a failure to disclose
6 material facts.

7 (3) (A) Is intended or is likely to create false or unjustified
8 expectations of favorable results, including the use of any
9 photograph or other image that does not accurately depict the
10 results of the procedure being advertised or that has been altered
11 in any manner from the image of the actual subject depicted in the
12 photograph or image.

13 (B) Use of any photograph or other image of a model without
14 clearly stating in a prominent location in easily readable type the
15 fact that the photograph or image is of a model is a violation of
16 subdivision (a). For purposes of this paragraph, a model is anyone
17 other than an actual patient, who has undergone the procedure
18 being advertised, of the licensee who is advertising for his or her
19 services.

20 (C) Use of any photograph or other image of an actual patient
21 that depicts or purports to depict the results of any procedure, or

22 presents “before” and “after” views of a patient, without specifying
23 in a prominent location in easily readable type size what procedures
24 were performed on that patient is a violation of subdivision (a).
25 Any “before” and “after” views (i) shall be comparable in
26 presentation so that the results are not distorted by favorable poses,
27 lighting, or other features of presentation, and (ii) shall contain a
28 statement that the same “before” and “after” results may not occur
29 for all patients.

30 (4) Relates to fees, other than a standard consultation fee or a
31 range of fees for specific types of services, without fully and
32 specifically disclosing all variables and other material factors.

33 (5) Contains other representations or implications that in
34 reasonable probability will cause an ordinarily prudent person to
35 misunderstand or be deceived.

36 (6) Makes a claim either of professional superiority or of
37 performing services in a superior manner, unless that claim is
38 relevant to the service being performed and can be substantiated
39 with objective scientific evidence.

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1 (7) Makes a scientific claim that cannot be substantiated by
2 reliable, peer reviewed, published scientific studies.

3 (8) Includes any statement, endorsement, or testimonial that is
4 likely to mislead or deceive because of a failure to disclose material
5 facts.

6 (c) Any price advertisement shall be exact, without the use of
7 phrases, including, but not limited to, “as low as,” “and up,”
8 “lowest prices,” or words or phrases of similar import. Any
9 advertisement that refers to services, or costs for services, and that
10 uses words of comparison shall be based on verifiable data
11 substantiating the comparison. Any person so advertising shall be
12 prepared to provide information sufficient to establish the accuracy
13 of that comparison. Price advertising shall not be fraudulent,
14 deceitful, or misleading, including statements or advertisements
15 of bait, discount, premiums, gifts, or any statements of a similar
16 nature. In connection with price advertising, the price for each
17 product or service shall be clearly identifiable. The price advertised
18 for products shall include charges for any related professional
19 services, including dispensing and fitting services, unless the
20 advertisement specifically and clearly indicates otherwise.

21 (d) Any person so licensed shall not compensate or give anything
22 of value to a representative of the press, radio, television, or other
23 communication medium in anticipation of, or in return for,
24 professional publicity unless the fact of compensation is made
25 known in that publicity.

26 (e) Any person so licensed may not use any professional card,
27 professional announcement card, office sign, letterhead, telephone

28 directory listing, medical list, medical directory listing, or a similar
29 professional notice or device if it includes a statement or claim
30 that is false, fraudulent, misleading, or deceptive within the
31 meaning of subdivision (b).

32 (f) Any person so licensed who violates this section is guilty of
33 a misdemeanor. A bona fide mistake of fact shall be a defense to
34 this subdivision, but only to this subdivision.

35 (g) Any violation of this section by a person so licensed shall
36 constitute good cause for revocation or suspension of his or her
37 license or other disciplinary action.

38 (h) Advertising by any person so licensed may include the
39 following:

40 (1) A statement of the name of the practitioner.

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1 (2) A statement of addresses and telephone numbers of the
2 offices maintained by the practitioner.

3 (3) A statement of office hours regularly maintained by the
4 practitioner.

5 (4) A statement of languages, other than English, fluently spoken
6 by the practitioner or a person in the practitioner's office.

7 (5) (A) A statement that the practitioner is certified by a private
8 or public board or agency or a statement that the practitioner limits
9 his or her practice to specific fields.

10 (B) A statement of certification by a practitioner licensed under
11 Chapter 7 (commencing with Section 3000) shall only include a
12 statement that he or she is certified or eligible for certification by
13 a private or public board or parent association recognized by that
14 practitioner's licensing board.

15 (C) A physician and surgeon licensed under Chapter 5
16 (commencing with Section 2000) by the Medical Board of
17 California may include a statement that he or she limits his or her
18 practice to specific fields, but shall not include a statement that he
19 or she is certified or eligible for certification by a private or public
20 board or parent association, including, but not limited to, a
21 multidisciplinary board or association, unless that board or
22 association is (i) an American Board of Medical Specialties
23 member board, (ii) a board or association with equivalent
24 requirements approved by that physician and surgeon's licensing
25 board, or (iii) a board or association with an Accreditation Council
26 for Graduate Medical Education approved postgraduate training
27 program that provides complete training in that specialty or
28 subspecialty. A physician and surgeon licensed under Chapter 5
29 (commencing with Section 2000) by the Medical Board of
30 California who is certified by an organization other than a board
31 or association referred to in clause (i), (ii), or (iii) shall not use the
32 term "board certified" in reference to that certification, unless the

33 physician and surgeon is also licensed under Chapter 4
34 (commencing with Section 1600) and the use of the term “board
35 certified” in reference to that certification is in accordance with
36 subparagraph (A). A physician and surgeon licensed under Chapter
37 5 (commencing with Section 2000) by the Medical Board of
38 California who is certified by a board or association referred to in
39 clause (i), (ii), or (iii) shall not use *any of the term terms “board,”*
40 *“certified,” “certification,” or “board certified”* unless the full

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1 name of the certifying board is also used and given comparable
2 prominence with the ~~term terms “board,” “certified,”~~
3 ~~“certification,” or “board certified”~~ in the statement *and unless*
4 *the term or terms are used in reference to a certifying board*
5 *meeting at least one of the criteria described in clause (i), (ii), or*
6 *(iii).*

7 For purposes of this subparagraph, a “multidisciplinary board
8 or association” means an educational certifying body that has a
9 psychometrically valid testing process, as determined by the
10 Medical Board of California, for certifying medical doctors and
11 other health care professionals that is based on the applicant’s
12 education, training, and experience.

13 ~~For purposes of the term “board certified,” as used in this~~
14 ~~subparagraph, the terms “board” and “association” mean an~~
15 ~~organization that is an American Board of Medical Specialties~~
16 ~~member board, an organization with equivalent requirements~~
17 ~~approved by a physician and surgeon’s licensing board, or an~~
18 ~~organization with an Accreditation Council for Graduate Medical~~
19 ~~Education approved postgraduate training program that provides~~
20 ~~complete training in a specialty or subspecialty.~~

21 The Medical Board of California shall adopt regulations to
22 establish and collect a reasonable fee from each board or
23 association applying for recognition pursuant to this subparagraph.
24 The fee shall not exceed the cost of administering this
25 subparagraph. Notwithstanding Section 2 of Chapter 1660 of the
26 Statutes of 1990, this subparagraph shall become operative July
27 1, 1993. However, an administrative agency or accrediting
28 organization may take any action contemplated by this
29 subparagraph relating to the establishment or approval of specialist
30 requirements on and after January 1, 1991.

31 (D) A doctor of podiatric medicine licensed under Chapter 5
32 (commencing with Section 2000) by the Medical Board of
33 California may include a statement that he or she is certified or
34 eligible or qualified for certification by a private or public board
35 or parent association, including, but not limited to, a

36 multidisciplinary board or association, if that board or association
37 meets one of the following requirements: (i) is approved by the
38 Council on Podiatric Medical Education, (ii) is a board or
39 association with equivalent requirements approved by the
40 California Board of Podiatric Medicine, or (iii) is a board or

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1 association with the Council on Podiatric Medical Education
2 approved postgraduate training programs that provide training in
3 podiatric medicine and podiatric surgery. A doctor of podiatric
4 medicine licensed under Chapter 5 (commencing with Section
5 2000) by the Medical Board of California who is certified by a
6 board or association referred to in clause (i), (ii), or (iii) shall not
7 use the term “board certified” unless the full name of the certifying
8 board is also used and given comparable prominence with the term
9 “board certified” in the statement. A doctor of podiatric medicine
10 licensed under Chapter 5 (commencing with Section 2000) by the
11 Medical Board of California who is certified by an organization
12 other than a board or association referred to in clause (i), (ii), or
13 (iii) shall not use the term “board certified” in reference to that
14 certification.

15 For purposes of this subparagraph, a “multidisciplinary board
16 or association” means an educational certifying body that has a
17 psychometrically valid testing process, as determined by the
18 California Board of Podiatric Medicine, for certifying doctors of
19 podiatric medicine that is based on the applicant’s education,
20 training, and experience. For purposes of the term “board certified,”
21 as used in this subparagraph, the terms “board” and “association”
22 mean an organization that is a Council on Podiatric Medical
23 Education approved board, an organization with equivalent
24 requirements approved by the California Board of Podiatric
25 Medicine, or an organization with a Council on Podiatric Medical
26 Education approved postgraduate training program that provides
27 training in podiatric medicine and podiatric surgery.

28 The California Board of Podiatric Medicine shall adopt
29 regulations to establish and collect a reasonable fee from each
30 board or association applying for recognition pursuant to this
31 subparagraph, to be deposited in the State Treasury in the Podiatry
32 Fund, pursuant to Section 2499. The fee shall not exceed the cost
33 of administering this subparagraph.

34 (6) A statement that the practitioner provides services under a
35 specified private or public insurance plan or health care plan.

36 (7) A statement of names of schools and postgraduate clinical

37 training programs from which the practitioner has graduated,
38 together with the degrees received.
39 (8) A statement of publications authored by the practitioner.

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1 (9) A statement of teaching positions currently or formerly held
2 by the practitioner, together with pertinent dates.

3 (10) A statement of his or her affiliations with hospitals or
4 clinics.

5 (11) A statement of the charges or fees for services or
6 commodities offered by the practitioner.

7 (12) A statement that the practitioner regularly accepts
8 installment payments of fees.

9 (13) Otherwise lawful images of a practitioner, his or her
10 physical facilities, or of a commodity to be advertised.

11 (14) A statement of the manufacturer, designer, style, make,
12 trade name, brand name, color, size, or type of commodities
13 advertised.

14 (15) An advertisement of a registered dispensing optician may
15 include statements in addition to those specified in paragraphs (1)
16 to (14), inclusive, provided that any statement shall not violate
17 subdivision (a), (b), (c), or (e) or any other section of this code.

18 (16) A statement, or statements, providing public health
19 information encouraging preventative or corrective care.

20 (17) Any other item of factual information that is not false,
21 fraudulent, misleading, or likely to deceive.

22 (i) Each of the healing arts boards and examining committees
23 within Division 2 shall adopt appropriate regulations to enforce
24 this section in accordance with Chapter 3.5 (commencing with
25 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
26 Code.

27 Each of the healing arts boards and committees and examining
28 committees within Division 2 shall, by regulation, define those
29 efficacious services to be advertised by businesses or professions
30 under their jurisdiction for the purpose of determining whether
31 advertisements are false or misleading. Until a definition for that
32 service has been issued, no advertisement for that service shall be
33 disseminated. However, if a definition of a service has not been
34 issued by a board or committee within 120 days of receipt of a
35 request from a licensee, all those holding the license may advertise
36 the service. Those boards and committees shall adopt or modify
37 regulations defining what services may be advertised, the manner
38 in which defined services may be advertised, and restricting
39 advertising that would promote the inappropriate or excessive use
40 of health services or commodities. A board or committee shall not,

1 by regulation, unreasonably prevent truthful, nondeceptive price
2 or otherwise lawful forms of advertising of services or
3 commodities, by either outright prohibition or imposition of
4 onerous disclosure requirements. However, any member of a board
5 or committee acting in good faith in the adoption or enforcement
6 of any regulation shall be deemed to be acting as an agent of the
7 state.

8 (j) The Attorney General shall commence legal proceedings in
9 the appropriate forum to enjoin advertisements disseminated or
10 about to be disseminated in violation of this section and seek other
11 appropriate relief to enforce this section. Notwithstanding any
12 other provision of law, the costs of enforcing this section to the
13 respective licensing boards or committees may be awarded against
14 any licensee found to be in violation of any provision of this
15 section. This shall not diminish the power of district attorneys,
16 county counsels, or city attorneys pursuant to existing law to seek
17 appropriate relief.

18 (k) A physician and surgeon or doctor of podiatric medicine
19 licensed pursuant to Chapter 5 (commencing with Section 2000)
20 by the Medical Board of California who knowingly and
21 intentionally violates this section may be cited and assessed an
22 administrative fine not to exceed ten thousand dollars (\$10,000)
23 per event. Section 125.9 shall govern the issuance of this citation
24 and fine except that the fine limitations prescribed in paragraph
25 (3) of subdivision (b) of Section 125.9 shall not apply to a fine
26 under this subdivision.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1000
Author: Wieckowski
Bill Date: June 18, 2012, amended
Subject: Physical Therapists: Direct Access to Services:
Sponsor: California Physical Therapy Association

STATUS OF BILL:

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

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow a physical therapist (PT) to make a physical therapy diagnosis. This bill would allow a patient to directly access PT services, without being referred by a physician, provided that the treatment is within the scope of a PT as long as specified conditions are met.

ANALYSIS:

This bill would allow a PT to make a “physical therapy diagnosis”, which is defined as a systemic examination process that culminates in assigning a diagnostic label identifying the primary dysfunction toward which physical therapy treatment will be directed, but shall not include a medical diagnosis or a diagnosis of a disease.

This bill would also allow a patient to directly access PT services, without being referred by a physician, provided that the treatment is within the scope of a PT and the following conditions are met:

- If the PT has reason to believe the patient has signs or symptoms of a condition that requires treatment beyond the scope of practice of a PT, the PT shall refer the patient to a physician, an osteopathic physician, or to a dentist, podiatrist or chiropractor.
- The PT shall disclose to the patient any financial interest in treating the patient.
- The PT shall notify the patient’s physician, with the patient’s written authorization, that the PT is treating the patient.

This bill would specify that it does not expand or modify the scope of practice of a PT, including the prohibition on a PT to diagnose a disease. This bill would also specify that it does not require a health care service plan or insurer to provide coverage for direct access to treatment by a PT.

This bill changes the scope of practice of a PT by allowing a PT to make a “physical therapy diagnosis” and allowing a PT to treat patients without a referral from a physician. The Board has taken opposite positions in the past on bills that allowed for direct patient access to PT services. The Board was opposed to these bills because they expanded the scope of practice for PT’s by allowing them to see patients directly, without having the patients first seen by a physician, which puts patients at risk. A patient’s condition cannot be accurately determined without first being examined by a physician, as PTs are not trained to make these comprehensive assessments and diagnoses. Because this bill will compromise patient care and consumer protection, staff is suggesting that the Board oppose this bill.

FISCAL: None

SUPPORT: California Physical Therapy Association (Sponsor)

OPPOSITION: None on file

POSITION: Recommendation: Oppose

AMENDED IN ASSEMBLY MARCH 21, 2013

california legislature—2013–14 regular session

ASSEMBLY BILL

No. 1000

Introduced by Assembly Member Wieckowski

February 22, 2013

An act to amend ~~Section 2630~~ of Sections 2620 and 2660 of, and to add Section 2620.1 to, the Business and Professions Code, relating to physical therapy.

legislative counsel's digest

AB 1000, as amended, Wieckowski. ~~Physical therapy.~~ *Physical therapists: direct access to services.*

Existing law, the Physical Therapy Practice Act, creates the Physical Therapy Board of California and makes it responsible for the licensure and regulation of physical therapists. The act defines the term “physical therapy” for its purposes as, among other things, including physical therapy evaluation, treatment planning, instruction, and consultative services. The act makes it a crime to violate any of its provisions. The act authorizes the board to suspend, revoke, or impose probationary conditions on a license, certificate, or approval issued under the act for unprofessional conduct, as specified.

This bill would revise the definition of “physical therapy” to instead include examination and evaluation to determine a physical therapy diagnosis, as defined, prognosis, treatment plan, instruction, or consultative service.

This bill would specify that patients may access physical therapy treatment directly and would, in those circumstances, require a physical therapist to refer his or her patient to another specified healing arts practitioner if the physical therapist has reason to believe the patient

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has a condition requiring treatment or services beyond that scope of practice, to disclose to the patient any financial interest he or she has in treating the patient, and, with the patient’s written authorization, to notify the patient’s physician and surgeon, if any, that the physical therapist is treating the patient. The bill would provide that failure to comply with these provisions constitutes unprofessional conduct subject to disciplinary action by the board.

Because the bill would specify additional requirements under the Physical Therapy Practice Act, the violation of which would be a crime, it would impose a state-mandated local program.

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

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

~~Existing law, until January 1, 2014, establishes the Physical Therapy Board of California, which oversees the licensing and regulation of physical therapists. Existing law prohibits any person or persons from practicing or offering to practice physical therapy in this state for compensation, or to hold himself or herself out as a physical therapist, unless he or she holds a valid license, as specified.~~

~~This bill would make a technical, nonsubstantive change to these provisions.~~

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

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

1 *SECTION 1. The Legislature finds and declares that an*
2 *individual's access to early intervention to physical therapy*
3 *treatment may decrease the duration of a disability, reduce pain,*
4 *and lead to a quicker recovery.*

5 *SEC. 2. Section 2620 of the Business and Professions Code is*
6 *amended to read:*

7 2620. (a) Physical therapy means the art and science of
8 physical or corrective rehabilitation or of physical or corrective
9 treatment of any bodily or mental condition of any person by the
10 use of the physical, chemical, and other properties of heat, light,
11 water, electricity, sound, massage, and active, passive, and resistive

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1 exercise, and shall include *examination and evaluation to determine*
2 *a physical therapy—evaluation, diagnosis, prognosis, treatment*
3 ~~*planning, instruction and plan, instruction, or consultative services.*~~
4 *service.* The practice of physical therapy includes the promotion
5 and maintenance of physical fitness to enhance the bodily
6 movement related health and wellness of individuals through the
7 use of physical therapy interventions. The use of roentgen rays
8 and radioactive materials, for diagnostic and therapeutic purposes,
9 and the use of electricity for surgical purposes, including
10 cauterization, are not authorized under the term “physical therapy”
11 as used in this chapter, and a license issued pursuant to this chapter
12 does not authorize the diagnosis of disease.

13 *(b) For the purposes of this section, “physical therapy*
14 *diagnosis” means a systematic examination process that culminates*
15 *in assigning a diagnostic label identifying the primary dysfunction*
16 *toward which physical therapy treatment will be directed, but shall*
17 *not include a medical diagnosis or a diagnosis of disease.*

18 ~~(b)~~

19 (c) Nothing in this section shall be construed to restrict or
20 prohibit other healing arts practitioners licensed or registered under
21 this division from practice within the scope of their license or
22 registration.

23 *SEC. 3. Section 2620.1 is added to the Business and Professions*
24 *Code, to read:*

25 2620.1. (a) *In addition to receiving wellness and evaluation*
26 *services from a physical therapist, a person may initiate physical*
27 *therapy treatment directly from a licensed physical therapist if the*
28 *treatment is within the scope of practice of physical therapists, as*
29 *defined in Section 2620, and all of the following conditions are*
30 *met:*

31 (1) *If, at any time, the physical therapist has reason to believe*
32 *that the patient has signs or symptoms of a condition that requires*
33 *treatment beyond the scope of practice of a physical therapist, the*
34 *physical therapist shall refer the patient to a person holding a*
35 *physician and surgeon's certificate issued by the Medical Board*
36 *of California or by the Osteopathic Medical Board of California*
37 *or to a person licensed to practice dentistry, podiatric medicine,*
38 *or chiropractic.*

39 (2) *The physical therapist shall disclose to the patient any*
40 *financial interest he or she has in treating the patient.*

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1 (3) *With the patient's written authorization, the physical*
2 *therapist shall notify the patient's physician and surgeon, if any,*
3 *that the physical therapist is treating the patient.*

4 (b) *The conditions in paragraphs (1), (2), and (3) of subdivision*
5 *(a) do not apply to a physical therapist when providing evaluation*
6 *or wellness physical therapy services to a patient as described in*
7 *subdivision (a) of Section 2620.*

8 (c) *This section does not expand or modify the scope of practice*
9 *for physical therapists set forth in Section 2620, including the*
10 *prohibition on a physical therapist diagnosing a disease.*

11 (d) *This section does not require a health care service plan or*
12 *insurer to provide coverage for direct access to treatment by a*
13 *physical therapist.*

14 *SEC. 4. Section 2660 of the Business and Professions Code is*
15 *amended to read:*

16 2660. The board may, after the conduct of appropriate
17 proceedings under the Administrative Procedure Act, suspend for
18 not more than 12 months, or revoke, or impose probationary
19 conditions upon any license, certificate, or approval issued under
20 this chapter for unprofessional conduct that includes, but is not
21 limited to, one or any combination of the following causes:

22 (a) Advertising in violation of Section 17500.

- 23 (b) Fraud in the procurement of any license under this chapter.
24 (c) Procuring or aiding or offering to procure or aid in criminal
25 abortion.
26 (d) Conviction of a crime that substantially relates to the
27 qualifications, functions, or duties of a physical therapist or
28 physical therapist assistant. The record of conviction or a certified
29 copy thereof shall be conclusive evidence of that conviction.
30 (e) Habitual intemperance.
31 (f) Addiction to the excessive use of any habit-forming drug.
32 (g) Gross negligence in his or her practice as a physical therapist
33 or physical therapist assistant.
34 (h) Conviction of a violation of any of the provisions of this
35 chapter or of the Medical Practice Act, or violating, or attempting
36 to violate, directly or indirectly, or assisting in or abetting the
37 violating of, or conspiring to violate any provision or term of this
38 chapter or of the Medical Practice Act.
39 (i) The aiding or abetting of any person to violate this chapter
40 or any regulations duly adopted under this chapter.

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- 1 (j) The aiding or abetting of any person to engage in the unlawful
2 practice of physical therapy.
3 (k) The commission of any fraudulent, dishonest, or corrupt act
4 that is substantially related to the qualifications, functions, or duties
5 of a physical therapist or physical therapist assistant.
6 (l) Except for good cause, the knowing failure to protect patients
7 by failing to follow infection control guidelines of the board,
8 thereby risking transmission of blood-borne infectious diseases
9 from licensee to patient, from patient to patient, and from patient
10 to licensee. In administering this subdivision, the board shall
11 consider referencing the standards, regulations, and guidelines of
12 the State Department of Public Health developed pursuant to
13 Section 1250.11 of the Health and Safety Code and the standards,
14 regulations, and guidelines pursuant to the California Occupational
15 Safety and Health Act of 1973 (Part 1 (commencing with Section
16 6300) of Division 5 of the Labor Code) for preventing the
17 transmission of HIV, hepatitis B, and other blood-borne pathogens
18 in health care settings. As necessary, the board shall consult with
19 the Medical Board of California, the California Board of Podiatric
20 Medicine, the Dental Board of California, the Board of Registered
21 Nursing, and the Board of Vocational Nursing and Psychiatric
22 Technicians of the State of California, to encourage appropriate
23 consistency in the implementation of this subdivision.
24 The board shall seek to ensure that licensees are informed of the
25 responsibility of licensees and others to follow infection control
26 guidelines, and of the most recent scientifically recognized

27 safeguards for minimizing the risk of transmission of blood-borne
28 infectious diseases.

29 (m) The commission of verbal abuse or sexual harassment.

30 (n) *Failure to comply with the provisions of Section 2620.1.*

31 *SEC. 5. No reimbursement is required by this act pursuant to*
32 *Section 6 of Article XIII B of the California Constitution because*
33 *the only costs that may be incurred by a local agency or school*
34 *district will be incurred because this act creates a new crime or*
35 *infraction, eliminates a crime or infraction, or changes the penalty*
36 *for a crime or infraction, within the meaning of Section 17556 of*
37 *the Government Code, or changes the definition of a crime within*
38 *the meaning of Section 6 of Article XIII B of the California*
39 *Constitution.*

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1 ~~SECTION 1. Section 2630 of the Business and Professions Code~~
2 ~~is amended to read:~~

3 ~~2630. It is unlawful for any person or persons to practice, or~~
4 ~~offer to practice, physical therapy in this state for compensation~~
5 ~~received or expected, or to hold himself or herself out as a physical~~
6 ~~therapist, unless at the time of so doing he or she holds a valid,~~
7 ~~unexpired, and unrevoked license issued under this chapter.~~

8 ~~Nothing in this section shall restrict the activities authorized by~~
9 ~~their licenses on the part of any persons licensed under this code~~
10 ~~or any initiative act, or the activities authorized to be performed~~
11 ~~pursuant to Article 4.5 (commencing with Section 2655) or Chapter~~
12 ~~7.7 (commencing with Section 3500).~~

13 ~~A physical therapist licensed pursuant to this chapter may utilize~~
14 ~~the services of one aide engaged in patient-related tasks to assist~~
15 ~~the physical therapist in his or her practice of physical therapy.~~
16 ~~“Patient-related task” means a physical therapy service rendered~~
17 ~~directly to the patient by an aide, excluding non-patient-related~~
18 ~~tasks. “Non-patient related task” means a task related to~~
19 ~~observation of the patient, transport of the patient, physical support~~
20 ~~only during gait or transfer training, housekeeping duties, clerical~~
21 ~~duties, and similar functions. The aide shall at all times be under~~
22 ~~the orders, direction, and immediate supervision of the physical~~
23 ~~therapist. Nothing in this section shall authorize an aide to~~
24 ~~independently perform physical therapy or any physical therapy~~
25 ~~procedure. The board shall adopt regulations that set forth the~~
26 ~~standards and requirements for the orders, direction, and immediate~~
27 ~~supervision of an aide by a physical therapist. The physical~~
28 ~~therapist shall provide continuous and immediate supervision of~~
29 ~~the aide. The physical therapist shall be in the same facility as, and~~
30 ~~in proximity to, the location where the aide is performing~~

31 ~~patient-related tasks, and shall be readily available at all times to~~
32 ~~provide advice or instruction to the aide. When patient-related~~
33 ~~tasks are provided to a patient by an aide, the supervising physical~~
34 ~~therapist shall, at some point during the treatment day, provide~~
35 ~~direct service to the patient as treatment for the patient's condition,~~
36 ~~or to further evaluate and monitor the patient's progress, and shall~~
37 ~~correspondingly document the patient's record.~~

38 ~~The administration of massage, external baths, or normal exercise~~
39 ~~not a part of a physical therapy treatment shall not be prohibited~~
40 ~~by this section.~~

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1278
Author: Hueso
Bill Date: As proposed to be amended
Subject: Integrative Cancer Treatment
Sponsor: California Citizens for Health Freedom

STATUS OF BILL:

This bill is in the Assembly Health Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow a physician to prescribe integrative cancer treatment, under specified circumstances.

ANALYSIS

Current law restricts cancer therapy exclusively to conventional drugs, surgery, and radiation (those approved by the Food and Drug Administration). This bill would allow a physician to prescribe integrative cancer treatment, under specified circumstances.

This bill defines integrative cancer treatment as the use of a combination of evidence-based substances or therapies for the purpose of reducing the size of cancer, slowing the progression of cancer, or improving the quality of life of a patient with cancer. This bill would specify that a treatment meets the evidence-based medical standard if the methods of treatment are recognized by the Physician's Data Query of the National Cancer Institute; or if the methods of treatment have been reported in at least three peer reviewed articles published in complementary and alternative medicine journals to reduce the size of cancer, slow the progression of cancer, or improve the quality of life of a patient with cancer; or if the methods have been published in at least three peer-reviewed scientific medical journals.

This bill would prohibit a physician from recommending or prescribing integrative cancer treatment, unless specified informed consent is given; the treatment meets the evidence-based medical standard; the physician complies with the patient reevaluation requirements; and the physician complies with the standards of care for integrative cancer treatment.

In order to comply with the informed consent requirements, the physician must have the patient sign a form that either includes the contact information for the physician who is providing the patient conventional care, or that the patient has declined to be under the care of an oncologist or other physician providing conventional cancer care. The form must also include a statement that says the type of care the patient is receiving or that is being recommended is not the standard of care for treating cancer in California; that the standard of care for treating cancer in California consists of radiation, chemotherapy, and surgery; that the

treatment the physician will be prescribing or recommending is not approved by the federal Food and Drug Administration for the treatment of cancer; that the care that the patient will be receiving or is being recommended is not mutually exclusive of the patient receiving conventional cancer treatment. The form must also include the following written statements:

THE STATE DEPARTMENT OF PUBLIC HEALTH AND THE PHYSICIAN PRESCRIBING YOUR INTEGRATIVE CANCER CARE RECOGNIZE THE IMPORTANCE OF USING CONVENTIONAL CANCER TREATMENTS, INCLUDING RADIATION, CHEMOTHERAPY, AND SURGERY. IT IS HIGHLY RECOMMENDED THAT YOU SEE AN ONCOLOGIST OR ANOTHER PHYSICIAN TO PROVIDE YOU WITH CONVENTIONAL CANCER CARE.

ANY AND ALL MEDICAL TREATMENTS INVOLVE SOME DEGREE OF RISK OF INJURY UP TO AND INCLUDING DEATH.

This bill would require a physician prescribing integrative cancer treatment to comply with patient reevaluation requirements, as follows:

- The patient must be informed of the measurable results achieved within an established timeframe and at regular and appropriate intervals during the treatment plan.
- The physician must reevaluate the treatment when progress stalls or reverses in the opinion of the physician or the patient, or as evidenced by objective evaluations.
- The patient must be informed about and agree to any proposed changes in treatment, including but not limited to, the risks and benefits of the proposed changes, the costs associated, and the timeframe in which the proposed changes will be reevaluated.

This bill would also set forth the standards of care in prescribing integrative cancer treatment that the physician must comply with, as follows:

- The physician must provide the patient information regarding the treatment prescribed, including its usefulness in treating cancer; a timeframe and plan for reevaluation the treatment using standard and conventional means in order to assess treatment efficacy; and a cost estimate for the prescribed treatment.
- The physician must make a good faith effort to obtain all relevant charts, records and laboratory results relating to the patient's conventional cancer care, prior to prescribing or changing treatment.
- At the request of the patient, the physician must make a good faith effort to coordinate the patient's care with the physician providing conventional cancer care to the patient.
- At the request of the patient, the physician must provide a synopsis of any treatment rendered to the physician providing conventional cancer care to the patient, including subjective and objective assessment of the patient's state of health and response to the treatment.

This bill would specify that failure to comply with this bill's provisions would constitute unprofessional conduct and cause for discipline by that individual's licensing entity.

According to the author, integrative cancer treatment gives consumers options for care and helps patients cope with the common side effects of chemotherapy and radiation. Integrative treatment incorporates uses of unconventional medicines that have proven results. The author believes this bill will provide cancer patients with more options to complement conventional therapy. This bill requires integrative cancer treatment to meet an evidence-based medical standard, and includes language that encourages communication with a patient's oncologist, as well as treatment with conventional therapies.

FISCAL: None

SUPPORT: California Citizens for Health Freedom (sponsor)
Cancer Victors
Cancer Control Society
Bobbiey's Foundation
Several Individuals

OPPOSITION: Association of Northern California Oncologists
Medical Oncology Association of Southern California, Inc.

POSITION: Recommendation: Neutral

Amendments Mock-up for 2013-2014 AB-1278 (Hueso (A))

*******Amendments are in BOLD*******

Mock-up based on Version Number 99 - Introduced 2/22/13

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 2234.1 of the Business and Professions Code is amended to read:

2234.1. (a) A physician and surgeon shall not be subject to discipline pursuant to subdivision (b), (c), or (d) of Section 2234 solely on the basis that the treatment or advice he or she rendered to a patient is alternative or complementary medicine, including the treatment of persistent Lyme Disease, if that treatment or advice meets ~~at~~ *one* of the following requirements, *as applicable*:

(1) The treatment or advice is for a condition other than cancer and meets all of the following requirements:

~~(1)~~

(A) It is provided after informed consent and a good-faith prior examination of the patient, and medical indication exists for the treatment or advice, or it is provided for health or well-being.

~~(2)~~

(B) It is provided after the physician and surgeon has given the patient information concerning conventional treatment and describing the education, experience, and credentials of the physician and surgeon related to the alternative or complementary medicine that he or she practices.

~~(3)~~

(C) In the case of alternative or complementary medicine, it does not cause a delay in, or discourage traditional diagnosis of, a condition of the patient.

~~(4)~~

(D) It does not cause death or serious bodily injury to the patient.

(2) The treatment or advice is for cancer and is given in compliance with Article 2.5 (commencing with Section 109400) of Chapter 4 of Part 4 of Division 104 of the Health and Safety Code.

(b) For purposes of this section, “alternative or complementary medicine,” means those health care methods of diagnosis, treatment, or healing that are not generally used but that provide a reasonable potential for therapeutic gain in a patient’s medical condition that is not outweighed by the risk of the health care method.

(c) Since the National Institute of Medicine has reported that it can take up to 17 years for a new best practice to reach the average physician and surgeon, it is prudent to give attention to new developments not only in general medical care but in the actual treatment of specific diseases, particularly those that are not yet broadly recognized in California.

SEC. 2. Section 2257 of the Business and Professions Code is repealed.

~~2257.~~

~~The violation of Section 109275 of the Health and Safety Code, relating to informed consent for the treatment of breast cancer, constitutes unprofessional conduct.~~

SEC. 3. Section 109270 of the Health and Safety Code is amended to read:

109270. The department shall:

(a) Prescribe reasonable regulations with respect to the administration of this article and Article 2 (commencing with Section 109300).

(b) Investigate violations of this article ~~and~~, Article 2 (commencing with Section 109300), *and Article 2.5 (commencing with Section 109400)*, and report the violations to the appropriate enforcement authority.

(c) Secure the investigation and testing of the content, method of preparation, efficacy, or use of drugs, medicines, compounds, or devices proposed to be used, or used, by any individual, person, firm, association, or other entity in the state for the diagnosis, treatment, or cure of cancer, prescribe reasonable regulations with respect to the investigation and testing, and make findings of fact and recommendations upon completion of any such investigation and testing.

(d) Adopt a regulation prohibiting the prescription, administration, sale or other distribution of any drug, substance, or device found to be harmful or of no value in the diagnosis, prevention, or treatment of cancer, *except as authorized under Article 2.5 (commencing with Section 109400)*.

(e) Hold hearings ~~in~~ *with respect to* those matters involving compliance with this article ~~and~~, Article 2 (commencing with Section 109300), *and Article 2.5 (commencing with Section 109400)*, and subpoena witnesses and documents. Any or all hearings may be held before the Cancer Advisory Council. Any administrative action to be taken by the department as a result of

the hearings shall be taken only after receipt of the recommendations of the council. Prior to issuance of a cease and desist order under Section 109345, a hearing shall be held. The person furnishing a sample *or manufacturer contact information* under Section 109295 shall be given due notice of the hearing and an opportunity to be heard.

(f) Contract with independent scientific consultants for specialized services and advice.

In the exercise of the powers granted by this section, the department shall consult with the Cancer Advisory Council.

SEC. 4. Section 109285 of the Health and Safety Code is amended to read:

109285. For the purposes of this article ~~and~~, Article 2 (commencing with Section 109300), *and Article 2.5 (commencing with Section 109400)*, “cancer” means all malignant neoplasms regardless of the tissue of origin, including malignant lymphoma, Hodgkins disease, and leukemia.

SEC. 5. Section 109295 of the Health and Safety Code is amended to read:

109295. (a) On written request by the department, delivered personally or by mail, any individual, person, firm, association, or other entity engaged, or representing himself, *herself*, or itself, as engaged, in the diagnosis, treatment, alleviation, or cure of cancer shall ~~furnish~~ *do all of the following:*

(1) *Furnish* the department with the sample as the department may deem necessary for adequate testing of any drug, medicine, compound, or device used or prescribed by the individual, person, firm, association, or other entity in the diagnosis, treatment, alleviation, or cure of ~~cancer, and shall specify cancer.~~ *The individual, person, firm, association, or other entity may alternatively furnish the department with the contact information of the manufacturer of the drug, medicine, compound, or device.*

(2) *Specify* the formula of any drug or compound and name all ingredients by their common or usual ~~names, and shall, upon like names.~~

(3) *Upon request by* of the department, furnish further necessary information as ~~is~~ *the department* may request as to the composition and method of preparation of and the use that any drug, compound, or device is being put by the individual, person, firm, association, or other entity. ~~This~~

(b) *This* section shall apply to any individual, person, firm, association, or other entity that renders health care or services to individuals who have or believe they have cancer. This section also applies to any individual, person, firm, association, or other entity that by implication causes individuals to believe they have cancer.

~~The~~

(c) Upon the failure to either provide the sample or the manufacturer's contact information, disclose the formula, or name the ingredients as required by this section, it shall be conclusively presumed that the drug, medicine, compound or device that is the subject of the department's request has no value in the diagnosis, treatment, alleviation, or cure of cancer.

SEC. 6. Section 109300 of the Health and Safety Code is amended to read:

109300. The sale, offering for sale, holding for sale, delivering, giving away, prescribing, or administering of any drug, medicine, compound, or device to be used in the diagnosis, treatment, alleviation, or cure of cancer is unlawful and prohibited unless ~~(1) an~~ *one of the following applies:*

(a) An application with respect thereto has been approved under Section 505 of the federal Food, Drug, and Cosmetic Act, or (2) there.

(b) The use is consistent with Article 2.5 (commencing with Section 109400).

(c) There has been approved an application filed with the board setting forth all of the following:

~~(a)~~

(1) Full reports of investigations that have been made to show whether or not the drug, medicine, compound, or device is safe for the use, and whether the drug, medicine, compound, or device is effective in the use;

~~(b)~~

(2) A full list of the articles used as components of the drug, medicine, compound, or device;

~~(c)~~

(3) A full statement of the composition of the drug, medicine, compound, or device;

~~(d)~~

(4) A full description of the methods used in, and the facilities and controls used for, the manufacture, processing, and packing of the drug, medicine, or compound or in the case of a device, a full statement of its composition, properties, and construction and the principle or principles of its operation;

~~(e)~~

(5) Such samples of the drug, medicine, compound, or device and of the articles used as components of the drug, medicine, compound, or device as the board may require; and

~~(f)~~

(6) Specimens of the labeling and advertising proposed to be used for the drug, medicine, compound, or device.

SEC. 7. Section 109350 of the Health and Safety Code is amended to read:

109350. The department may direct that ~~any~~ *an* individual, person, firm, association, or other entity shall cease and desist any further prescribing, recommending, or use of any drug, medicine, compound, or device for which no application has been approved under this article and Article 1 (commencing with Section 109250) unless its use is exempt under Section 109325 or 109330 *or authorized under Article 2.5 (commencing with Section 109400).*

SEC. 8. Section 109375 of the Health and Safety Code is amended to read:

109375. The director shall investigate possible violations of this article ~~and~~, Article 1 (commencing with Section 109250), *and Article 2.5 (commencing with Section 109400)*, and report violations to the appropriate enforcement authority.

SEC. 9. Article 2.5 (commencing with Section 109400) is added to Chapter 4 of Part 4 of Division 104 of the Health and Safety Code, to read:

Article 2.5. Integrative Cancer Treatment

109400. For purposes of this article:

(a) “Integrative cancer treatment” means the use of *a combination of* evidence-based substances or therapies ~~that are not the standard of care for cancer treatment~~, for the purpose of reducing the size of a cancer, slowing the progression of a cancer, or improving the quality of life of a patient with cancer, by a physician and surgeon practicing within his or her scope of practice.

(b) “Physician and surgeon” means a physician and surgeon licensed pursuant to Section 2050 of the Business and Professions Code or an osteopathic physician and surgeon licensed pursuant to the Osteopathic Act.

~~(c) An individual “prescribes” a treatment when he or she orders the treatment or a course of treatment.~~

~~(d) An individual “provides” a treatment when he or she actually renders, administers, furnishes, or dispenses the treatment to the patient.~~

109401. (a) Notwithstanding any other provision of law, a physician and surgeon shall not recommend or prescribe integrative cancer treatment for cancer patients unless the following requirements are met, as applicable:

(1) The treatment is recommended or prescribed after informed consent is given, as provided in Section 109402.

(2) The treatment recommended or prescribed meets the evidence-based medical standard provided in Section 109403.

(3) The physician and surgeon prescribing the treatment complies with the patient reevaluation requirements set forth in Section 109404 after the treatment begins.

(4) The physician and surgeon prescribing the treatment complies with all of the standards of care set forth in Section 109405.

(b) A physician and surgeon shall not provide integrative cancer treatment for cancer patients unless the treatment is prescribed by a physician and surgeon in compliance with subdivision (a).

109402. (a) For purposes of paragraph (1) of subdivision (a) of Section 109401, informed consent has been given if the patient signs a form stating either of the following:

(1) The name and telephone number of the physician and surgeon from whom the patient is receiving conventional cancer care and whether the patient has been informed of the type of cancer from which the patient suffers and his or her prognosis using conventional treatment options.

(2) That the patient has declined to be under the care of an oncologist or other physician and surgeon providing conventional cancer care.

(b) The form described in subdivision (a) shall include all of the following information:

(1) The type of care the patient will be receiving or that is being recommended is not the standard of care for treating cancer in California.

(2) The standard of care for treating cancer in California consists of radiation, chemotherapy, and surgery.

(3) The treatment that the physician and surgeon will be prescribing or recommending is not approved by the federal Food and Drug Administration for the treatment of cancer.

(4) The care that the patient will be receiving or that is being recommended is not mutually exclusive of the patient receiving conventional cancer treatment.

(5) The following written statements:

THE STATE DEPARTMENT OF PUBLIC HEALTH AND THE PHYSICIAN PRESCRIBING YOUR INTEGRATIVE CANCER CARE RECOGNIZE THE IMPORTANCE OF USING CONVENTIONAL CANCER TREATMENTS, INCLUDING RADIATION, CHEMOTHERAPY, AND SURGERY. IT IS HIGHLY RECOMMENDED THAT YOU SEE AN ONCOLOGIST OR ANOTHER PHYSICIAN TO PROVIDE YOU WITH CONVENTIONAL CANCER CARE.

ANY AND ALL MEDICAL TREATMENTS INVOLVE SOME DEGREE OF RISK OF INJURY UP TO AND INCLUDING DEATH.

109403. For purposes of paragraph (2) of subdivision (a) of Section 109401, a treatment meets the evidence-based medical standard for integrative cancer treatment if **all one** of the following requirements are met:

The methods of treatment are recognized by the Physician's Data Query of the National Cancer Institute; or

(b) The methods have been published in at least three peer-reviewed scientific medical journals.

(c) The methods of treatment have been reported in at least three peer-reviewed articles published in complementary and alternative medicine journals to have the potential of reducing the size of a cancer, slowing the progression of a cancer, or improving the quality of life of a patient with cancer.

(a) The methods of treatment are recognized by the Physician's Data Query of the National Cancer Institute; or

~~(a) In the opinion of the physician and surgeon recommending or prescribing the treatment, the~~ **(b) The methods of treatment have been reported in at least three peer-reviewed articles published in complementary and alternative medicine journals has the potential** to reduce the size of a cancer, slow the progression of a cancer, or improve the quality of life of a patient with cancer, ~~based on reasonable evidence from peer-reviewed scientific medical journals; or~~

(c) The methods have been published in at least three peer-reviewed scientific medical journals.

~~(b) In the opinion of the physician and surgeon recommending or prescribing the treatment, the expected benefits of the treatment substantially outweigh the expected harm from the treatment, as derived from peer-reviewed scientific or medical journals.~~

~~(c) The treatment, when properly provided, does not cause death or bodily injury to the patient.~~

109404. For purposes of paragraph (3) of subdivision (a) of Section 109401, a physician and surgeon prescribing integrative cancer treatment complies with the patient reevaluation requirements if all of the following conditions are satisfied:

(a) The patient is informed regarding the measurable results achieved within the timeframe established pursuant to paragraph (2) of subdivision (a) of Section 109405 and at regular and appropriate intervals during the treatment plan.

(b) The physician and surgeon reevaluates treatment when progress stalls or reverses in the opinion of the physician and surgeon or the patient, or as evidenced by objective evaluations.

(c) The patient is informed about and agrees to any proposed change or changes in treatment, including, but not limited to, the risks and benefits of the proposed change or changes, the costs associated with the proposed change or changes, and the timeframe within which the proposed change or changes will be reevaluated.

109405. For purposes of paragraph (4) of subdivision (a) of Section 109401, a physician and surgeon complies with all of the standards of care in prescribing integrative cancer treatment under this article if all of the following requirements are met:

(a) The physician and surgeon provides the patient with all of the following when prescribing the treatment:

(1) Information regarding the treatment prescribed, including its usefulness in treating cancer.

(2) A timeframe and plan for reevaluating the treatment using standard and conventional means in order to assess treatment efficacy.

(3) A cost estimate for the prescribed treatment.

(b) The physician and surgeon ensures that relevant, generally accepted tests are administered to confirm the effectiveness and progress of the treatment.

(c) The physician and surgeon, prior to prescribing or changing the treatment, makes a good faith effort to obtain from the patient all relevant charts, records, and laboratory results relating to the patient's conventional cancer care.

(d) At the request of the patient, the physician and surgeon makes a good faith effort to coordinate the care of the patient with the physician and surgeon providing conventional cancer care to the patient.

(e) At the request of the patient, the physician and surgeon provides a synopsis of any treatment rendered pursuant to this article to the physician and surgeon providing conventional cancer care to the patient, including subjective and objective assessments of the patient's state of health and response to that treatment.

109406. The failure of a physician and surgeon to comply with this article constitutes unprofessional conduct and cause for discipline by that individual's licensing entity. That person shall not be subject to Section 109335 or 109370.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1308
Author: Bonilla
Bill Date: March 21, 2013, Amended
Subject: Midwifery
Sponsor: American Congress of Obstetricians and Gynecologists, District IX

STATUS OF BILL:

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

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow a licensed midwife (LM) to directly obtain supplies, order testing, and receive reports that are necessary to the LM's practice of midwifery and consistent with the scope for practice for a LM. This bill would also require the Medical Board of California (Board) to adopt regulations by July 1, 2015 defining the appropriate standard of care and level of supervisions required for the practice of midwifery and identifying complications necessitating referral to a physician. This bill would require a LM to disclose in oral and written form to a prospective client the specific arrangement for the referral of complications to a physician and surgeon.

ANALYSIS

Current law requires the Board to adopt regulations defining the appropriate standard of care and level of supervisions required for the practice of midwifery. Due to the inability to reach consensus on the supervision issue, the Board bifurcated this requirement and in 2006 adopted Standards of Care for Midwifery. Three previous attempts to resolve the physician supervision issue via legislation and/or regulation have been unsuccessful due to the widely divergent opinions of interested parties and their inability to reach consensus.

This bill would allow a LM to directly obtain supplies, order testing, and receive reports that are necessary to his or her practice of midwifery and consistent with the scope for practice for a LM. This bill would also require the Board to adopt regulations by July 1, 2015 defining the appropriate standard of care and level of supervision required for the practice of midwifery and identifying complications necessitating referral to a physician and surgeon. This bill would require a LM to disclose in oral and written form to a prospective client the specific arrangement for the referral of complications to a physician.

Although required by law, physician supervision is essentially unavailable to LMs

performing home births, as California physicians are generally prohibited by their malpractice insurance companies from providing supervision of LMs who perform home births. According to these companies, if a physician supervises or participates in a home birth the physician will lose their insurance coverage resulting in loss of hospital privileges. The physician supervision requirement creates numerous barriers to care, in that if the LM needs to transfer a patient/baby to the hospital, many hospitals will not accept a patient transfer from a LM as the primary provider who does not have a supervising physician. California is currently the only state that requires physician supervision of LMs. Among states that regulate midwives, most require some sort of collaboration between the midwife and a physician.

LMs have difficulty securing diagnostic lab accounts, even though they are legally allowed to have lab accounts. Many labs require proof of physician supervision. In addition, LMs are not able to obtain the medical supplies they have been trained and are expected to use; oxygen and medical supplies that are included in approved licensed midwifery school curriculum (CCR section 1379.30). The inability for a licensed midwife to order lab tests often means the patient will not obtain the necessary tests to help the midwife monitor the patient during pregnancy. In addition, not being able to obtain the necessary medical supplies for the practice of midwifery adds additional risk to the LMs patient and child.

The Board, through the Midwifery Advisory Council (MAC) has held many meetings regarding physician supervision of licensed midwives and has attempted to create regulations to address this issue. The concepts of collaboration, such as required consultation, referral, transfer of care, and physician liability have been discussed among the interested parties with little success. There is disagreement over the appropriate level of physician supervision, with licensed midwives expressing concern with any limits being placed on their ability to practice independently. The physician and liability insurance communities have concerns over the safety of midwife-assisted homebirths, specifically delays and/or the perceived reluctance of midwives to refer patients when the situation warrants referral or transfer of care.

The Board, through MAC has also held meetings regarding the lab order and medical supplies/medication issues and has attempted to create regulatory language to address this issue. However, based upon discussions with interested parties, it appears the lab order and medical supplies/medication issues will need to be addressed through the legislative process.

This bill would address one of the barriers of care by allowing a LM to directly obtain supplies, order testing and receive reports necessary to the LM's practice of midwifery, which would help to ensure consumer protection. This bill would also require the Board to adopt regulations to address physician supervision and to identify complications necessitating referral to a physician; however, the Board has been unsuccessful in endeavors to adopt regulations regarding physician supervision in the past. Board staff will continue to work with the author's office and sponsors on language that will help to solve the issue of physician supervision and remove barriers to care, while at the same time help to ensure consumer protection. Board staff is suggesting that the Board support this bill if it is amended to better clarify what the supervision requirements should be in statute, versus in regulation.

FISCAL: None, as the Board is already required to adopt regulations, but has been unsuccessful as of yet.

SUPPORT: ACOG (sponsor)

OPPOSITION: None on file

POSITION: Recommendation: Support if amended to better clarify what the supervision requirements should be in statute, versus in regulation.

AMENDED IN ASSEMBLY MARCH 21, 2013

california legislature—2013–14 regular session

ASSEMBLY BILL

No. 1308

Introduced by Assembly Member Bonilla

February 22, 2013

An act to amend Sections 2507 and 2508 of the Business and Professions Code, relating to professions and vocations.

legislative counsel's digest

AB 1308, as amended, Bonilla. Midwifery.

Existing law, the Licensed Midwifery Practice Act of 1993, provides for the licensing and regulation of midwives by the Board of Licensing of the Medical Board of California. The license to practice midwifery authorizes the holder, under the supervision of a licensed physician and surgeon, as specified, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn. *Under the act, a licensed midwife is required to make certain oral and written disclosures to prospective clients. A violation of the act is a crime.*

This bill would additionally authorize a licensed midwife to directly obtain supplies, order testing, and receive reports that are necessary to his or her practice of midwifery and consistent with his or her scope of practice and would require a licensed midwife to disclose to prospective clients the specific arrangements for referral of complications to a physician and surgeon.

~~This bill would state the intent of the Legislature to enact legislation to remove barriers to care in order to provide a more efficient and safer delivery method for mother and infant by allowing licensed midwives to practice in a manner originally intended in prior legislation.~~

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Existing law requires the board, by July 1, 2003, to adopt regulations defining the appropriate standard of care and level of supervision required for the practice of midwifery.

This bill would require the board, by July 1, 2015, to revise and adopt regulations defining the appropriate standard of care and level of supervision required for the practice of midwifery and identifying complications necessitating referral to a physician and surgeon.

By expanding the disclosures a licensed midwife is required to make to prospective clients, this bill would expand the scope of a crime thereby imposing a state-mandated local program.

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

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

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

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

1 SECTION 1. ~~(a)~~—The Legislature finds and declares the
2 following:

3 ~~(1)~~

4 (a) Licensed midwives have been authorized to practice since
5 1993 under Senate Bill 350 (Chapter 1280 of the Statutes of 1993),
6 which was authored by Senator Killea. Additional legislation,
7 Senate Bill 1950 (Chapter 1085 of the Statutes of 2002), which
8 was authored by Senator Figueroa, was needed in 2002 to clarify
9 certain practice issues. While the midwifery license does not
10 specify or limit the practice setting in which licensed midwives
11 may provide care, the reality is that the majority of births delivered
12 by licensed midwives are planned as home births.

13 ~~(2)~~

14 (b) Planned home births are safer when care is provided as part
15 of an integrated delivery model. For a variety of reasons, this
16 integration rarely occurs, and creates a barrier to the best and safest
17 care possible. This is due, in part, to the attempt to fit a midwifery
18 model of care into a medical model of care.

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1 ~~(b) It is the intent of the Legislature to enact legislation that~~
2 ~~would systematically remove unnecessary barriers to care in order~~
3 ~~to provide a more efficient and safer delivery for mother and infant~~
4 ~~by allowing licensed midwives to practice in a manner originally~~
5 ~~intended in the authorizing legislation.~~

6 *SEC. 2. Section 2507 of the Business and Professions Code is*
7 *amended to read:*

8 2507. (a) The license to practice midwifery authorizes the
9 holder, under the supervision of a licensed physician and surgeon,
10 to attend cases of normal childbirth and to provide prenatal,
11 intrapartum, and postpartum care, including family-planning care,
12 for the mother, and immediate care for the newborn.

13 (b) As used in this article, the practice of midwifery constitutes
14 the furthering or undertaking by any licensed midwife, under the
15 supervision of a licensed physician and surgeon who has current
16 practice or training in obstetrics, to assist a woman in childbirth
17 so long as progress meets criteria accepted as normal. All
18 complications shall be referred to a physician and surgeon
19 immediately. The practice of midwifery does not include the

20 assisting of childbirth by any artificial, forcible, or mechanical
21 means, nor the performance of any version.

22 (c) As used in this article, "supervision" shall not be construed
23 to require the physical presence of the supervising physician and
24 surgeon.

25 (d) The ratio of licensed midwives to supervising physicians
26 and surgeons shall not be greater than four individual licensed
27 midwives to one individual supervising physician and surgeon.

28 (e) A midwife is not authorized to practice medicine and surgery
29 by this article.

30 (f) *A midwife is authorized to directly obtain supplies, order*
31 *testing, and receive reports that are necessary to his or her practice*
32 *of midwifery and consistent with his or her scope of practice.*

33 ~~(f)~~

34 (g) The board shall, not later than July 1, ~~2003~~, 2015, revise
35 and adopt in accordance with the Administrative Procedure Act
36 (Chapter 3.5 (commencing with Section 11340) of Part 1 of
37 Division 3 of Title 2 of the Government Code), regulations defining
38 the appropriate standard of care and level of supervision required
39 for the practice of ~~midwifery~~. *midwifery and identifying*
40 *complications necessitating referral to a physician and surgeon.*

1

SEC. 3. Section 2508 of the Business and Professions Code is
2 *amended to read:*

3 2508. (a) A licensed midwife shall disclose in oral and written
4 form to a prospective client all of the following:

5 (1) All of the provisions of Section 2507.

6 (2) If the licensed midwife does not have liability coverage for
7 the practice of midwifery, he or she shall disclose that fact.

8 (3) *The specific arrangements for the referral of complications*
9 *to a physician and surgeon.*

10 ~~(3)~~

11 (4) The specific arrangements for the transfer of care during the
12 prenatal period, hospital transfer during the intrapartum and
13 postpartum periods, and access to appropriate emergency medical
14 services for mother and baby if necessary.

15 ~~(4)~~

16 (5) The procedure for reporting complaints to the Medical Board
17 of California.

18 (b) The disclosure shall be signed by both the licensed midwife
19 and the client and a copy of the disclosure shall be placed in the
20 client's medical record.

21 (c) The Medical Board of California may prescribe the form for
22 the written disclosure statement required to be used by a licensed
23 midwife under this section.

24 *SEC. 4. No reimbursement is required by this act pursuant to*
25 *Section 6 of Article XIII B of the California Constitution because*
26 *the only costs that may be incurred by a local agency or school*

27 *district will be incurred because this act creates a new crime or*
28 *infraction, eliminates a crime or infraction, or changes the penalty*
29 *for a crime or infraction, within the meaning of Section 17556 of*
30 *the Government Code, or changes the definition of a crime within*
31 *the meaning of Section 6 of Article XIII B of the California*
32 *Constitution.*

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 352
Author: Pavley
Bill Date: February 20, 2013, Introduced
Subject: Medical Assistants: Supervision
Sponsor: California Academy of Physician Assistants (CAPA)

STATUS OF BILL:

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

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow a physician assistants (PAs), nurse practitioner (NPs) and nurse-midwives (NMs) to supervise medical assistants (MAs)

ANALYSIS

MAs are unlicensed personnel trained to perform basic administrative, clerical, and technical support services in a medical office or clinical setting. These services include, but are not limited to, taking blood pressure, charting height and weight, administering medication, performing skin tests, and withdrawing blood by venipuncture. The Bureau of Labor and Statistics (2011) reports nearly 82,000 MAs are employed in California.

Currently, a physician must be present in the practice site to supervise an MA in most settings. PAs and NPs can currently supervise MAs in licensed community and free clinics. If a physician is not present, MAs are limited to performing administrative and clerical duties and cannot perform or assist with simple technical supportive services if the physician is not on the premises, except in community and free clinics. This means that in many settings, MAs cannot perform many of the tasks that they are qualified for and are needed to perform. This bill would allow PAs, NPs, and NMs to supervise MAs in all settings.

According to the sponsors, physicians have been delegating the task of supervising MAs when the physician is not in the office for over a decade in community clinics and the Physician Assistant Board and the Department of Consumer Affairs have not reported any patient safety issues or disciplinary action related to PA supervision of MAs. The sponsors believe that this bill will eliminate legal restrictions and barriers to efficient coordinated care. The sponsors believe this change is necessary if California hopes to accommodate the dramatic increase in patients expected to result from health care reform.

With the health care reform being implemented in 2014, this bill may help to

accommodate the expected increase in patients, as well as help to ensure that MAs are being supervised while a physician is not physically present in the office. Given that PAs, NPs, and NMs are currently allowed to supervise MAs in some settings now, and that this authority would have to be delegated by the physician, it makes sense for this to be allowed in all settings. However, existing law (BPC 2264) prohibits physicians from aiding and abetting unlicensed individuals from engaging in the practice of medicine. Board staff suggests that the Board take a Neutral position on this bill if it is amended to include language to ensure that if a PA, NP, or NM were to allow the MA to perform tasks that are not in the approved scope of responsibility, that the PA, NP, or NM would be held responsible and subject to discipline by their licensing board.

FISCAL: None

SUPPORT: CAPA (sponsor)

OPPOSITION: None on file

POSITION: Recommendation: Neutral if Amended

SENATE BILL

No. 352

**Introduced by Senator Pavley
(Principal coauthor: Senator Hernandez)**

February 20, 2013

An act to amend Section 2069 of the Business and Professions Code, relating to healing arts.

legislative counsel's digest

SB 352, as introduced, Pavley. Medical assistants: supervision.

Existing law authorizes a medical assistant to perform specified services relating to the administration of medication and performance of skin tests and simple routine medical tasks and procedures upon specific authorization from and under the supervision of a licensed physician and surgeon or podiatrist, or in a specified clinic upon specific authorization of a physician assistant, nurse practitioner, or nurse-midwife.

This bill would delete the requirement that the services performed by the medical assistant be in a specified clinic when under the specific authorization of a physician assistant, nurse practitioner, or nurse-midwife. The bill would also delete several obsolete references and make other technical, nonsubstantive changes.

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

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

- 1 SECTION 1. Section 2069 of the Business and Professions
- 2 Code is amended to read:
- 3 2069. (a) (1) Notwithstanding any other ~~provision of~~ law, a
- 4 medical assistant may administer medication only by intradermal,

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- 1 subcutaneous, or intramuscular injections and perform skin tests
- 2 and additional technical supportive services upon the specific
- 3 authorization and supervision of a licensed physician and surgeon
- 4 or a licensed podiatrist. A medical assistant may also perform all
- 5 these tasks and services ~~in a clinic licensed pursuant to subdivision~~
- 6 ~~(a) of Section 1204 of the Health and Safety Code~~ upon the specific
- 7 authorization of a physician assistant, a nurse practitioner, or a
- 8 nurse-midwife.

- 9 (2) The supervising physician and surgeon ~~at a clinic described~~
- 10 ~~in paragraph (1)~~ may, at his or her discretion, in consultation with
- 11 the nurse practitioner, nurse-midwife, or physician assistant,

12 provide written instructions to be followed by a medical assistant
13 in the performance of tasks or supportive services. These written
14 instructions may provide that the supervisory function for the
15 medical assistant for these tasks or supportive services may be
16 delegated to the nurse practitioner, nurse-midwife, or physician
17 assistant within the standardized procedures or protocol, and that
18 tasks may be performed when the supervising physician and
19 surgeon is not onsite, ~~so long as~~ *if either of* the following apply:

20 (A) The nurse practitioner or nurse-midwife is functioning
21 pursuant to standardized procedures, as defined by Section 2725,
22 or protocol. The standardized procedures or protocol shall be
23 developed and approved by the supervising physician and surgeon,
24 the nurse practitioner or nurse-midwife, and the facility
25 administrator or his or her designee.

26 (B) The physician assistant is functioning pursuant to regulated
27 services defined in Section 3502 and is approved to do so by the
28 supervising physician ~~or~~ and surgeon.

29 (b) As used in this section and Sections 2070 and 2071, the
30 following definitions ~~shall~~ apply:

31 (1) "Medical assistant" means a person who may be unlicensed,
32 who performs basic administrative, clerical, and technical
33 supportive services in compliance with this section and Section
34 2070 for a licensed physician and surgeon or a licensed podiatrist,
35 or group thereof, for a medical or podiatry corporation, for a
36 physician assistant, a nurse practitioner, or a nurse-midwife as
37 provided in subdivision (a), or for a health care service plan, who
38 is at least 18 years of age, and who has had at least the minimum
39 amount of hours of appropriate training pursuant to standards
40 established by the ~~Division of Licensing~~ board. The medical

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1 assistant shall be issued a certificate by the training institution or
2 instructor indicating satisfactory completion of the required
3 training. A copy of the certificate shall be retained as a record by
4 each employer of the medical assistant.

5 (2) "Specific authorization" means a specific written order
6 prepared by the supervising physician and surgeon or the
7 supervising podiatrist, or the physician assistant, the nurse
8 practitioner, or the nurse-midwife as provided in subdivision (a),
9 authorizing the procedures to be performed on a patient, which
10 shall be placed in the patient's medical record, or a standing order
11 prepared by the supervising physician and surgeon or the
12 supervising podiatrist, or the physician assistant, the nurse
13 practitioner, or the nurse-midwife as provided in subdivision (a),

14 authorizing the procedures to be performed, the duration of which
15 shall be consistent with accepted medical practice. A notation of
16 the standing order shall be placed on the patient's medical record.

17 (3) "Supervision" means the supervision of procedures
18 authorized by this section by the following practitioners, within
19 the scope of their respective practices, who shall be physically
20 present in the treatment facility during the performance of those
21 procedures:

22 (A) A licensed physician and surgeon.

23 (B) A licensed podiatrist.

24 (C) A physician assistant, nurse practitioner, or nurse-midwife
25 as provided in subdivision (a).

26 (4) "Technical supportive services" means simple routine
27 medical tasks and procedures that may be safely performed by a
28 medical assistant who has limited training and who functions under
29 the supervision of a licensed physician and surgeon or a licensed
30 podiatrist, or a physician assistant, a nurse practitioner, or a
31 nurse-midwife as provided in subdivision (a).

32 (c) Nothing in this section shall be construed as authorizing ~~the~~
33 *any of the following*:

34 (1) ~~The licensure of medical assistants. Nothing in this section~~
35 ~~shall be construed as authorizing the~~

36 (2) ~~The administration of local anesthetic agents by a medical~~
37 ~~assistant. Nothing in this section shall be construed as authorizing~~
38 ~~the division to~~

39 (3) ~~The board to~~ adopt any regulations that violate the
40 prohibitions on diagnosis or treatment in Section 2052.

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(e) Nothing in this section shall be construed as authorizing a
2 medical assistant to perform any clinical laboratory test or
3 examination for which he or she is not authorized by Chapter 3
4 (commencing with Section 1206.5). Nothing in this section shall
5 be construed as authorizing a nurse practitioner, nurse-midwife,
6 or physician assistant to be a laboratory director of a clinical
7 laboratory, as those terms are defined in paragraph (8) of
8 subdivision (a) of Section 1206 and subdivision (a) of Section
9 1209.

10 (d) Notwithstanding any other ~~provision of~~ law, a medical
11 assistant ~~may~~ shall not be employed for inpatient care in a licensed
12 general acute care hospital, as defined in subdivision (a) of Section
13 1250 of the Health and Safety Code.

14 (4) *A medical assistant to perform any clinical laboratory test*
15 *or examination for which he or she is not authorized by Chapter*
16 *3 (commencing with Section 1200).*

17 (5) *A nurse practitioner, nurse-midwife, or physician assistant*
18 *to be a laboratory director of a clinical laboratory, as those terms*
19 *are defined in paragraph (8) of subdivision (a) of Section 1206*
20 *and subdivision (a) of Section 1209.*

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 809
Author: DeSaulnier and Steinberg
Bill Date: February 22, 2013, introduced
Subject: Controlled Substances: Reporting
Sponsor: Department of Justice

STATUS OF BILL:

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

DESCRIPTION OF CURRENT LEGISLATION:

This bill would establish the Controlled Substance Utilization Review and Evaluation System (CURES) Fund that would be administered by the Department of Justice (DOJ), and would consist of funds collected from boards that license prescribers and dispensers, manufacturers, and health insurers, for purposes of funding the CURES program and upgrading the CURES system. Once the CURES program is funded and the system is upgraded, all prescribers and pharmacists would be required to consult CURES before prescribing or dispensing Schedule II, III, or IV controlled substances.

ANALYSIS:

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

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

The only funding currently available to DOJ for CURES is through renewable contracts with five separate regulatory boards (including the Medical Board of California (Board)) and one grant. While DOJ has been able to successfully renew contracts with the boards and receive grant funding this year, these sources of funding are not permanent and may not be available in future years and cannot be used to fund staff positions. In addition, these funding sources are insufficient to operate and maintain the PDMP system, make necessary enhancements or fully fund a PDMP modernization effort.

This bill would make findings and declarations related to the importance of CURES. This bill would establish the CURES Fund that would be funded by an annual 1.16% licensing, certification and renewal fee increase for licensees of the following boards that are authorized to prescribe or dispense Schedule II, III, or IV controlled substances: Medical Board of California; Dental Board of California; Board of Pharmacy (including wholesalers non-resident wholesalers, and veterinary food-animal drug retailers); Veterinary Medical Board; Board of Registered Nursing; Physician Assistant Board; Osteopathic Medical Board of California; State Board of Optometry; and the California Board of Podiatric Medicine. This bill would make the money in the CURES Fund available for allocation to DOJ, upon appropriation by the Legislature, for the purposes of funding the CURES Program. This bill would specify that the fee increase shall not exceed the reasonable costs associated with maintaining CURES.

The 1.16% annual fee would result in an increase of \$18 for physician renewal fees (\$9 each year of the two-year renewal cycle), and a \$9 initial licensing fee increase. Staff suggests that the word “annual” be taken out, which would instead result in a \$9 renewal fee increase and a \$9 initial licensing fee increase.

This bill would impose an unspecified one-time tax on health insurers for the purposes of upgrading the CURES system. This bill would impose an unspecified on-going tax on manufacturers of controlled substances for the purposes of creating and maintaining a new enforcement team in DOJ, which would focus on prescription diversion and abuse and criminal activity associated with bringing large quantities of illegal prescription drugs into California. The team would coordinate with state, federal and local law enforcement entities, and work with the various health care boards and departments to conduct investigations based on CURES data and intelligence.

Once CURES is funded, upgraded, and able to handle inquiries from all eligible prescribers and dispensers in California, this bill would require DOJ to notify all prescribers and dispensers who have submitted applications to CURES that they are capable of accommodating this workload. DOJ would also be required to notify the Legislature and post the notification on DOJ’s Web site. Once DOJ issues this notification, all prescribers and dispensers eligible to prescribe and dispense Schedule II, III, and IV controlled substances would be required to access and consult the electronic history of controlled substances dispensed to a patient under his or her care, prior to prescribing or dispensing a Schedule II, III, or IV controlled substance.

This bill contains an urgency clause, which means it would take effect immediately once signed into law by the Governor.

This is a concern in relation to the collection of the renewal fee. There needs to be an implementation schedule included, as the Board sends out renewal notices 90 days in advance and would need to give licensees appropriate notice of the renewal fee increase.

Board staff is suggesting the fee increase not be an annual fee increase, but be a 1.16% increase on licensing and renewals. Although this bill requires physicians to utilize CURES prior to prescribing Schedule II, III, and IV controlled substances once DOJ has provided notice that the system is capable, there is no penalty associated if a physician does not comply. In addition, requiring a physician to utilize CURES each time they prescribe a Schedule II, III, or IV controlled substance and also requiring the pharmacist to utilize CURES before they dispense that same prescription, may be overly excessive. In addition, placing a tax on manufacturers to support a new enforcement team in DOJ may be premature, as CURES will not be upgraded for some time.

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

Board staff suggests that the Board take a Support in Concept position, as this bill is still a work in progress. Board staff will continue to participate in work group meetings and will work with the authors’ offices on any amendments needed.

FISCAL: This bill would result in an annual 1.16% licensing fee increase for physicians, which equates to a \$18 increase for renewals and a \$9 increase for initial licensing fees.

SUPPORT: DOJ (sponsor)

OPPOSITION: None on file

POSITION: Recommendation: Support in Concept with noted concerns:

- Fee increase should be biennial versus annual.
- An implementation schedule for the fee increase should be addressed, as it is impossible to implement on the day the bill is signed.
- The requirement for use of CURES should include a minimum penalty if it is not used (cite/fine).
- DOJ enforcement team should not be funded until CURES system is fully operational and upgraded.

SENATE BILL

No. 809

Introduced by Senators DeSaulnier and Steinberg
(Coauthors: Senators Hancock, Lieu, Pavley, and Price)
(Coauthor: Assembly Member Blumenfield)

February 22, 2013

An act to add Section 805.8 to the Business and Professions Code, to amend Sections 11165 and 11165.1 of the Health and Safety Code, and to add Part 21 (commencing with Section 42001) to Division 2 of the Revenue and Taxation Code, relating to controlled substances, and declaring the urgency thereof, to take effect immediately.

legislative counsel's digest

SB 809, as introduced, DeSaulnier. Controlled substances: reporting.

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

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

This bill would establish the CURES Fund within the State Treasury to receive funds to be allocated, upon appropriation by the Legislature, to the Department of Justice for the purposes of funding CURES, and would make related findings and declarations.

This bill would require the Medical Board of California, the Dental Board of California, the California State Board of Pharmacy, the

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Veterinary Medical Board, the Board of Registered Nursing, the Physician Assistant Committee of the Medical Board of California, the Osteopathic Medical Board of California, the State Board of Optometry, and the California Board of Podiatric Medicine to increase the licensure, certification, and renewal fees charged to practitioners under their supervision who are authorized to prescribe or dispense controlled substances, by up to 1.16%, the proceeds of which would be deposited into the CURES Fund for support of CURES, as specified. This bill would also require the California State Board of Pharmacy to increase

the licensure, certification, and renewal fees charged to wholesalers, nonresident wholesalers, and veterinary food-animal drug retailers under their supervision by up to 1.16%, the proceeds of which would be deposited into the CURES Fund for support of CURES, as specified.

(2) Existing law permits a licensed health care practitioner, as specified, or a pharmacist to apply to the Department of Justice to obtain approval to access information stored on the Internet regarding the controlled substance history of a patient under his or her care. Existing law also authorizes the Department of Justice to provide the history of controlled substances dispensed to an individual to licensed health care practitioners, pharmacists, or both, providing care or services to the individual.

This bill would require licensed health care practitioners, as specified, and pharmacists to apply to the Department of Justice to obtain approval to access information stored on the Internet regarding the controlled substance history of a patient under his or her care, and, upon the happening of specified events, to access and consult that information prior to prescribing or dispensing Schedule II, Schedule III, or Schedule IV controlled substances.

(3) Existing law imposes various taxes, including taxes on the privilege of engaging in certain activities. The Fee Collection Procedures Law, the violation of which is a crime, provides procedures for the collection of certain fees and surcharges.

This bill would impose a tax upon qualified manufacturers, as defined, for the privilege of doing business in this state, as specified. This bill would also impose a tax upon specified insurers, as defined, for the privilege of doing business in this state, as specified. The tax would be administered by the State Board of Equalization and would be collected pursuant to the procedures set forth in the Fee Collection Procedures Law. The bill would require the board to deposit all taxes, penalties, and interest collected pursuant to these provisions in the CURES Fund,

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as provided. Because this bill would expand application of the Fee Collection Procedures Law, the violation of which is a crime, it would impose a state-mandated local program.

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

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

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

Vote: $\frac{2}{3}$. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

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

1 SECTION 1. The Legislature finds and declares all of the
2 following:

3 (a) The Controlled Substance Utilization Review and Evaluation
4 System (CURES) is a valuable investigative, preventive, and
5 educational tool for law enforcement, regulatory boards,
6 educational researchers, and the health care community. Recent
7 budget cuts to the Attorney General's Division of Law Enforcement
8 have resulted in insufficient funding to support the CURES
9 Prescription Drug Monitoring Program (PDMP). The PDMP is
10 necessary to ensure health care professionals have the necessary
11 data to make informed treatment decisions and to allow law
12 enforcement to investigate diversion of prescription drugs. Without
13 a dedicated funding source, the CURES PDMP is not sustainable.

14 (b) Each year CURES responds to more than 60,000 requests
15 from practitioners and pharmacists regarding all of the following:

16 (1) Helping identify and deter drug abuse and diversion of
17 prescription drugs through accurate and rapid tracking of Schedule
18 II, Schedule III, and Schedule IV controlled substances.

19 (2) Helping practitioners make better prescribing decisions.

20 (3) Helping reduce misuse, abuse, and trafficking of those drugs.

21 (c) Schedule II, Schedule III, and Schedule IV controlled
22 substances have had deleterious effects on private and public
23 interests, including the misuse, abuse, and trafficking in dangerous
24 prescription medications resulting in injury and death. It is the
25 intent of the Legislature to work with stakeholders to fully fund

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1 the operation of CURES which seeks to mitigate those deleterious
2 effects, and which has proven to be a cost-effective tool to help
3 reduce the misuse, abuse, and trafficking of those drugs.

4 SEC. 2. Section 805.8 is added to the Business and Professions
5 Code, to read:

6 805.8. (a) (1) The Medical Board of California, the Dental
7 Board of California, the California State Board of Pharmacy, the
8 Veterinary Medical Board, the Board of Registered Nursing, the
9 Physician Assistant Committee of the Medical Board of California,
10 the Osteopathic Medical Board of California, the State Board of
11 Optometry, and the California Board of Podiatric Medicine shall
12 increase the licensure, certification, and renewal fees charged to
13 practitioners under their supervision who are authorized pursuant
14 to Section 11150 of the Health and Safety Code to prescribe or

15 dispense Schedule II, Schedule III, or Schedule IV controlled
16 substances by up to 1.16 percent annually, but in no case shall the
17 fee increase exceed the reasonable costs associated with
18 maintaining CURES for the purpose of regulating prescribers and
19 dispensers of controlled substances licensed or certificated by these
20 boards.

21 (2) The California State Board of Pharmacy shall increase the
22 licensure, certification, and renewal fees charged to wholesalers
23 and nonresident wholesalers of dangerous drugs, licensed pursuant
24 to Article 11 (commencing with Section 4160) of Chapter 9, by
25 up to 1.16 percent annually, but in no case shall the fee increase
26 exceed the reasonable costs associated with maintaining CURES
27 for the purpose of regulating wholesalers and nonresident
28 wholesalers of dangerous drugs licensed or certificated by that
29 board.

30 (3) The California State Board of Pharmacy shall increase the
31 licensure, certification, and renewal fees charged to veterinary
32 food-animal drug retailers, licensed pursuant to Article 15
33 (commencing with Section 4196) of Chapter 9, by up to 1.16
34 percent annually, but in no case shall the fee increase exceed the
35 reasonable costs associated with maintaining CURES for the
36 purpose of regulating veterinary food-animal drug retailers licensed
37 or certificated by that board.

38 (b) The funds collected pursuant to subdivision (a) shall be
39 deposited in the CURES accounts, which are hereby created, within
40 the Contingent Fund of the Medical Board of California, the State

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1 Dentistry Fund, the Pharmacy Board Contingent Fund, the
2 Veterinary Medical Board Contingent Fund, the Board of
3 Registered Nursing Fund, the Osteopathic Medical Board of
4 California Contingent Fund, the Optometry Fund, and the Board
5 of Podiatric Medicine Fund. Moneys in the CURES accounts of
6 each of those funds shall, upon appropriation by the Legislature,
7 be available to the Department of Justice solely for maintaining
8 CURES for the purposes of regulating prescribers and dispensers
9 of controlled substances. All moneys received by the Department
10 of Justice pursuant to this section shall be deposited in the CURES
11 Fund described in Section 11165 of the Health and Safety Code.

12 SEC. 3. Section 11165 of the Health and Safety Code is
13 amended to read:

14 11165. (a) To assist law enforcement and regulatory agencies
15 in their efforts to control the diversion and resultant abuse of

16 Schedule II, Schedule III, and Schedule IV controlled substances,
17 and for statistical analysis, education, and research, the Department
18 of Justice shall, contingent upon the availability of adequate funds
19 ~~from~~ *in the CURES accounts within* the Contingent Fund of the
20 Medical Board of California, the Pharmacy Board Contingent
21 Fund, the State Dentistry Fund, the Board of Registered Nursing
22 Fund, ~~and~~ the Osteopathic Medical Board of California Contingent
23 Fund, *the Veterinary Medical Board Contingent Fund, the*
24 *Optometry Fund, the Board of Podiatric Medicine Fund, and the*
25 *CURES Fund*, maintain the Controlled Substance Utilization
26 Review and Evaluation System (CURES) for the electronic
27 monitoring of, and Internet access to information regarding, the
28 prescribing and dispensing of Schedule II, Schedule III, and
29 Schedule IV controlled substances by all practitioners authorized
30 to prescribe or dispense these controlled substances.

31 (b) The reporting of Schedule III and Schedule IV controlled
32 substance prescriptions to CURES shall be contingent upon the
33 availability of adequate funds ~~from~~ *for* the Department of Justice
34 *for the purpose of finding CURES*. The department may seek and
35 use grant funds to pay the costs incurred from the reporting of
36 controlled substance prescriptions to CURES.—~~Funds~~ *The*
37 *department shall make information about the amount and the*
38 *source of all private grant funds it receives for support of CURES*
39 *available to the public. Grant funds shall not be appropriated from*
40 *the Contingent Fund of the Medical Board of California, the*

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1 Pharmacy Board Contingent Fund, the State Dentistry Fund, the
2 Board of Registered Nursing Fund, the Naturopathic Doctor's
3 Fund, or the Osteopathic Medical Board of California Contingent
4 Fund to pay the costs of reporting Schedule III and Schedule IV
5 controlled substance prescriptions to CURES.

6 (c) CURES shall operate under existing provisions of law to
7 safeguard the privacy and confidentiality of patients. Data obtained
8 from CURES shall only be provided to appropriate state, local,
9 and federal persons or public agencies for disciplinary, civil, or
10 criminal purposes and to other agencies or entities, as determined
11 by the Department of Justice, for the purpose of educating
12 practitioners and others in lieu of disciplinary, civil, or criminal
13 actions. Data may be provided to public or private entities, as
14 approved by the Department of Justice, for educational, peer
15 review, statistical, or research purposes, provided that patient
16 information, including any information that may identify the
17 patient, is not compromised. Further, data disclosed to any
18 individual or ~~agency~~ *agency*, as described in this ~~subdivision~~
19 *subdivision*, shall not be disclosed, sold, or transferred to any third
20 party.

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

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

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

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

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1 (4) ~~NDC (National Drug Code)~~ *National Drug Code (NDC)*
2 number of the controlled substance dispensed.

3 (5) Quantity of the controlled substance dispensed.

4 (6) ~~ICD-9 (diagnosis code),~~ *International Statistical*
5 *Classification of Diseases, 9th revision (ICD-9) Code*, if available.

6 (7) Number of refills ordered.

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

9 (9) Date of origin of the prescription.

10 (10) Date of dispensing of the prescription.

11 (e) ~~This section shall become operative on January 1, 2005. The~~
12 *CURES Fund is hereby established within the State Treasury. The*
13 *CURES Fund shall consist of all funds made available to the*
14 *Department of Justice for the purpose of funding CURES. Money*
15 *in the CURES Fund shall, upon appropriation by the Legislature,*
16 *be available for allocation to the Department of Justice for the*
17 *purpose of funding CURES.*

18 SEC. 4. Section 11165.1 of the Health and Safety Code is
19 amended to read:

20 11165.1. (a) (1) A licensed health care practitioner eligible
21 to prescribe Schedule II, Schedule III, or Schedule IV controlled
22 substances or a pharmacist ~~may~~ *shall* provide a notarized
23 application developed by the Department of Justice to obtain
24 approval to access information stored on the Internet regarding
25 the controlled substance history of a patient maintained within the

26 Department of Justice, ~~and~~ *and, upon approval*, the department
27 ~~may~~ *shall* release to that practitioner or pharmacist, the electronic
28 history of controlled substances dispensed to an individual under
29 his or her care based on data contained in the CURES Prescription
30 Drug Monitoring Program (PDMP).

31 (A) An application may be denied, or a subscriber may be
32 suspended, for reasons which include, but are not limited to, the
33 following:

34 (i) Materially falsifying an application for a subscriber.

35 (ii) Failure to maintain effective controls for access to the patient
36 activity report.

37 (iii) Suspended or revoked federal Drug Enforcement
38 Administration (DEA) registration.

39 (iv) Any subscriber who is arrested for a violation of law
40 governing controlled substances or any other law for which the

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1 possession or use of a controlled substance is an element of the
2 crime.

3 (v) Any subscriber accessing information for any other reason
4 than caring for his or her patients.

5 (B) Any authorized subscriber shall notify the Department of
6 Justice within 10 days of any changes to the subscriber account.

7 (2) To allow sufficient time for licensed health care practitioners
8 eligible to prescribe Schedule II, Schedule III, or Schedule IV
9 controlled substances and a pharmacist to apply and receive access
10 to PDMP, a written request may be made, until July 1, 2012, and
11 the Department of Justice may release to that practitioner or
12 pharmacist the history of controlled substances dispensed to an
13 individual under his or her care based on data contained in CURES.

14 (b) Any request for, or release of, a controlled substance history
15 pursuant to this section shall be made in accordance with guidelines
16 developed by the Department of Justice.

17 (c) ~~In~~ *(1) Until the Department of Justice has issued the*
18 *notification described in paragraph (3), in order to prevent the*
19 *inappropriate, improper, or illegal use of Schedule II, Schedule*
20 *III, or Schedule IV controlled substances, the Department of Justice*
21 *may initiate the referral of the history of controlled substances*
22 *dispensed to an individual based on data contained in CURES to*
23 *licensed health care practitioners, pharmacists, or both, providing*
24 *care or services to the individual.*

25 *(2) Upon the Department of Justice issuing the notification*
26 *described in paragraph (3) and approval of the application*

27 required pursuant to subdivision (a), licensed health care
28 practitioners eligible to prescribe Schedule II, Schedule III, or
29 Schedule IV controlled substances and pharmacists shall access
30 and consult the electronic history of controlled substances
31 dispensed to an individual under his or her care prior to
32 prescribing or dispensing a Schedule II, Schedule III, or Schedule
33 IV controlled substance.

34 (3) The Department of Justice shall notify licensed health care
35 practitioners and pharmacists who have submitted the application
36 required pursuant to subdivision (a) when the department
37 determines that CURES is capable of accommodating the mandate
38 contained in paragraph (2). The department shall provide a copy
39 of the notification to the Secretary of the State, the Secretary of
40 the Senate, the Chief Clerk of the Assembly, and the Legislative

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1 Counsel, and shall post the notification on the department's
2 Internet Web site.

3 (d) The history of controlled substances dispensed to an
4 individual based on data contained in CURES that is received by
5 a practitioner or pharmacist from the Department of Justice
6 pursuant to this section shall be considered medical information
7 subject to the provisions of the Confidentiality of Medical
8 Information Act contained in Part 2.6 (commencing with Section
9 56) of Division 1 of the Civil Code.

10 (e) Information concerning a patient's controlled substance
11 history provided to a prescriber or pharmacist pursuant to this
12 section shall include prescriptions for controlled substances listed
13 in Sections 1308.12, 1308.13, and 1308.14 of Title 21 of the Code
14 of Federal Regulations.

15 SEC. 5. Part 21 (commencing with Section 42001) is added to
16 Division 2 of the Revenue and Taxation Code, to read:

17

18 PART 21. CONTROLLED SUBSTANCE UTILIZATION 19 REVIEW AND EVALUATION SYSTEM (CURES) TAX LAW

20

21 42001. For purposes of this part, the following definitions
22 apply:

23 (a) "Controlled substance " means a drug, substance, or
24 immediate precursor listed in any schedule in Section 11055,
25 11056, or 11057 of the Health and Safety Code.

26 (b) "Insurer" means a health insurer licensed pursuant to Part
27 2 (commencing with Section 10110) of Division 2 of the Insurance
28 Code, a health care service plan licensed pursuant to the

29 Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2
30 (commencing with Section 1340) of Division 2 of the Health and
31 Safety Code), and a workers' compensation insurer licensed
32 pursuant to Part 3 (commencing with Section 11550) of Division
33 2 of the Insurance Code.

34 (c) "Qualified manufacturer" means a manufacturer of a
35 controlled substance doing business in this state, as defined in
36 Section 23101, but does not mean a wholesaler or nonresident
37 wholesaler of dangerous drugs, regulated pursuant to Article 11
38 (commencing with Section 4160) of Chapter 9 of Division 2 of
39 the Business and Professions Code, a veterinary food-animal drug
40 retailer, regulated pursuant to Article 15 (commencing with Section

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1 4196) of Chapter 9 of Division 2 of the Business and Professions
2 Code, or an individual regulated by the Medical Board of
3 California, the Dental Board of California, the California State
4 Board of Pharmacy, the Veterinary Medical Board, the Board of
5 Registered Nursing, the Physician Assistant Committee of the
6 Medical Board of California, the Osteopathic Medical Board of
7 California, the State Board of Optometry, or the California Board
8 of Podiatric Medicine.

9 42003. (a) For the privilege of doing business in this state, an
10 annual tax is hereby imposed on all qualified manufacturers in an

11 amount of dollars (\$), for the purpose of establishing

12 and maintaining enforcement of the Controlled Substance
13 Utilization Review and Evaluation System (CURES), established
14 pursuant to Section 11165 of the Health and Safety Code.

15 (b) For the privilege of doing business in this state, a tax is
16 hereby imposed on a one time basis on all insurers in an amount

17 of dollars (\$), for the purpose of upgrading CURES.

18 42005. Each qualified manufacturer and insurer shall prepare
19 and file with the board a return, in the form prescribed by the board,
20 containing information as the board deems necessary or appropriate
21 for the proper administration of this part. The return shall be filed
22 on or before the last day of the calendar month following the
23 calendar quarter to which it relates, together with a remittance
24 payable to the board for the amount of tax due for that period.

25 42007. The board shall administer and collect the tax imposed
26 by this part pursuant to the Fee Collection Procedures Law (Part
27 30 (commencing with Section 55001)). For purposes of this part,
28 the references in the Fee Collection Procedures Law (Part 30

29 (commencing with Section 55001)) to “fee” shall include the tax
30 imposed by this part and references to “feepayer” shall include a
31 person required to pay the tax imposed by this part.

32 42009. All taxes, interest, penalties, and other amounts
33 collected pursuant to this part, less refunds and costs of
34 administration, shall be deposited into the CURES Fund.

35 42011. The board shall prescribe, adopt, and enforce rules and
36 regulations relating to the administration and enforcement of this
37 part.

38 SEC. 6. No reimbursement is required by this act pursuant to
39 Section 6 of Article XIII B of the California Constitution because
40 the only costs that may be incurred by a local agency or school

1 district will be incurred because this act creates a new crime or
2 infraction, eliminates a crime or infraction, or changes the penalty
3 for a crime or infraction, within the meaning of Section 17556 of
4 the Government Code, or changes the definition of a crime within
5 the meaning of Section 6 of Article XIII B of the California
6 Constitution.

7 SEC. 7. This act is an urgency statute necessary for the
8 immediate preservation of the public peace, health, or safety within
9 the meaning of Article IV of the Constitution and shall go into
10 immediate effect. The facts constituting the necessity are:

11 In order to protect the public from the continuing threat of
12 prescription drug abuse at the earliest possible time, it is necessary
13 this act take effect immediately.

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SB 809

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: March 21, 2013
ATTENTION: Members, Executive Committee
SUBJECT: Board Member Administrative Procedure Manual

RECOMMENDED ACTION:

Review the updates to the manual, provide any further edits that need to be made, and recommend these changes to the full Board.

BACKGROUND AND ANALYSIS:

At the January 31, 2013 Executive Committee Meeting, the Board Member Administrative Procedure Manual (Manual) was provided to the Members with suggested edits. At the meeting the Members approved the recommended amendments and requested further edits to the document, specifically in the section on the role of the Board Officers/Committee Chairs/Panel Officers. All of the edits have been made.

The Members also requested that edits be made to the Manual regarding written comments to the Board, meetings requested with Members by interested parties, and procedures for Members when contacted by the media. Board staff also added in a section on the process for Members to follow when they are served with a lawsuit. The attached document has the suggested edits. Please see specifically pages EXEC 5-8 to EXEC 5-9 and EXEC 5-16 to EXEC 5-17.

**State of California
State and Consumer Services Agency**

MEDICAL BOARD OF CALIFORNIA

Board Member Administrative Procedure Manual



2005 Evergreen Street, Suite 1200
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Board Member Administrative Procedure Manual

Updates to Manual – ~~February 2013~~ April 2013

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Chapter 1. Introduction

Overview The Medical Board of California (MBC) was created by the California Legislature in 1876. Today the MBC is one of the boards, bureaus, commissions, and committees within the Department of Consumer Affairs (DCA), part of the State and Consumer Services Agency under the aegis of the Governor. The Department is responsible for consumer protection and representation through the regulation of certain licensed professions and the provision of consumer services. While the DCA provides oversight in various areas including, but not limited to, budget change proposals, regulations, and contracts, and also provides support services, MBC has policy autonomy and sets its own policies procedures, and initiates its own regulations. (See Business and Professions Code sections 108, 109(a), and 2018.)

The MBC is presently comprised of 15 Members. By law, seven are public Members, and eight are physicians. The Senate Rules Committee and the Speaker of the Assembly each appoint one public member. Board Members may serve two full four-year terms. Board Members fill non-salaried positions, and are paid \$100 per day for each day worked and are reimbursed travel expenses.

This procedure manual is provided to Board Members as a ready reference of important laws, regulations, and Board policies, to guide the actions of Board Members and ensure Board effectiveness and efficiency.

Due notice of each meeting and the time and place thereof shall be given each member in the manner provided by law.

Definitions	B&P	Business and Professions Code
	SAM	State Administrative Manual
	President	Where the term “President” is used in this manual, it includes “his or her designee”

**General Rules
of Conduct**

Board Members shall not speak to interested parties (such as vendors, lobbyists, legislators, or other governmental entities) on behalf of the Board or act for the Board without proper authorization.

Board Members shall maintain the confidentiality of confidential documents and information.

Board Members shall commit time, actively participate in Board activities, and prepare for Board meetings, which includes reading Board packets and all required legal documents.

Board Members shall respect and recognize the equal role and responsibilities of all Board Members, whether public or licensee.

Board Members shall act fairly and in a nonpartisan, impartial, and unbiased manner.

Board Members shall treat all applicants and licensees in a fair and impartial manner.

Board Members' actions shall uphold the Board's primary mission – protection of the public.

Board Members shall not use their positions on the Board for political, personal, familial, or financial gain.

Chapter 2. Board Meeting Procedures

Frequency of Meetings *(B&P Code sections 2013, 2014)*

The Board shall meet at least once each calendar quarter in various parts of the state for the purpose of transacting such business as may properly come before it.

Special meetings of the Board may be held at such times as the Board deems necessary.

Four Members of a panel of the Board shall constitute a quorum for the transaction of business at any meeting of the panel.

Eight Members shall constitute a quorum for the transaction of business at any Board meeting.

Due notice of each meeting and the time and place thereof shall be given each member in the manner provided by the law.

Board Member Attendance at Board Meetings *(B&P Code sections 106, 2011)*

Board Members shall attend each meeting of the Board. If a member is unable to attend, he or she must contact the Board President and ask to be excused from the meeting for a specific reason. The Governor has the power to remove from office any member appointed by him for continued neglect of duties, which may include unexcused absences from meetings.

Board Members shall attend the entire meeting and allow sufficient time to conduct all Board business at each meeting.

Public Attendance at Board Meetings *(Government Code section 11120 et. seq.)*

Meetings are subject to all provisions of the Bagley-Keene Open Meetings Act. This act governs meetings of state regulatory boards and meetings of committees of those boards where the committee consists of more than two Members. It specifies meeting notice and agenda requirements and prohibits discussing or taking action on matters not included on the agenda.

If the agenda contains matters that are appropriate for closed session, the agenda must cite the particular statutory section and subdivision authorizing the closed session.

Quorum *(B&P Code section 2013)*

Eight of the Members of the Board constitute a quorum of the Board for the transaction of business. The concurrence of a majority of those Members of the Board present and voting at a duly noticed meeting at which a quorum is present shall be necessary to constitute an act or decision of the Board.

Agenda Items

(Board Policy)

Any Board Member may submit items for a meeting agenda to the Executive Director not fewer than 30 days prior to the meeting with the approval of the Board President or Chair of the Committee.

Notice of Meetings

(Government Code section 11120 et seq.)

In accordance with the Open Meetings Act, meeting notices (including agendas for Board, Committee, or Panel meetings) shall be sent to persons on the Board's mailing list at least 10 calendar days in advance. The notice shall include the name, work address, and work telephone number of a staff person who can provide further information prior to the meeting.

Notice of Meetings to be Posted on the Internet

(Government Code section 11125 et seq.)

Notice shall be given and also made available on the Internet at least 10 days in advance of the meeting and shall include the name, address, and telephone number of any person who can provide further information prior to the meeting, but need not include a list of witnesses expected to appear at the meeting. The written notice shall additionally include the address of the Internet site where notices required by this article are made available.

Record of Meetings

(B&P Code section 2017)

The Board and each Committee or Panel shall keep an official record of all their proceedings. The minutes are a summary, not a transcript, of each Board or Committee meeting. They shall be prepared by staff and submitted to Members for review before the next meeting. Minutes shall be approved at the next scheduled meeting of the Board, Committee, or Panel. When approved, the minutes shall serve as the official record of the meeting.

Tape Recording/Web Casting

(Board Policy)

The meeting may be tape-recorded if determined necessary for staff purposes. Tape recordings will be disposed of upon approval of the minutes in accordance with record retention schedules. The meeting will be Web cast, as DCA staff is available, including the Committees of the Board. The Web cast will be posted on the Board's Web site within two weeks and kept for 10 years or more.

Meeting Rules

(Board Policy)

The Board will use Robert's Rules of Order, to the extent that it does not conflict with state law (e.g. Bagley-Keene Open Meeting Act), as a guide when conducting its meetings.

Public Comment

(Board Policy)

Due to the need for the Board to maintain fairness and neutrality when performing their adjudicative function, the Board shall not receive any substantive information from a member of the public regarding any matter that is currently under or subject to investigation or involves a pending criminal or administrative action.

1. If, during a Board meeting, a person attempts to provide the Board with substantive information regarding matters that are currently under or subject to investigation or involve a pending administrative or criminal action, the person shall be advised that the Board cannot properly consider or hear such substantive information, and the person shall be instructed to refrain from making such comments.
2. If, during a Board meeting, a person wishes to address the Board concerning alleged errors of procedure or protocol or staff misconduct, involving matters that are currently under or subject to investigation or involve a pending administrative or criminal action, the Board will address the matter as follows:
 - a. Where the allegation involves errors of procedure or protocol, the Board may designate either its Executive Director or a Board employee to review whether the proper procedure or protocol was followed and to report back to the Board.
 - b. Where the allegation involves significant staff misconduct, the Board may designate one of its Members to review the allegation and to report back to the Board.
3. The Board may deny a person the right to address the Board and have the person removed if such person becomes disruptive at the Board meeting.
4. Persons wishing to address the Board or a Committee of the Board shall be requested to complete a speaker request slip in order to have an appropriate record of the speaker for the minutes. At the discretion of the Board President or Chair of the Committee, speakers may be limited in the amount of time to present to give adequate time to everyone who wants to speak. In the event the number of people wishing to address the Board exceeds the allotted time, the Board President or Chair of the Committee may limit each speaker to a statement of his/her name, organization, and whether they support or do not support the proposed action

(Government Code section 11120 et seq.)

Written Comment
(Board Policy)

Prior to a Board meeting, an individual or group may submit materials related to a meeting agenda item to the Executive Director and request that the material be provided to the Board or Committee Members. Upon receipt of such a request, the Executive Director will verify that the materials are related to an open session agenda item (no materials will be distributed regarding complaints, investigations, contested cases, litigation, or other matters that may be properly discussed in closed session) and then forward the materials to the Board or

Committee Members. When forwarding the applicable materials to the Board members, the Executive Director may include information regarding existing law, regulation, or past Board action relevant to the issue presented. The written communication must be provided at least four business days prior to the meeting in order to ensure delivery to the Board Members.

NOTE: This section is not applicable to a formal regulatory hearing.

Chapter 3. Travel & Salary Policies & Procedures

Travel Approval

(DCA Memorandum 96-01)

The Board President's approval is required for all Board Members for travel, except for travel to regularly scheduled Board and Committee meetings to which the Board Member is assigned.

Travel Arrangements

(Board Policy)

Board Members should make their own travel arrangements but are encouraged to coordinate with the Executive Director's Administrative Assistant on lodging accommodations.

Out-of-State Travel

(SAM section 700 et seq.)

For out-of-state travel, Board Members will be reimbursed for actual lodging expenses, supported by vouchers, and will be reimbursed for meal and supplemental expenses. Out-of-state travel for all persons representing the State of California is controlled by and approved by the Governor's Office.

Travel Claims

(SAM section 700 et seq. and DCA Memorandum 96-01)

Rules governing reimbursement of travel expenses for Board Members are the same as for management-level state staff. All expenses shall be claimed on the appropriate travel expense claim forms. The Executive Director's Administrative Assistant maintains these forms and completes them as needed. Board Members should submit their travel expense forms immediately after returning from a trip and no later than two weeks following the trip.

For the expenses to be reimbursed, Board Members shall follow the procedures contained in DCA Departmental Memoranda, which are periodically disseminated by the Executive Director and are provided to Board Members.

Salary Per Diem

(B&P Code section 103)

Compensation in the form of salary per diem and reimbursement of travel and other related expenses for Board Members is regulated by B&P Code Section 103.

In relevant part, this section provides for the payment of salary per diem for Board Members "for each day actually spent in the discharge of official duties," and provides that the Board Member "shall be reimbursed for traveling and other expenses necessarily incurred in the performance of official duties."

Accordingly, the following general guidelines shall be adhered to in the payment of salary per diem or reimbursement for travel:

1. No salary per diem or reimbursement for travel-related expenses shall be paid to Board Members, except for attendance at an official Board, Committee, or Panel meeting, unless a substantial official service is performed by the Board Member. Attendance at gatherings, events, hearings, conferences, or meetings other than official Board, Committee, or Panel meetings, in which a substantial official service is performed, shall be approved in advance by the Board President. The Executive Director shall be notified of the event and approval shall be obtained from the Board President prior to Board Member's attendance.
2. The term "day actually spent in the discharge of official duties" shall mean such time as is expended from the commencement of a Board, Committee, or Panel meeting to the conclusion of that meeting.

For Board-specified work, Board Members will be compensated for actual time spent performing work authorized by the Board President. That work includes, but is not limited to, authorized attendance at other gatherings, events, meetings, hearings, or conferences. It includes preparation time for Board, Committee, or Panel meetings.

Chapter 4. Selection of Officers & Committees

Officers of the Board

(B&P Code Section 2012)

The Board shall select a President, Vice President, and Secretary from its Members.

Election of Officers

(Board Policy)

The Board shall elect the officers at the first meeting of the fiscal year. Officers shall serve a term of one year beginning the next meeting day. All officers may be elected on one motion or ballot as a slate of officers unless more than one Board Member is running per office. An officer may be re-elected and serve for more than one term.

Panel Members

(B&P Code section 2008)

A Panel of the Board shall at no time be composed of less than four Members and the number of public Members assigned shall not exceed the number of licensed physician and surgeon Members assigned to the Panel. The Board President shall not be a member of any Panel if a full complement of the Board has been appointed (15 Members). The Board usually is comprised of two panels, however, if there is an insufficient number of Members, there may only be one Panel.

Election of Panel Members

(B&P Code section 2008)

Each Panel shall annually, at the last meeting of the calendar year, elect a Chair and a Vice Chair.

Officer Vacancies

(Board Policy)

If an office becomes vacant during the year, an election shall be held at the next meeting. If the office of the President becomes vacant, the Vice President shall assume the office of the President. Elected officers then shall serve the remainder of the term.

Committee Appointments

(Board Policy)

The Board President shall establish Committees, whether standing or special, as he or she deems necessary. The composition of the Committees and the appointment of the Members shall be determined by the Board President in consultation with the Vice President, Secretary, and the Executive Director. Committees may include the appointment of non-Board Members.

Attendance at Committee Meetings

(Government Code section 11120 et seq.)

Board Members are encouraged to attend a meeting of a Committee of which he or she is not a member. Board Members who are not Members of the Committee that is meeting cannot vote during the Committee meeting and may participate only as observers if a majority of the Board is present at a Committee meeting.

Duties of the Officers

The following matrix delineates the duties of the Board officers, Committee Chairs, and Panel officers.

Roles of Board Officers/Committee Chairs/Panel Officers

- President**
- Spokesperson for the Medical Board (including but not limited to) – may attend legislative hearings and testify on behalf of the Board, may attend meetings with stakeholders and Legislators on behalf of Board, may talk to the media on behalf of the Board, and signs letters on behalf of the Board
 - Meets and communicates with the Executive Director on a regular basis
 - Communicates with other Board Members for Board business
 - Authors a president’s message in every quarterly newsletter
 - Approves Board Meeting agendas
 - Chairs and facilitates Board Meetings
 - Chairs the Executive Committee
 - Signs specified full board enforcement approval orders
 - Signs the minutes for each of the Board’s quarterly Board Meetings
 - Represents the Board at Federation of State Medical Boards’ meetings and other such meetings
- Vice President**
- Is the Back-up for the duties above in the President’s absence.
 - Is a member of Executive Committee
- Secretary**
- Signs the minutes for each of the Board’s quarterly Board Meetings
 - Is a member of Executive Committee
- Past President**
- Is responsible for mentoring and imparting knowledge to the new Board President
 - May attend meetings and legislative hearings to provide historical background information, as needed
 - Is a member of Executive Committee
- Committee Chair**
- Approves the Committee Agendas
 - Chairs and facilitates Committee Meetings
- Panel Officers**
- Chair – Chairs and facilitates Panel Meetings
 - Chair – Signs orders for Panel decisions
 - Vice Chair – Acts as Chair when Chair is absent

Chapter 5. Board Administration & Staff

Board Administration

(DCA Reference Manual)

Board Members should be concerned primarily with formulating decisions on Board policies rather than decisions concerning the means for carrying out a specific course of action. It is inappropriate for Board Members to become involved in the details of program delivery. Strategies for the day-to-day management of programs and staff shall be the responsibility of the Executive Director. Board Members should not interfere with day-to-day operations, which are under the authority of the Executive Director.

Strategic Planning

The Board will conduct periodic strategic planning sessions.

Executive Director Evaluation

(Board Policy)

Board Members shall evaluate the performance of the Executive Director on an annual basis.

Board Staff

(DCA Reference Manual)

Employees of the Board, with the exception of the Executive Director, are civil service employees. Their employment, pay, benefits, discipline, termination, and conditions of employment are governed by a myriad of civil service laws and regulations and often by collective bargaining labor agreements. Because of this complexity, it is most appropriate that the Board delegate all authority and responsibility for management of the civil service staff to the Executive Director. Board Members shall not intervene or become involved in specific day-to-day personnel transactions.

Business Cards

Business cards will be provided to each Board Member with the Board's name, address, telephone and fax number, and Web site address.

Chapter 6. Other Policies & Procedures

Board Member Disciplinary Actions

(Board Policy)

A member may be censured by the Board if, after a hearing before the Board, the Board determines that the member has acted in an inappropriate manner.

The President of the Board shall sit as chair of the hearing unless the censure involves the President's own actions, in which case the Vice President of the Board shall sit as President. In accordance with the Open Meeting Act, the censure hearing shall be conducted in open session.

Removal of Board Members

(B&P Code sections 106 & 2011)

The Governor has the power to remove from office, at any time, any member of any Board appointed by him or her for continued neglect of duties required by law or for incompetence or unprofessional or dishonorable conduct.

Resignation of Board Members

(Government Code section 1750)

In the event that it becomes necessary for a Board Member to resign, a letter shall be sent to the appropriate appointing authority (Governor, Senate Rules Committee, or Speaker of the Assembly) with the effective date of the resignation. Written notification is required by state law. A copy of this letter also shall be sent to the director of the Department, the Board President, and the Executive Director.

Conflict of Interest

(Government Code section 87100)

No Board Member may make, participate in making, or in any way attempt to use his or her official position to influence a governmental decision in which he or she knows or has reason to know he or she has a financial interest. Any Board Member who has a financial interest shall disqualify himself or herself from making or attempting to use his or her official position to influence the decision. Any Board Member who feels he or she is entering into a situation where there is a potential for a conflict of interest should immediately consult the Executive Director or the Board's legal counsel.

Board Members should refrain from attempting to influence staff regarding applications for licensure or potential disciplinary matters.

Gifts from Candidates

(Board Policy)

Gifts of any kind to Board Members from candidates for licensure with the Board shall not be permitted.

Request for Records Access

(Board Policy)

No Board Member may access the file of a licensee or candidate without the Executive Director's knowledge and approval of the conditions of access. Records or copies of records shall not be removed from the MBC's office.

Meetings with the Public and Interested Parties

(Board Policy)

Interested parties may request to meet with a Board Member on a matter or matters under the Board's jurisdiction. Members must remember that the power of the Board is vested in the Board itself and not with any individual Board Member. For that reason, Board Members are cautioned to not express their personal opinions as a Board policy or position or represent that the Board has taken a position on a particular issue when it has not. It is strongly suggested that Board Members disclose their attendance at any meeting of this type at the next scheduled Board meeting as identified in the next section, "Communication with Interested Parties".

Communication with Interested Parties

Board Members are required to disclose at Board Meetings all discussions and communications with interested parties regarding any item pending or likely to be pending before the Board. The Board minutes shall reflect the items disclosed by the Board Members. All agendas will include, as a regular item, a disclosure agenda item where each Member relays any relevant conversations with interested parties.

Media Inquiries

(Board Policy)

If a Board Member receives a media call, the Member should promptly refer the caller to the Board's Public Information Officer who is employed to interface with all types of media on any type of inquiry. Members are recommended to make this referral as the power of the Board is vested in the Board itself and not with any individual Board Member. Expressing a personal opinion can be seen as a Board policy or position and may be represented as the Board has taken a position on a particular issue when it has not.

A Board Member who receives a call should politely thank the caller for the call, but state that it is the Board's policy to refer all callers to the Public Information Officer. The Board Member should then send an email to the Executive Director indicating they received a media call and relay any information supplied by the caller.

Service of Lawsuits

The Board Members may receive service of a lawsuit against themselves and the Board pertaining to a certain issue (e.g. a disciplinary matter, a complaint, a legislative matter, etc.). To prevent a confrontation, the Board Member should accept service. Upon receipt, the Board Member should notify the Executive Director of the service and indicate the name of the matter that was served and any other pertinent information. The Board Member should then mail the entire package that was served to the Executive Director as soon as possible. The Board's legal counsel will provide instructions to the Board

Ex Parte Communications

(Government Code section 11430.10 et seq.)

Members on what is required of them once service has been made. The Board Members may be required to submit a request for representation to the Board to provide to the Attorney General's Office.

The Government Code contains provisions prohibiting *ex parte* communications. An “*ex parte*” communication is a communication to the decision-maker made by one party to an enforcement action without participation by the other party. While there are specified exceptions to the general prohibition, the key provision is found in subdivision (a) of section 11430.10, which states:

“While the proceeding is pending, there shall be no communication, direct or indirect, regarding any issue in the proceeding to the presiding officer from an employee or representative or if an agency that is a party or from an interested person outside the agency, without notice and an opportunity for all parties to participate in the communication.”

~~Occasionally, a~~An applicant who is being formally denied licensure, or a licensee against whom a disciplinary action is being taken, ~~will~~may attempt to directly contact Board Members.

If the communication is written, the member should read only enough to determine the nature of the communication. Once he or she realizes it is from a person against whom an action is pending, he or she should reseal the documents and send them to the Executive Director, or forward the email.

If a Board Member receives a telephone call from an applicant or licensee against whom an action is pending, he or she should immediately tell the person he or she cannot speak to him or her about the matter. If the person insists on discussing the case, he or she should be told that the Board Member will be required to recuse himself or herself from any participation in the matter. Therefore, continued discussion is of no benefit to the applicant or licensee.

If a Board Member believes that he or she has received an unlawful *ex parte* communication, he or she should contact the Board's assigned attorney or Executive Director.

Board Member Training Requirements

Upon initial appointment, Board Members will be given an overview of Board operations, policies, and procedures by Board Executive Staff.

(B&P Code section 453)

Every newly appointed Board Member shall, within one year of assuming office, complete a training and orientation program offered by the Department of Consumer Affairs. This is in addition to the Board orientation given by Board staff. This is a one-time training requirement.

(Government Code section 11146)

All Board Members are required to file an annual Form 700 statement of economic interest. Members must also complete an orientation course on the relevant ethics statutes and regulations that govern the official conduct of state officials. The Government Code requires completion of this ethics orientation within the first six months of appointment and completion of a refresher every two years thereafter.

(Government Code section 12950.1)

AB 1825 (Chapter 933, Statutes of 2004, Reyes) requires supervisors, including Board Members, to complete two hours of sexual harassment prevention training by January 1, 2006, and every two years thereafter.

Appendix 1

Board Member Responsibilities

Board members represent the State of California and although he/she is an individual member, Members have an obligation to represent the Board as a body. Each member should carefully consider each responsibility and time commitment prior to agreeing to become a Board Member.

Attending meetings (12-20 days per year)

- Attend all meetings; be prepared for all meetings by reviewing and analyzing all Board materials; actively participate in meeting discussions; serve on committees of the Board to provide expertise in matters related to the Board

Disciplinary Matters (12-40 days per year)

- Review and analyze all materials pertaining to disciplinary matters and provide a fair, unbiased decision; timely respond to every request for a decision on any disciplinary matter; review and understand the Board's disciplinary guidelines; review and amend the Board's disciplinary guidelines on a regular basis to align with the policies set by the Board

Policy Decision Making (included above)

- Make educated policy decisions based upon both qualitative and quantitative data; obtain sufficient background information on issues upon which decisions are being made; seek information from Board staff regarding the functions/duties/requirements for the licensees being overseen; allow public participation and comment regarding matters prior to making decisions; ensure public protection is the highest priority in all decision making

Governance (2-4 days per year)

- Monitor key and summary data from the Board's programs to evaluate whether business processes are efficient and effective; obtain training on issues pertaining to the Board (e.g. budget process, legislative process, enforcement/licensing process, etc.); make recommendations regarding improvements to the Board's mandated functions
- Participate in the drafting and approval of a Strategic Plan; oversee the Strategic Plan on a quarterly basis to ensure activities are being implemented and performed; monitor any new tasks/projects to ensure they are in-line with the Strategic Plan
- Provide guidance and direction to the Executive Officer on the policies of the Board; annually evaluate the Executive Officer; assist the Executive Officer in reaching the goals for the Board

Outreach (1-4 days per year)

- When approved by the Board, represent the Board in its interaction with interested parties, the legislature, and the Department of Consumer Affairs

Training (2 day per year)

- Obtain the required Board Member training, i.e. Board Member Orientation Training, Sexual Harassment Prevention Training, and Ethics Training

Total Time: 29 – 70 days per year

DCA Orientation: July 27, 2010

EXEC 5-19

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: March 21, 2013
ATTENTION: Members, Executive Committee
SUBJECT: Strategic Plan Update
STAFF CONTACT: Kimberly Kirchmeyer, Deputy Director

RECOMMENDED ACTION:

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

BACKGROUND AND ANALYSIS:

Attached is the progress on the Board's Strategic Plan, including a status on each item that has a current or past due date. As requested at the January, 2013 Executive Committee Meeting, the activities of the Objectives have been color coded to identify where they are in the process. The coding is as follows:

- Blue – Activity is complete (some may be ongoing too)
- Green – Activity is on schedule or has a future due date
- Yellow – Activity is close to being due and is still being completed
- Red – Activity is past due and still in progress

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

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

Activity	Date	Staff	Priority	STATUS
<ul style="list-style-type: none"> Provide annual CME audit statistics to the Medical Board members. 	Winter 2012	Licensing	A	7/20/12 – Provided to the Licensing Committee at the July 2012 meeting.
<ul style="list-style-type: none"> Examine and verify the current CME Audit effectiveness. 	Winter 2013 Fall 2014	Licensing	A	1/31/13 – This has not been completed, but in retrospect, this examination should be conducted at the same time as the review of Maintenance of Licensure options to determine if the Board should change its current process. 4/5/13 – Change due date to Fall 2014 in line with Objective 1.4 as outlined above.
<ul style="list-style-type: none"> Educate the Board and staff on current CME structure. Invite organizations that accredit CME [such as the Accreditation Council for Continuing Medical Education (ACCME), the Institute for Medical Quality (IMQ), or the American Board of Medical Specialties (ABMS) Boards and their member societies] to educate the members on how requirements have changed, what is required for course accreditation, and what is done to ensure compliance. If needed, revise the paper written in 2009, and distribute. 	Spring 2012	Licensing	A	7/20/12 - Presentation made at the July 2012 Licensing Committee meeting. 9/19/12 – Based upon feedback from the Licensing Committee, staff will be identifying presenters on CME that can make presentations at future meetings, beginning Spring 2013. 4/5/13 – Speakers to present beginning Spring 2013.

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

<ul style="list-style-type: none"> Examine current CME environment and California’s requirements to determine if they are relevant to keeping physicians current, including elements of the training that promote education in cultural issues that affect medical practice. 	<p>Summer 2012</p>	<p>Licensing</p>	<p>A</p>	<p>7/20/12 – Discussion after the above-mentioned presentation at the July 2012 Licensing Committee meeting. 9/19/12 – The Licensing Program will work with the Public Affairs Office to provide information to physicians on requirements for CME, methods of compliance, and opportunities for CME, as instructed by the Licensing Committee. 4/5/13 – Awaiting hiring of new PIO.</p>
<ul style="list-style-type: none"> Examine how CME requirements may relate to the Federation of State Medical Board’s (FSMB) Maintenance of Licensure (MOL) initiative. (See objective 1.4) 	<p>Winter 2012-13</p>	<p>Licensing</p>	<p>B</p>	<p>9/19/12 - The FSMB gave a presentation at the May 2012 Board meeting regarding MOL. There are other States beginning pilot programs for MOL. The Board will await the findings from these programs, but staff will report on progress as appropriate.</p>
<ul style="list-style-type: none"> Under the Board’s current regulatory authority, determine if the CME regulations are sufficient or need to be amended. 	<p>Winter 2013 Fall 2014</p>	<p>Licensing</p>	<p>A</p>	<p>1/31/13 – This has not been completed, but in retrospect, this examination should be conducted at the same time as the review for Maintenance of Licensure occurs. 4/5/13 – Change due date to Fall 2014 in line with Objective 1.4 as outlined above.</p>
<ul style="list-style-type: none"> Develop and promulgate regulations or develop and seek legislation, as appropriate. 	<p>Fall 2014</p>	<p>Licensing</p>	<p>A</p>	

Objective 1.2: Examine and identify methods available to the Medical Board to ensure physicians remain current in knowledge and skills.

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Educate the Board members and staff. Establish a workgroup, consisting of licensing and enforcement staff, to identify problems caused by physicians not remaining current. 	Spring 2013	Licensing	B	
<ul style="list-style-type: none"> Gather information about other states and other professions in their approach to this issue. 	Summer 2013	Licensing	B	
<ul style="list-style-type: none"> Identify the most feasible methods for the Board to promote licensees remaining current, and identify the Board's authority in taking action. 	Spring 2014	Licensing	B	
<ul style="list-style-type: none"> Draft an issue paper for the Board. 	Summer 2014	Licensing	B	
<ul style="list-style-type: none"> Depending upon the Board's authority, establish policies or programs, promulgate regulations, develop and seek legislation, or a combination. 	Fall 2014	Licensing	B	

Objective 1.3: Define what is necessary to promote safe re-entry into medical practice after extended absences.

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Conduct a review of current data, including the ongoing work of the FSMB, to determine what physicians re-entering practice after long absences need/require prior to resuming clinical practice. 	Spring 2012	Licensing	B	<p>9/19/12 - The FSMB gave a presentation at the May 2012 Board meeting regarding physician re-entry and discussion will ensue at future Board meetings. Staff is beginning to look into this issue to determine what steps need to be taken in California. This may be an issue discussed during Sunset Review.</p> <p>4/5/13 – Issue placed in Sunset Review Report</p>
<ul style="list-style-type: none"> Determine what the Board’s role should be, and how it should be involved in determining the safety of those reentering practice for the purpose of public protection. 	Winter 2013	Licensing	B	<p>1/31/13 – This is an issue that has been placed in the Sunset Review Report. Legislation may be introduced from the legislative review during 2013.</p> <p>4/5/13 – Sunset Review Committee has recommended the Board study the issue in light of consumer protection and make recommendations to the Committee. The Board needs to study and review what the FSMB has done.</p>
<ul style="list-style-type: none"> As necessary and appropriate, develop and promulgate regulations or develop and seek legislation. 	Spring 2013	Licensing	B	<p>4/5/13 – If study and review complete, then statute changes could be part of Sunset Bill.</p>

Objective 1.4: The Licensing Committee (or subcommittee) will examine the FSMB Maintenance of Licensure (MOL) and ABMS Maintenance of Certification (MOC) initiatives and study what should be adopted in California, and determine how it can collaborate with the FSMB and ABMS certifying boards.

Activity	Date*	Staff	Priority	Status
<ul style="list-style-type: none"> Appoint a subcommittee to evaluate the FSMB MOL Initiative and determine what is feasible in California. 	Fall 2012 2014	Licensing	B	9/19/12 - The FSMB gave a presentation at the May 2012 Board meeting regarding MOL and discussion will ensue at future Board meetings. There are other States beginning pilot programs for MOL. The Board will await the findings from these programs. The due date on these activities will need to change based upon FSMB pilot programs. The Board Manager appointed to the MOL issue will remain in contact with the FSMB and provide updates to the Board as appropriate. 4/5/13 – Change due date to Fall 2014.
<ul style="list-style-type: none"> Invite a participant in the FSMB Working Group to make a presentation to the Full Board/Committee. 	Winter 2013	Licensing	B	1/31/13 – Staff will be identifying someone to make a presentation at the Spring 2013 meeting regarding the FSMB Work Group on MOL. 4/5/13 – Not enough information has been gathered from the pilot programs. When more information is available, the Board will invite a speaker.
<ul style="list-style-type: none"> Conduct a study of other states’ actions relating to the FSMB MOL Initiative, and examine the experience of states participating in the FSMB pilot program. 	Winter 2013- Winter 2014	Licensing	B	1/31/13 – The pilot programs are just starting. As more information is received regarding the pilots, information will be provided to the Board during an update on MOL. In addition, information has been placed in the Sunset Review Supplemental Report regarding the pilot programs.
<ul style="list-style-type: none"> Identify what should be adopted in California, and examine what is needed for implementation. 	Fall 2014	Licensing	B	
<ul style="list-style-type: none"> Depending on what is determined to be needed, develop and promulgate regulations or develop and seek legislation. 	Winter 2015	Licensing	B	
<p>*The dates of these objectives may need to be reconsidered, as they are dependent upon when the FSMB has concluded and published sufficient data from their MOL pilot programs.</p>				

Objective 1.5: Conduct a comprehensive review of international schools.

Activity	Date*	Staff	Priority	Status
<ul style="list-style-type: none"> Establish a working task force including the Chief of Licensing and an experienced Medical Consultant. 	Winter 2012	Licensing	A	5/3/12 – Completed. The Chief of Licensing has established a task force.
<ul style="list-style-type: none"> An experienced medical consultant should present a history of the issue to the Board so that they may understand the law and history of off-shore medical school evaluation. 	Spring 2012	Licensing	A	7/20/12 – Presentation made at the July 2012 Licensing Committee meeting.
<ul style="list-style-type: none"> Staff to present a complete overview of the California Code of Regulations and educate the Board on the extent and limits of its legal authority. 	Fall 2011	Licensing	A	5/3/12 – Completed. A presentation was conducted at the October 27, 2011 Board Meeting. The presentation can be viewed at http://www.dca.ca.gov/publications/multimedia/mbc_20111027a.wmv
<ul style="list-style-type: none"> Identify those schools that may need site visits or additional information. 	Summer 2012- Winter 2014	Licensing	A	7/20/12 - The Licensing Program provided a plan to the Licensing Committee at the July 2012 meeting. 9/19/12 – The Licensing Program will provide updates to the Licensing Committee/Board on the status of the plan.
<ul style="list-style-type: none"> Research all international medical schools to create a comprehensive database. 	Summer 2012 - Summer 2014, ongoing	Licensing	A	9/19/12 – The Licensing Program has begun the research to develop this database now that the staff for this program has been hired and trained.
<ul style="list-style-type: none"> Update school names and locations on the Board’s database in instances where schools have moved or changed their names. 	Summer 2013	Licensing	A	4/5/13 – Staff are working on the updates to the Board’s database.

Objective 1.5 (cont.): Conduct a comprehensive review of international schools.

<ul style="list-style-type: none"> Update the schools' application process, including the surveys and evaluations, identify ways to expedite the approval process, and determine if application fees cover the Board's cost. 	<p>**Winter 2012-Summer 2012</p>	<p>Licensing</p>	<p>A</p>	<p>5/3/12 - Due to the lack of staff this review and update had been delayed until Summer 2012 – Fall 2012. 7/20/12 - Now that the staff has been hired for this program, they are beginning the process of reviewing the application, surveys, and evaluations. 9/19/12 – Due to the training period for staff and the Sunset review, this will not be completed until Summer 2013. 4/5/13 –This will be delayed due to the staffing need for the BreEZe project.</p>
<p>*The dates of these objectives may need to be reconsidered, as they are dependent upon the hiring and training of AGPA staff in Licensing. Tasks to be conducted in approximate 6 month intervals.</p>				

Objective 1.6: Conduct a literature review and internal study of the performance of physicians in training and how it may predict later performance in practice. (See objective 2.5)

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Review the 2004 report prepared by Maxine Papadakis M.D. on performance and behavior in medical school as a predictor of future practice problems. 	Winter 2014	Research Program Specialist	B	
<ul style="list-style-type: none"> Review disciplinary files in conjunction with licensing applications to determine if a link can be established between performance problems in medical school and future practice problems. 	Winter 2014 - Spring 2015	Research Program Specialist	B	
<ul style="list-style-type: none"> Evaluate whether such a study should be expanded or whether there is an opportunity with a medical school to do a retrospective study on the correlation between medical practice and behavior in medical school. 	Spring 2015	Research Program Specialist	B	
<ul style="list-style-type: none"> If there is significant data obtained, determine how the information may be communicated to those who may find it useful (Goal 3). 	Fall 2015	Research Program Specialist	B	

Goal 2: Regulations and enforcement: Protect the public by effectively enforcing laws and standards.

Objective 2.1: Develop a plan to conduct a complete review of all laws and regulations relating to licensing to identify those no longer relevant and what needs to be added or eliminated. Identify requirements that are not necessary to the safety of practice but may be serving as barriers for qualified applicants, as well as simply updating requirements to be congruent with current educational environments. (To be done in conjunction with Objective 2.2)

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Staff will develop an outline of priorities and a calendar/timeline for the evaluation of statutes and regulations, taking into account the timing for Sunset Review. (Including the development of an interested parties contact list for inclusion in discussions.) 	<p>Spring 2012 – **Fall 2012</p>	<p>Legislative/ Licensing</p>	<p>A</p>	<p>5/3/12 - The Chief of Legislation and Chief of Licensing developed a licensing staff task force and held an introductory meeting to discuss the process for reviewing the laws and regulations. A timeline will be established and presented at future meetings. 9/19/12 – The review of statutes will be part of the Sunset review process. However, due to the inability to move forward with hiring a legal counsel retired annuitant, a revised timeline, including regulatory changes, will need to be developed and presented in Spring 2013. 4/5/13 – Due to Sunset Review Report/Supplemental, this activity has not been completed.</p>
<ul style="list-style-type: none"> Schedule interested parties meetings by legal topic and statute/regulation under analysis. 	<p>Summer 2012 - Winter 2015</p>	<p>Legislative/ Licensing</p>	<p>A</p>	
<ul style="list-style-type: none"> Work is delegated to the Licensing Committee; updates provided to full Board as actions are needed. As each section of the evaluation concludes, proposals will be taken to the full Board for regulations to be promulgated and legislation sought. 	<p>Summer 2012 - Winter 2015</p>	<p>Legislative/ Licensing</p>	<p>A</p>	
<ul style="list-style-type: none"> As appropriate, develop and promulgate regulations; develop and seek legislation. 	<p>Various 2013-15</p>	<p>Legislative/ Licensing</p>	<p>B</p>	

Objective 2.2: Develop a plan to conduct a complete review of all laws and regulations relating to enforcement. Identify those laws /regulations that are no longer useful and augment those that are needed for public protection. Identify the Board's regulatory authority for promulgating new regulations and also identify those issues that require legislation. (To be done in conjunction with Objective 2.1)

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Staff will develop an outline of priorities and a calendar/timeline for the evaluation of statutes and regulations, taking into account the timing for Sunset Review. (Including the development of an interested parties contact list for inclusion in discussions.) 	Spring 2012 – Fall 2012	Legislative/ Enforcement	A	5/3/12 - The Chief of Legislation and Chief of Enforcement developed an enforcement staff task force and held an introductory meeting to discuss the process for reviewing the laws and regulations. A timeline will be established and presented at future meetings. 9/19/12 – The review of statutes will be part of the Sunset review process. However, due to the inability to move forward with hiring a legal counsel retired annuitant, a revised timeline, including regulatory changes, will need to be developed and presented in Spring 2013. 4/5/13 – Due to Sunset Review Report/Supplemental, this activity has not been completed.
<ul style="list-style-type: none"> Schedule interested parties meetings by legal topic and statute/regulation under analysis. 	Summer 2012 - Winter 2015	Legislative/ Enforcement	A	
<ul style="list-style-type: none"> Work is delegated to the Enforcement Committee; updates provided to full Board as actions are needed. As each section of the evaluation concludes, proposals will be taken to the full Board for regulations to be promulgated and legislation sought. 	Summer 2012 - Winter 2015	Legislative/ Enforcement	A	
<ul style="list-style-type: none"> As appropriate, develop and promulgate regulations; develop and seek legislation. 	Various 2012- 15	Legislative/ Enforcement	B	

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

Activity	*Date	Staff	Priority	Status
<ul style="list-style-type: none"> Initiate a review of the VEP performance data. 	Summer 2011	Enforcement	A	5/3/12 –In October 2011 a task force was established to review the Board’s enforcement data. This task force, made up of a Board Member, the AG’s office, and staff, will provide quarterly reports of their findings to the Enforcement Committee.
<ul style="list-style-type: none"> Begin to conduct a statistical analysis of performance in the various geographic areas on number of cases, number of personnel hours, and results, including the time taken in various steps of the process. Identify similar and inconsistent data in various regions. 	Summer 2011 - Fall 2012	Enforcement	A	5/3/12 – The review of the enforcement data by the task force has begun. However, the task force is awaiting further data from the Attorney General’s Office so a comparative review can be performed. 9/19/12 – The Board continues to work with the Attorney General’s office on reconciling the data provided. 4/5/13 – The data and a recommendation on the VEP was provided in the Supplemental Sunset Review Report.
<ul style="list-style-type: none"> Begin to conduct a statistical analysis of the enforcement timelines to indentify which steps may be delaying the process. 	Summer 2011	Enforcement	A	5/3/12 – See notes above – a task force has been established and it has begun to look at the timelines. The task force has identified the length of time it takes for the Central Complaint Unit expert review as an issue and steps are being performed to improve this delay. 4/5/13 – This will be an ongoing process as the Board continues to look for ways of reducing timeframes.
<ul style="list-style-type: none"> Compare the California process to other states’ and other California licensing Boards, including those handled by the Attorney General’s (AG) licensing section rather than Health Quality Enforcement Section (HQES). (As an example, how default decisions are handled.) 	Summer 2011- Fall 2012	Enforcement	A	5/3/12 – Board staff have begun to look at other states’ processes by reviewing information from the FSMB. Staff will also be looking at other California agencies’ processes. 9/19/12 – Staff continues to research the information from other states and will provide a report on the data in the future.

*Some of these dates will need to change to coincide with the Sunset Review Report, as a full VEP report will be provided at Sunset Review in Spring 2013.

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

<ul style="list-style-type: none"> Draft a report to the Board on the analysis of statistical data, including recommendations for actions by the Board to reduce the timeline, increase efficiency, and obtain better outcomes for public protection. 	Fall 2012	Enforcement	A	<p>9/19/12 – This report will need to be completed for the Sunset Review Hearing in Spring 2013, therefore the due date should change to Spring 2013.</p> <p>4/5/13 – The data and a recommendation on the VEP was provided in the Supplemental Sunset Review Report.</p>
<ul style="list-style-type: none"> Depending upon findings and within budgetary restraints, amend policies and procedures, promulgate regulations, or seek legislation. 	Fall 2012	Enforcement	A	<p>9/19/12 – This report will need to be completed for the Sunset Review Hearing in Spring 2013, therefore the due date should change to Spring 2013.</p> <p>4/5/13 - The data and a recommendation on the VEP was provided in the Supplemental Sunset Review Report.</p>

Objective 2.4: Examine complaint handling priorities. Educate Board members on how complaints are prioritized, as well as the legislatively mandated priorities. Determine if there is a need to change the priorities.

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Educate the Board members on the current policy and legislative priorities in complaint handling. 	Winter 2012	Enforcement	A	7/20/12 – Presentation made at the July 2012 Enforcement Committee meeting.
<ul style="list-style-type: none"> Review and evaluate the complaints and their relation to physician disciplinary action. 	Winter – Summer 2012	Enforcement	A	7/20/12 – The presentation above included information obtained by the Department of Consumer Affairs’ Internal Audits Office during their review of the Central Complaint Unit and its processing/complaint prioritization.
<ul style="list-style-type: none"> Present a report on review of complaint handling, including whether current priorities are congruent with public safety or what other priorities might better serve public protection. 	Summer 2012	Enforcement	A	7/20/12 – Presentation made at the July 2012 Enforcement Committee meeting.
<ul style="list-style-type: none"> Depending upon the Board’s authority and resources, amend policies, develop and promulgate regulations, or develop and seek legislation. 	Summer 2012- Spring 2013	Legislative/ Enforcement	A	<p>7/20/12 – Discussion will ensue after above presentations.</p> <p>9/19/12 – Discussion for guidance regarding complaint processing will be held at the Executive Committee meeting. Based upon input from Members, some of the recommended changes may be part of the Sunset Review Report.</p> <p>4/5/13 – Several recommendations were placed in the Sunset Review Report for areas of improvement that need legislative changes.</p>

Objective 2.5: Study disciplinary cases to identify trends or issues that may signal dangerous practices or risks. (Done in conjunction with Objective 1.6)

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Staff to perform a study to identify risk factors for patient harm and physician discipline. Study should examine disciplinary cases causing serious harm and determine if there are trends and “red flags” that could be used for the purpose of identifying patterns before serious harm occurs. 	Winter 2014 - Spring 2015	Research Program Specialist	B	
<ul style="list-style-type: none"> Report of study will be presented to the Board, including recommendations for establishing priorities, wellness initiatives, remedial actions, further study, other initiatives, etc. 	Spring 2015	Research Program Specialist	B	
<ul style="list-style-type: none"> Dependent upon findings and opinion of the board, and in keeping with the Board’s authority and resources, establish or amend policies and procedures, develop and promulgate regulations, or develop and seek legislation. 	Fall 2015	Research Program Specialist	B	

Objective 2.6: Examine the Expert Reviewer Program and policies to determine how it may be improved, including recruitment, evaluation of experts, opportunities for education, and policies governing the Board's use of experts.

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Evaluate, revise, and update the training program and materials for experts. 	Fall 2011	Enforcement	A	5/3/12 – The Enforcement Program has established a new Expert Reviewer Training Program, which will provide CME to the experts attending. At the February 2012 Enforcement Committee meeting a presentation on the components of this new training was provided.
<ul style="list-style-type: none"> Educate the Board as to the current policies, laws, and regulations governing the Expert Reviewer program. 	Winter 2012	Enforcement	A	5/3/12 - At the February and May 2012 Enforcement Committee meetings a presentation on the components of the new Expert Reviewer Training Program was provided.
<ul style="list-style-type: none"> Examine the training and evaluation measures, as well as policies to identify problem areas and those that should be amended. 	Spring 2012	Enforcement	A	7/20/12 - Board staff provided the new training to the Northern California Expert Reviewers on May 19, 2012. An update on the training was provided at the July 2012 Enforcement Committee meeting.
<ul style="list-style-type: none"> Examine the use of experts by other states and by other California boards and commissions. 	Spring – Fall 2012	Enforcement	A	5/3/12 – The Board will offer the Board’s Expert Reviewer Training Program to other states and will be obtaining any information regarding differences in the programs at that time.
<ul style="list-style-type: none"> Examine which policies and regulations (under the Board’s authority) should be amended to further the program’s efficiency. 	Fall 2012	Enforcement	A	9/19/12 – An evaluation will be performed after the roll out of this new program to identify where changes, if any, need to be made. After the first training provided in May, it was identified that more feedback needs to be provided to the experts after their review, testimony, and examinations. Enforcement staff is working on the implementation of this feedback process. 4/5/13 – On February 9 th training provided at the Irvine UC Med Center with over 100 attendees. Feedback will be reviewed to determine if any changes are needed.
<ul style="list-style-type: none"> Based on the study and review of the current program, as appropriate to the Board’s authority and resources, revise policies and procedures, promulgate regulations, or seek legislation. 	Fall 2012	Legislative/ Enforcement	A	4/5/13 – This will be an ongoing item. As more training is provided, the Board will continue to review the evaluations to determine what future changes need to be made.

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

Activity	Date*	Staff	Priority	Status
<ul style="list-style-type: none"> Evaluate the current training and information furnished to the Office of Administrative Hearing judges/hearing officers. 	Winter 2012	Enforcement	B	<p>5/3/12 – Completed. The Executive Director, Chief of Enforcement and a Board Member have reviewed the training being provided to the Administrative Law Judges (ALJ). Based upon this review, they have been working with the Presiding ALJs to identify training that would be appropriate for the ALJs.</p> <p>9/19/12 – The Board and OAH performed training for the ALJs on June 22, 2012. An update was provided at the July 2012 Enforcement Committee meeting.</p>
<ul style="list-style-type: none"> Conduct OAH training semiannually. 	Spring 2012 Ongoing	Enforcement	B	<p>7/20/12 – On June 22, 2012 the training was held and staff will continue this in the future, although it has been suggested that a full day of training may not be the best format on a semi-annual basis. Quarterly lunch presentations or half day sessions may work better for ALJ schedules.</p> <p>9/19/12 – In accordance with the request to have shorter training sessions, lunchtime training sessions are going to be provided on September 21, 2012 and October 19, 2012.</p> <p>1/31/13 – The Board has continued to assist OAH in providing training to the ALJs. This will be an ongoing effort throughout 2013. The next training is scheduled Spring 2013.</p> <p>4/5/13 – Training was provided February 19 and 21, 2013 and March 15, 2013.</p>
<ul style="list-style-type: none"> Examine disciplinary decisions to determine if they meet the Board’s mission to protect the public. 	Winter 2012- Spring 2012	Enforcement	B	<p>9/19/12 – Due to staffing vacancies and Sunset Review this item has deferred; however, it will begin during Spring 2013.</p>
<ul style="list-style-type: none"> Identify any inconsistent outcomes in disciplinary cases and present the findings to the Board. 	Spring 2012	Enforcement	B	<p>9/19/12 – Due to staffing vacancies and Sunset Review this item has deferred; however, it will begin during Spring 2013.</p>

<ul style="list-style-type: none"> Determine if the disciplinary guidelines are being utilized consistently or if the guidelines need amending to create greater consistency in decisions. 	<p>Spring 2012 -Fall 2012</p>	<p>Enforcement/ Research Program Specialist/ Legislative</p>	<p>B</p>	<p>9/19/12 – Due to staffing vacancies and Sunset Review this item has deferred; it will begin after the above studies are completed.</p>
<p>*The dates of implementation and completion of these tasks may need to be reconsidered, as they are dependent upon the hiring of the Supervisor I in the Standards & Training Unit in the Enforcement Program.</p>				

Objective 2.8: Work to clarify the Board's responsibility to regulate outpatient surgery centers, and obtain the resources to be effective.

Activity	Date *	Staff	Priority	Status
<ul style="list-style-type: none"> Evaluate the impact of SB 100. Begin developing goals and timelines for SB 100 implementation. 	Fall 2011	Licensing/ Enforcement	A	5/3/12 – Completed. The Chief of Legislation has worked with both the Chief of Licensing and the Chief of Enforcement on the implementation of SB 100. A presentation was provided at the Licensing Committee Meeting in February 2012 on the implementation of SB 100.
<ul style="list-style-type: none"> Examine the current Board responsibility and authority to regulate outpatient surgery facilities. Identify what can be done under current authority. Begin implementation of SB 100. 	Fall 2011- Fall 2012	Licensing/ Enforcement	A	5/3/12 – Completed initial review and will continue to evaluate the Board’s role with outpatient surgery facilities. 9/19/12 – Implementation has begun and will continue throughout the year. 1/31/13 – Implementation is complete and the Board will be evaluating the changes to determine if any other amendments are necessary.
<ul style="list-style-type: none"> Identify the resources needed to implement an effective program. 	Spring 2012	Licensing/ Enforcement	A	5/3/12 – Board staff will review the need for more investigators based upon this new legislation. If necessary, more staff will be requested. 9/19/12 – SB 100 must be fully implemented before the need for additional staff can be fully realized.
<ul style="list-style-type: none"> Communicate to all interested parties what is within the Board’s authority in regards to outpatient surgery centers and what is outside of the Board’s authority 	Spring 2012	Licensing/ Enforcement	A	9/19/12 – A presentation was made to the Licensing Committee in February 2012. Additionally, a presentation will be made at the July 2012 Enforcement Committee meeting. Both Committees will receive quarterly updates on this program.
<ul style="list-style-type: none"> Work with the Legislature to enact legislation or gain resources and procure what is necessary for California to have an effective program, ensuring a minimum standard of safety in outpatient settings. 	Fall 2012	Licensing/ Enforcement/ Legislative	A	4/5/13 - 4/5/13 – A presentation was provided at the February 2013 Board meeting. The Board will be evaluating the changes to determine if any other amendments are necessary.
<p>*Dates for these tasks are pending the hiring of staff for the outpatient surgery regulation program.</p>				

Objective 2.9: Examine Board responsibilities that could be eliminated or moved to a more appropriate board, bureau, or program. (Midwives, Registered Dispensing Opticians, Spectacle Lens Dispensers, Research Psychoanalysts, approval of non-ABMS specialty boards, etc.)

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Educate the membership about the Board’s authority over allied health professions. Staff should make a presentation at a Board meeting. 	Summer 2012	Executive	B	7/20/12 – A presentation was made at the July 2012 Licensing Committee meeting on the other allied health professions within the Board’s authority. 9/19/12 – The Licensing Committee asked for more information on these programs, which will be presented at the October 2012 meeting.
<ul style="list-style-type: none"> Identify those areas where the Board may not have sufficient expertise or resources to adequately provide consumer protection. 	Fall 2012 through Spring 2013	Executive	B	9/19/12 – This discussion will be part of the Executive Committee and the Sunset Review Report. 4/5/13 – The Sunset Review Report and the Supplemental Report identifies and includes the areas where the Board determined that its oversight should be changed.
<ul style="list-style-type: none"> Depending upon areas identified by the membership, seek legislation to move or eliminate responsibilities of the Board that appear to be inappropriate. (To be completed to coincide with Sunset Review.) 	Summer 2013	Executive	B	9/19/12 – This discussion will be part of the Executive Committee and the Sunset Review Report. 4/5/13 – The Sunset Review Report and the Supplemental Report identifies and includes the areas where the Board determined that its oversight should be changed. The Board will await language in the Sunset Bill.

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

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Review the history of Business and Professions Code (BPC) section 805 reports, the history of the law, statistical data, and how they relate to the Board’s disciplinary actions. 	Spring 2012	Research Program Specialist	c	<p>5/3/12 – Board staff have begun an internal study of 805 reporting and will provide a report to the Board at its October 2012 Board meeting. Based upon the study, this information may be provided to the legislature during the Sunset Review Hearings.</p> <p>9/19/12 – Preliminary review has begun on this issue. Based upon that information, this item will be discussed for guidance at the Executive Committee as a possible item for the Sunset Review Report. Due to Sunset Review, a report will not be provided until Summer 2013.</p>
<ul style="list-style-type: none"> Obtain information from those required to file BPC section 805 reports (individual hospitals, medical groups, societies and associations) and the reasons the reports have declined over the years. 	Spring – Fall 2012	Research Program Specialist	c	<p>5/3/12 – Board staff have begun an internal study of 805 reporting and will provide a report to the Board at its October 2012 Board meeting.</p> <p>9/19/12 – Preliminary review has begun on this issue. Based upon that information, this item will be discussed for guidance at the Executive Committee as a possible item for the Sunset Review Report. Due to Sunset Review, a report will not be provided until Summer 2013.</p>
<ul style="list-style-type: none"> Evaluate Peer review – what it does, how it impacts what the Board does, what institutions file BPC section 805 reports. 	Fall 2012	Research Program Specialist	c	<p>9/19/12 – Due to Sunset Review preparation, this will not be completed until Summer 2013.</p>
<ul style="list-style-type: none"> Study practices not subject to peer review to determine if quality of care can be monitored. 	Fall 2012	Research Program Specialist	c	<p>9/19/12 – Due to Sunset Review preparation, this will not be completed until Summer 2013.</p>
<ul style="list-style-type: none"> Invite the CDPH to share information on how they determine violations and how they may relate to compliance with B&P 805. 	Summer 2013	Research Program Specialist	c	

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

<ul style="list-style-type: none"> Review how other states handle peer review and mandatory reporting, and how, or if, they correlate with disciplinary action. 	<p>Summer 2013</p>	<p>Research Program Specialist</p>	<p>c</p>	
<ul style="list-style-type: none"> Determine if there are problems with the reporting system. Is there anything that could and should be done by the Board to improve patient protection by legislation, regulation, greater enforcement, greater investigatory authority, etc. Seek legislation, if needed. 	<p>Fall 2013</p>	<p>Research Program Specialist/ Legal/ Legislative</p>	<p>c</p>	

Goal 3: Consumer and Licensee Education: Increase Public and Licensee awareness of the Board, its mission, activities and services.

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

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Review the Board Web site to determine what can be improved. 	Winter 2012	Public Affairs	B	<p>5/3/12 – In January 2012, the new Public Information Officer (PIO) began looking at the Board’s Web site layout and identified improvements that are needed. The Board also has developed a Web Design Committee that meets to review the Web Site for improvements.</p> <p>7/20/12 - The PIO has developed a plan to implement the Objectives of Goal 3.1. This information was provided to the Education & Wellness Committee at its July 2012 Meeting.</p> <p>9/19/12 – A new format is expected from the Governor’s office that will be implemented in the new Board Web site.</p> <p>4/5/13 – This will be continued now that a new PIO has been hired.</p>
<ul style="list-style-type: none"> Utilize the Board Web site and newsletters to inform licensees of issues relating to legal responsibilities, changes in law and regulations, practice patterns and tools (telemedicine, translation methods and opportunities, etc.), issues of public health, and cultural and linguistic literacy. 	Fall 2012	Public Affairs		<p>7/20/12 – Feature articles and sections are a part of the Newsletter, keeping licensees informed via News 2 Use, Tech Corner, and World Pulse. New sections are being developed for future issues.</p> <p>9/19/12 – The Board continues to see cooperative opportunities with other agencies, Boards and Associations to identify issues that impact health care.</p>

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

<ul style="list-style-type: none"> Work with state, county and federal agencies to inform licensees. 	Fall 2012	Public Affairs	B	<p>7/20/12 - The PIO has developed a plan to implement the Objectives of Goal 3. This information was provided to the Education & Wellness Committee at its July 2012 Meeting.</p> <p>9/19/12 – The Board continues to work with state county and federal agencies to inform licensees about changes in the law. Articles about other agency’s programs have been written for publication in the MBC Newsletter.</p> <p>4/5/13 – This will be continued now that a new PIO has been hired and input received from the Education & Wellness Committee.</p>
<ul style="list-style-type: none"> Educate physicians about complying with the law. Initiate programs to promote the Board's information and programs to its licensees. If resources permit, send every physician a new handbook with license renewals. 	Fall 2012	Public Affairs	B	<p>4/5/13 – The Guide to the Laws Governing the Practice of Medicine is being updated and will be posted on the Board’s Web site by May 2013.</p>
<ul style="list-style-type: none"> Re-establish a speakers' bureau, and reinstitute the “teams of 2” consisting of one staff person and one board member to talk to professional meetings. (This can only begin after hire, resources, and travel restrictions are lifted.) 	Winter 2012	Public Affairs	B	<p>9/19/12 – After the Education & Wellness Committee in July 2012 the Public Affairs Unit is working to implement the MBC speakers’ bureau “Teams of 2” in Northern California. Once Teams of 2 are established, the Board will offer a catalog of speaking topics. This catalog will be made available to educational institutions and professional organizations that have a stake in the work of the MBC. Such groups will be asked to book a “Team of 2” presentation at a minimum of six months in advance. Teams and the catalog are projected to be available in late Spring 2013.</p> <p>4/5/13 – This will be continued now that a new PIO has been hired.</p>

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

<ul style="list-style-type: none"> Conduct outreach to various organizations such as hospitals and group practices through providing speakers or articles for their publications. 	<p>Spring – Fall 2012</p>	<p>Public Affairs</p>	<p>B</p>	<p>7/20/12 – Specific outreach was identified in the PIO’s plan provided to the Education & Wellness Committee at the July 2012 meeting. 9/19/12 – Outreach continues on a local basis. The Public Affairs Office continues to accept opportunities for outreach, the most recent occurring in August as the PIO participated in a Senior Scam Stopper program in Sun City, California. 1/31/13 – The PIO participated in a Senior Scam Stopper in Hayward in October. This will be continued upon the hiring of a new PIO. 4/5/13 – This will be continued now that a new PIO has been hired.</p>
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Objective 3.2: Improve public education by expanding current outreach efforts and initiating more outreach programs to educate the public on the board's programs, the rights of patients, and how to file complaints.

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Review the Board Web site to determine what can be improved. 	<p>Winter 2012</p>	<p>Public Affairs</p>	<p>C</p>	<p>5/3/12 – In January 2012, the new PIO began looking at the Board’s Web site layout and identified improvements that are needed. The Board also has developed a Web Design Committee that meets to review the Web Site for improvements.</p> <p>7/20/12 - The PIO has developed a plan to implement the Objectives of Goal 3.2. This information was provided to the Education & Wellness Committee at its July 2012 Meeting.</p> <p>9/19/12 - A new format is expected from the Governor’s office that will be implemented in the new Board Web site.</p> <p>4/5/13 – This will be continued now that a new PIO has been hired.</p>
<ul style="list-style-type: none"> Identify consumer education groups and publications to distribute Board material. 	<p>Various 2012-13</p>	<p>Public Affairs</p>	<p>C</p>	<p>9/19/12 – The Board of Pharmacy, the EDD, the California Medical Association, the California Department of Public Health, and MRMIB has agreed to distribute Board materials. Each of these groups will be adding a link to the Medical Board’s Website and reprinting articles from our Newsletter in their own publications.</p>
<ul style="list-style-type: none"> Schedule meetings with editorial boards of major media at least once a year; more, when necessary. 	<p>Various 2012-13</p>	<p>Public Affairs</p>	<p>C</p>	<p>7/20/12 – Phone discussions have occurred with KOVR 13, News10, Fox40, and KCRA3.</p> <p>9/19/12 – Meetings with editorial boards of major media organizations will be identified and will be scheduled to begin in November 2012. Due to the travel restrictions, phone and video conferencing will need to be utilized.</p> <p>4/5/13 – This will be continued now that a new PIO has been hired.</p>

Objective 3.2 (cont.): Improve public education by expanding current outreach efforts and initiating more outreach programs to educate the public on the board's programs, the rights of patients, and how to file complaints.

<ul style="list-style-type: none"> Update the content of brochures to reflect the current practice environment. 	<p>Various 2012-13</p>	<p>Public Affairs</p>	<p>c</p>	<p>7/20/12 – Brochures are being updated on a priority basis; working on the older ones or those requiring immediate updating first. 9/20/12 – Most recently updated are the, “How Complaints are Handled” brochure, and the “Guide to Laws Governing the Practice of Medicine” is being updated too.</p>
<ul style="list-style-type: none"> Work with other state agencies to provide Board materials to consumers 	<p>Various 2012-13</p>	<p>Public Affairs</p>	<p>c</p>	<p>7/20/12 – Relationships have been established with the California Medical Association, Los Angeles County Medical Association, Employment Development Department, Managed Risk Medical Insurance Board, and others will be identified. 9/12/12 – Relationships have been established with Contractors State Licensing Board and Board of Pharmacy, others will also be identified to provide Board materials for distribution. 4/5/13 – This will be continued now that a new PIO has been hired.</p>
<ul style="list-style-type: none"> Work with the Department of Consumer Affairs (DCA) and State and Consumer Services Agency (SCSA) to develop an integrated communications plan that would promote the Board and its services. 	<p>Various 2012-15</p>	<p>Public Affairs</p>	<p>c</p>	<p>9/19/12 – The DCA and SCSA work together on a regular basis to updated communications efforts. The Board will use DCA video production facilities for the purpose of public service announcements designed to promote public participation in the events of the Board and awareness of the Board and its programs. 4/5/13 – This will be continued now that a new PIO has been hired.</p>

Objective 3.2 (cont.): Improve public education by expanding current outreach efforts and initiating more outreach programs to educate the public on the board's programs, the rights of patients, and how to file complaints.

<ul style="list-style-type: none"> Explore the use of social media in outreach to the public. 	<p>Summer 2012</p>	<p>Public Affairs</p>	<p>^c</p>	<p>7/20/12 – This process has begun and the Board staff is exploring social media as a conduit to the public. This information was provided to the Education & Wellness Committee at its July 2012 Meeting. 9/19/12 – The Education & Wellness Committee requested more information. Background information for the evaluation of the need will be presented at the next Committee meeting. 4/5/13 – This will be continued now that a new PIO has been hired and input received from the Education & Wellness Committee.</p>
<ul style="list-style-type: none"> Add Board information to the California Healthcare Insurance Exchange Web site, with timing to be established after discussion with California Health Benefit Exchange (HBEX) Executive Director and the Board. 	<p>Fall 2013</p>	<p>Public Affairs</p>	<p>^c</p>	

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

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Establish a committee to work with staff and professional associations to promote the Expert Reviewer program through various methods, including articles in Board newsletters and other professional publications, speakers at facilities and professional societies, etc. (See Objective 3.1) 	<p>Fall 2011 Ongoing</p>	<p>Enforcement/ Public Affairs</p>	<p>A</p>	<p>5/3/12 - An article regarding this program was placed in the Spring 2012 Newsletter; and the Chief of Enforcement contacted a society that agreed to post an advertisement on its Web site educating members about the Program and seeking experts. 9/19/12 – The Newsletter and the Web site are being utilized to achieve this objective. With the launch of the social media campaign and the Teams of 2 speaker’s program, this effort will be expanded with a focus on the recruiting and educating physicians about the program and how to be involved. The Fall 2012 MBC Newsletter will contain an article seeking to recruit additional experts for the program. 1/31/13 – The Fall 2012 MBC Newsletter contained an article seeking to recruit additional experts for the program.</p>

Objective 3.4: Establish a more proactive approach in communicating with the media to educate consumers and publicize disciplinary cases and criminal investigations, including those done in cooperation with other agencies.

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Build relationships with major media so that all disciplinary cases are provided to the appropriate outlets. 	Winter 2012	Public Affairs	c	<p>5/3/12 – The PIO is reaching out to major media outlets to ensure that all disciplinary cases are provided to the appropriate individuals. News releases are sent to local media in close proximity to the disciplined physician’s practice location or the areas where the violation(s) occurred. Subscriber blasts also report disciplinary actions to media and interested parties.</p> <p>9/19/12 – The Public Affairs Unit uses every opportunity to educate media representatives on how to use the Board’s Web site and how to research information on physicians. The Public Affairs Unit will also continue to generate story ideas for journalists and producers and provide media outlets with video for use in news stories and broadcasts on the Web.</p> <p>4/5/13 – This will be continued now that a new PIO has been hired.</p>
<ul style="list-style-type: none"> Work with the DCA and the District Attorney’s office to establish joint news release procedures to use on joint investigations or actions. 	Winter 2012	Public Affairs	c	<p>5/3/12 – The PIO has begun to communicate with the DCA’s Public Affairs Office and will establish a procedure on joint actions. Relationships with the San Francisco and Los Angeles District Attorney’s Offices have been established.</p> <p>9/19/12 – News releases are distributed to DCA, and DCA is notified of any on camera or recorded interviews. The Board provides a week ahead report to DCA, informing them of any actions or anticipated events that would generate publicity to the positive or the negative.</p>

Objective 3.4(cont.): Establish a more proactive approach in communicating with the media to educate consumers and publicize disciplinary cases and criminal investigations, including those done in cooperation with other agencies.

<ul style="list-style-type: none"> When the budget allows, provide press kits about the Board to all media outlets. 	<p>Winter 2013</p>	<p>Public Affairs</p>	<p>c</p>	<p>9/19/12 – Press kits were distributed at the May and July Board Meetings and will be updated and distributed at all upcoming Board meetings. An electronic Press Kit is being designed for email distribution. 4/5/13 – This will be continued now that a new PIO has been hired.</p>
<ul style="list-style-type: none"> Participate in professional/public outreach programs (see Objective 3.2) 	<p>Various 2012-15</p>	<p>Public Affairs</p>	<p>c</p>	<p>7/20/12 – The PIO participated in a class at Sacramento State University discussing medical ethics 9/19/12 – The PIO participated in a Senior Scam Stopper outreach program in Sun City, California in August. 1/31/13 – The PIO participated in a Senior Scan Stopper in Hayward in October. 4/5/13 – This will be continued now that a new PIO has been hired.</p>

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

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Using focus groups, surveys, etc., evaluate how the current Newsletter is being utilized by licensees, what is useful and what is not. 	Spring 2012	Public Affairs	c	<p>7/20/12 – This item was addressed in the plan developed by the PIO and discussed with the Education & Wellness Committee at the July 2012 meeting.</p> <p>9/19/12 – The Fall MBC Newsletter will contain an online survey asking participants their opinions about content of the Newsletter and suggestions for expanded articles of interest. The extensive survey can be taken online and electronically tabulated, allowing the Board to have metrics to determine what sections of the Newsletter are of most interest to readers and how best to expand the Newsletter to meet the expectation of the readers. Once this information is gathered and analyzed, changes will be proposed to better reflect the needs of readers. This information will be provided to the Education & Wellness Committee.</p> <p>1/31/13 – The Fall Newsletter did contain the online survey. The information will be discussed at a future Education & Wellness Committee once the Board hires a new PIO.</p> <p>4/5/13 – This will be continued now that a new PIO has been hired.</p>
<ul style="list-style-type: none"> Allow applicants to receive the Newsletter by email or social media, as well as licensees. 	Various 2011-13	Public Affairs	c	<p>5/3/12 – Completed via email, social media pending. Currently, approximately 6,000 applicants and 89,000 licensees and interested parties receive an email alert each quarter when the Newsletter is posted online. The PIO is working on developing social media (Facebook, Twitter, etc.) for the Board and these will be used to inform readers that the most recent Newsletter is available online.</p>

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

<ul style="list-style-type: none"> Establish some kind of feedback for the Newsletters' content to determine who is reading it, and for what information. 	<p>Various 2012-13</p>	<p>Public Affairs</p>	<p>c</p>	<p>7/20/12 – Each Newsletter contains information that encourages feedback. Additionally, the Fall Newsletter will have a feature where the reader can “click” to provide a comment directly to the Board. 9/19/12 – When the new Board Web site goes live in late December, a direct link to the editor will be provided to make it easier to provide this feedback. 1/31/13 - The Fall Newsletter did contain the online survey. The information will be discussed at a future Education & Wellness Committee once the Board hires a new PIO. 4/5/13 – This will be continued now that a new PIO has been hired.</p>
<ul style="list-style-type: none"> Examine ways of promoting the Newsletter to encourage more readers. 	<p>Winter 2012</p>	<p>Public Affairs</p>	<p>c</p>	<p>7/20/12 – This item was addressed in the plan developed by the PIO and discussed with the Education & Wellness Committee. The Board currently sends out an email blast to subscribers and licensees notifying them of the Newsletter to encourage review/readership. 9/19/12 – Each edition promotes articles that are coming up in the next edition. Also, by creating reciprocal agreements with other boards, agencies, and associations, readership is expected to flourish, as these groups provide links to the Board’s Newsletter and the Board’s Web site. 4/5/13 – This will be continued now that a new PIO has been hired.</p>

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

<ul style="list-style-type: none"> Reach out to other agencies and foundations to contribute to the Newsletter. 	<p>Various 2012-13</p>	<p>Public Affairs</p>	<p>c</p>	<p>7/20/12 – Articles from the Employment Development Department, Board of Pharmacy, and Managed Risk Medical Insurance Board are included in the Summer Newsletter. 9/19/12 – The Fall Newsletter will contain a special section dedicated to Electronic Health Records from outside authors. Articles have been published from the Federation of State Medical Boards, the California Department of Public Health, the Center for Disease Control, and many others. Video and audio links have also been created in the Newsletter. 1/31/13 – The Fall Newsletter included a special section dedicated to Electronic Health Records from outside authors. 4/5/13 – This will be continued now that a new PIO has been hired.</p>
<ul style="list-style-type: none"> Incorporate into the Newsletter more information about Board activities, including encouraging attendance of Board meetings, topics discussed at meetings, and so forth. 	<p>Various 2011-15</p>	<p>Public Affairs</p>	<p>c</p>	<p>5/3/12 – Completed and ongoing. The two most recent Newsletters included information about both Board activities and topics at the Board Meeting, including pictures of presenters.</p>
<ul style="list-style-type: none"> Encourage professional associations and societies to include a link to the Newsletter. 	<p>Various 2011-13</p>	<p>Public Affairs</p>	<p>c</p>	<p>7/20/12 – This item was addressed in the plan developed by the PIO and discussed with the Education & Wellness Committee at its July 2012 meeting. 9/19/12 – As relations have been established with other groups, associations, and societies, requests are made to provide links to the Newsletter in their publications. 4/5/13 – This will be continued now that a new PIO has been hired.</p>

Objective 3.6: Expand the Web site capabilities to create a portal to provide intuitive and searchable web experience. Develop more online services and surveys to help improve Board's program (see Objective 3.2).

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Determine how and what can be done to improve the Web site and its search ability. 	Various 2012-13	Public Affairs / Information Systems Branch	B	4/5/13 - This will be a focus of the Board's new PIO.
<ul style="list-style-type: none"> Determine if the current Web site is user friendly and how it might be improved. 	Various 2012-13	Public Affairs / Information Systems Branch	B	4/5/13 - This will be a focus of the Board's new PIO.
<ul style="list-style-type: none"> Establish a program to periodically update frequently asked questions (FAQs) on the various subjects. 	Various 2012-13	Public Affairs	B	4/5/13 - This will be a focus of the Board's new PIO.
<ul style="list-style-type: none"> Identify what areas of the Web site are utilized, and if users are finding what they need. Provide a survey to users to provide feedback. 	Winter 2013	Public Affairs	B	4/5/13 - This will be a focus of the Board's new PIO.

Objective 3.7: Examine how the Board might provide training to the profession via the Internet, including hosting webinars on subjects of importance to public protection and public health.

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Determine the feasibility of providing courses and the priority of this venture. 	Winter 2013	Public Affairs	D	4/5/13 - This will be a focus of the Board's new PIO.
<ul style="list-style-type: none"> Work with DCA's current Information Officer and Public Affairs, to expand interactive webcasting. (As part of the Board's pro-rata funding) 	Winter 2013	Public Affairs	D	4/5/13 - This will be a focus of the Board's new PIO.

Objective 3.8: Establish a method of holding public seminars taught by legal or enforcement personnel on disciplinary cases, the laws violated, and other issues of importance to the profession and public.

Activity	Date*	Staff	Priority	Status
<ul style="list-style-type: none"> Establish a method or procedure to identify issues that could benefit from holding a public briefing. 	2014	Public Affairs	C	
<ul style="list-style-type: none"> Identify AGs, legal counsels, investigators, that should be called upon to develop and deliver briefings. 	2014	Public Affairs	C	
<ul style="list-style-type: none"> Work with DCA's current Information Officer and Public Affairs, to expand interactive webcasting. (As part of the Board's pro-rata funding) 	2014	Public Affairs	C	
<ul style="list-style-type: none"> Publicize the briefings to foster viewership. 	2014	Public Affairs	C	

Objective 3.9: Conduct outreach to ethnic and other language publications and groups.

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Identify the ethnic and cultural groups to be targeted. 	Summer 2012	Public Affairs	C	<p>7/20/12 – This item was addressed in the plan developed by the PIO and discussed with the Education & Wellness Committee at its July 2012 meeting.</p> <p>9/19/12 – A list of media opportunities is being compiled and expected to be completed in the Winter of 2013. The Executive Director provided a presentation to the National Hispanic Medical Association in August.</p> <p>4/5/13 – This will be continued now that a new PIO has been hired.</p>
<ul style="list-style-type: none"> Identify the media outlets for various ethnic groups and other-than-English publications, including community newspapers, radio, television stations, and web groups. 	Summer 2012	Public Affairs	C	<p>7/20/12 – This item was addressed in the plan developed by the PIO and discussed with the Education & Wellness Committee at its July 2012 meeting.</p> <p>9/19/12 – As these outlets are identified, the Board will provide materials to the entity in the language that represents their audience.</p> <p>4/5/13 – This will be continued now that a new PIO has been hired.</p>
<ul style="list-style-type: none"> Identify those in staff or on the Board who may be able to communicate with the targeted groups, either through language fluency, or cultural sensitivity. 	Summer 2012	Public Affairs	C	<p>7/20/12 – This item was addressed in the plan developed by the PIO and discussed with the Education & Wellness Committee at its July 2012 meeting.</p> <p>4/5/13 – This will be continued now that a new PIO has been hired.</p>
<ul style="list-style-type: none"> Establish a plan to coincide with the outreach to English language and general audience. 	Summer 2012	Public Affairs	C	<p>7/20/12 – This item was addressed in the plan developed by the PIO and discussed with the Education & Wellness Committee at its July 2012 meeting.</p> <p>9/19/12 – This activity will incorporate the Teams of 2 speakers program, giving the Board a greater opportunity to reach ethnic groups to explain what the Medical Board does and the services it provides for healthcare consumers.</p> <p>4/5/13 – This will be continued now that a new PIO has been hired.</p>

Goal 4: Organizational Relationships: Improve effectiveness of relationships with related organizations to further the Board’s mission and goals.

Objective 4.1: Improve relationships with elected officials and their staffs. Build and strengthen collaborative relationships to work toward common goals – create partnerships on areas of common interests.

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Develop a plan to visit legislators and their staffs with Board members, at the Capitol and field offices. 	Fall 2011	Legislative	B	1/31/13 – Completed and ongoing. The Chief of Legislation will report quarterly during the Legislative Report at the Board meetings on the status of any legislator visits.
<ul style="list-style-type: none"> Provide training and briefing to the Board members about the Board’s legislative initiatives, and who is contacted and why. 	Winter 2012	Legislative	B	1/31/13 – The Chief of Legislation will provide a briefing at each quarterly Board meeting regarding any legislative initiatives and discuss any interested party contacts.
<ul style="list-style-type: none"> Prepare Board members to be effective when communicating with legislators and their staff. 	Various 2012-13	Legislative	B	
<ul style="list-style-type: none"> Invite legislative field staff to board meetings, and visit field offices. 	Winter 2012	Legislative	B	1/31/13 – Completed and ongoing. The Chief of Legislation has continued to invite legislative field staff, in the area of the Board meeting, to attend the meeting. The Chief will report on the invitations at the quarterly Board meetings.

Objective 4.2: Work with California medical schools and training programs on common needs and goals. Create a better partnership with them on educational issues beyond licensing requirements, such as those relating to professionalism, ethics, unprofessional behavior, etc.

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Appoint a medical consultant(s) to work with staff and schools on developing a program to address ethical questions and emerging issues developing in the new practice environment (prescribing practices, enticements from pharmaceutical and medical device industries, boundary issues, social media, working for and in various industries, etc.). 	Winter 2013	Licensing/ Public Affairs	B	4/5/13 – The Chief of Licensing and the PIO will begin working on this. Preliminary discussions have taken place.
<ul style="list-style-type: none"> Survey Directors of postgraduate training programs and invite comment from all schools on issues they are identifying as troubling trends. 	2013	Licensing/ Public Affairs	B	
<ul style="list-style-type: none"> Develop issue/position papers in coordination with the medical schools on trends found, to be shared with medical students and licensees. 	Winter 2014 Ongoing	Licensing/ Public Affairs	B	

Objective 4.3: Work to establish better relationships with the accreditation agencies, associations representing hospitals and medical groups, professional associations and societies, the Federation of State Medical Boards, Federal government agencies, and other state agencies, including Department of Consumer Affairs and State and Consumer Services Agency.

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Identify areas of concern that may be of common interest among various organizations. 	Fall 2012	Executive	c	9/19/12 – After completion of the Sunset Review Report, the Executive Staff will develop a plan to meet with these interested parties to discuss common concerns/issues.
<ul style="list-style-type: none"> Schedule meetings with organizations to establish better relationships as needed, and driven by emerging issues of common interest. 	Fall 2012	Executive	c	9/19/12 – After completion of the Sunset Review Report, the Executive Staff will develop a plan to meet with these interested parties to discuss common concerns/issues.
<ul style="list-style-type: none"> Develop a communication plan for California agencies. 	2013	Executive	c	
<ul style="list-style-type: none"> Develop a communication plan for categories of agenda items for various groups. 	2013	Executive	c	
<ul style="list-style-type: none"> Utilize the “Teams of 2” or others in speaking to various professional groups. 	After lifting of travel restrictions.	Executive	c	

Objective 4.4: Improve educational outreach to hospitals, health systems, and similar organizations about the Board and its programs. Educate the health care profession not only about the Medical Board, but all of the health boards in the Department of Consumer Affairs. Re-establish a speakers' bureau or some other outreach for this purpose.

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Identify and create a database of those organizations and groups that the Board wants to target. 	2012	Public Affairs	C	9/19/12 – Due to the Sunset Review, this will not be completed until Spring 2013. 4/5/13 – This will be continued now that a new PIO has been hired.
<ul style="list-style-type: none"> Contact all appropriate practice groups, and associations and offer to provide speakers and contribute articles about the board for their newsletters or email broadcasts. 	2012	Public Affairs	C	9/19/12 – Due to the Sunset Review, this will not be completed until Spring 2013. 4/5/13 – This will be continued now that a new PIO has been hired.
<ul style="list-style-type: none"> Utilize the speakers' bureau, or "Teams of two" to speak at lunch meetings, dinners, etc., annual meetings, or conferences. 	2013	Public Affairs	C	
<ul style="list-style-type: none"> Work with various foundations and groups, such as the Hospital association, to provide information to their membership. 	Upon lifting of travel restrictions.	Public Affairs	C	

Goal 5: Organizational Effectiveness: Evaluate and enhance organizational effectiveness and systems to improve service.

Objective 5.1: Licensing applications to be reviewed within 45 days.

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Goal communicated to staff 	Fall 2011	Licensing	A	5/3/12 – Completed and ongoing. The Chief of Licensing has communicated this goal to all of his staff and provides weekly statistics to each of the staff to indicate where they are in meeting this goal.
<ul style="list-style-type: none"> Monitor reports to be automatically sent to managers, and report when review has not been conducted in a specified amount of days. 	2011 Ongoing	Licensing	A	5/3/12 – Completed and ongoing. The Chief of Licensing sends out weekly reports to the Licensing Managers.
<ul style="list-style-type: none"> Report to the Board at every quarter on the time taken to review licensing applications. 	2011 Ongoing	Licensing	A	5/3/12 – Completed and ongoing. The Chief of Licensing sends out weekly reports to the Board Members regarding the Licensing statistics. In addition, the Chief of Licensing will report at the quarterly Board meeting where the Licensing Program is with meeting this goal.

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

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Analyze current process, including breaking down types of cases by time taken for each element of the process. 	Winter 2012	Enforcement	A	5/3/12 – Completed. The Chief of Enforcement has put together reports to review the complaint process by each element by the type of case. Additionally, the Chief of Enforcement will report at the quarterly Board meeting where the Enforcement Program is with reaching the goal stated in the Objective title.
<ul style="list-style-type: none"> Identify reasons for delays in the Board's processes from complaint handling through disposition. 	Various 2012-13	Enforcement	A	5/3/12 – This is an ongoing process for the task force within the Enforcement Committee. The task force and staff have already identified delays and have worked towards resolutions to the delays. The first delay was the time for obtaining certified medical records in the district offices; legislation amended current statutes to require certified medical records from the onset of the complaint. Time frames for interviewing the respondent were also identified as an issue; legislation was implemented which strengthened the requirement for the respondent to attend the interview. Lastly, the task force has identified the time frames for the initial expert review to be a problem; staff is working on streamlining the process and asking for the reviews to be done more timely.
<ul style="list-style-type: none"> Research and identify best practices from other states' processing of complaints and disciplinary actions. Identify areas in California's system that may be unnecessary and slowing the process. 	Various 2012-13	Enforcement	A	

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

<ul style="list-style-type: none"> Research and identify best practices from other California boards' processing of complaints and disciplinary actions. Identify areas in the Board's system that may be unnecessary and slowing the process (including the use of the AG's Licensing Section in comparison to HQES). 	<p>Various 2012-13</p>	<p>Enforcement</p>	<p>A</p>	
<ul style="list-style-type: none"> Survey regional deputies and supervising investigators on management tools needed to better monitor investigation handling. 	<p>Various 2012</p>	<p>Enforcement</p>	<p>A</p>	<p>5/3/12 – This will be done during the research and analysis for the Sunset Report. 4/5/13 – This will need to be completed through the year to identify what tools are needed. This can be done at joint meetings with the AG’s Office.</p>
<ul style="list-style-type: none"> In conjunction with Objective 2.3, identify how VEP model may be amended if it is slowing the process. 	<p>Various 2012</p>	<p>Enforcement</p>	<p>A</p>	<p>4/5/13 - The data and a recommendation on the VEP was provided in the Supplemental Sunset Review Report.</p>
<ul style="list-style-type: none"> After analyzing all of the data collected, as appropriate, establish or amend policies and procedures, develop and promulgate regulations, or develop and seek legislation. 	<p>Winter 2013</p>	<p>Enforcement</p>	<p>A</p>	<p>4/5/13 - The data and a recommendation on the VEP was provided in the Supplemental Sunset Review Report. This may be part of the Sunset Bill</p>

Objective 5.3: Conduct a review of all outside agencies' billing (Department of Consumer Affairs, Attorney General, Office of Administrative Hearings, etc.) to identify redundancies, cost savings, and promote efficiency.

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Staff to prepare a report on all spending for past 4 years to all regularly used agencies (DCA pro-rata, Attorney General's HQES, and Office of Administrative Hearings) 	Spring-Fall 2012	Administration/Budget	B	7/20/12 – A new report was provided to the Board at the July 2012 Board meeting and ongoing.
<ul style="list-style-type: none"> Conduct an analysis of spending through the years, broken down by function and region, to identify trends, and possible inconsistencies, if any. 	Spring-Fall 2012	Administration/Budget	B	9/19/12 – This activity is intended to relate to the VEP. Staff is preparing reports that look at the spending for the prosecution of cases by the Attorney General's Office and the Office of Administrative Hearings. This information will be provided as part of the sunset report. 4/5/13 – This information will be provided at the April Board Meeting.
<ul style="list-style-type: none"> Identify areas that require discussion and examination by reviewing what areas have improved efficiency and those that have declined. (Incorporate data and analysis on VEP – see Objective 2.3) 	Spring-Fall 2012	Administration/Budget	B	9/19/12 – Staff is awaiting information from the Attorney General's Office on spending due to VEP and will compare to the reports prepared above. Additionally, staff will look into the spending at the Office of Administrative Hearings. 4/5/13 – This information will be provided at the April Board Meeting.
<ul style="list-style-type: none"> Establish a procedure to regularly evaluate the value of spending to outside areas. 	Spring-Fall 2012	Administration/Budget	B	9/19/12 – Staff has begun reviewing the billing to determine the value of VEP and also determining if the spending is commensurate to the activities of the Board (e.g. when more stipulations are occurring the spending at the Office of Administrative Hearings is decreasing). Staff will continue tracking the spending data and verifying that when reductions occur the Board sees the decreases in the billing provided by the outside agencies.
<ul style="list-style-type: none"> Establish a reporting method that will keep the Board updated, and also will be helpful in providing information at Sunset evaluation. 	Spring-Fall 2012	Administration/Budget	B	7/20/12 – A new report was provided to the Board at the July 2012 Board meeting and ongoing. Any findings will be reported to the Board during the quarterly meetings.

Objective 5.4: Conduct a review every two years of all of the Committees established by the Board to determine if they are still needed, if they are fulfilling the purpose of which they were established, and determine if they should continued, be eliminated, or be merged with other committees.

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Prior to new committee appointments by the Board President, the Board should conduct a review of all committees/subcommittees/task forces. 	Every Other Fall Board Meeting	Deputy Director	A	5/3/12 – Completed. At the February 2012 Board meeting a full evaluation was completed. The next evaluation will be Fall 2013.

Objective 5.5 Establish and conduct an annual self-evaluation.

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Staff will provide a report on the progress of the Strategic Plan, highlighting successes, failures, and those areas that should be eliminated, expanded, or amended. 	Fall 2012	Deputy Director	A	9/19/12 – An update on the Strategic Plan has been provided at each Board meeting since its adoption. 1/31/13 – In September 2012 it was determined that the update on the Strategic Plan would occur during the Executive Committee Meetings.

Objective 5.6: Establish a means of better educating staff about the Board's activities and priorities set by the membership, including encouraging staff to attend meetings.

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Executive Director to provide e-mail updates approximately every two months to inform staff of board activities and positions. 	2011 ongoing	Executive Director	C	5/3/12 – Completed and ongoing. The Executive Director has and will continue to send an email to all staff prior to each meeting.
<ul style="list-style-type: none"> At the time of the Agenda mailing, Division Chiefs will contact appropriate staff about the meeting, what will be on the agenda, and encourage attendance, where appropriate. 	Begin 2012	Division Chiefs	C	5/3/12 – Completed and ongoing. The Chiefs have begun to discuss the Board meetings with staff, and when meeting locations are nearby, staff will be encouraged to attend.

Objective 5.7: Establish a means of better educating the Board membership about operational activities by providing tours of headquarters, district or regional offices when they are at or near the location for Board meetings.

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> A report of these visits will be part of the Executive Directors/Enforcement Chiefs' report at the quarterly Board meetings. 	2011 ongoing	Executive Director	c	5/3/12 – As appropriate, the Executive Director will provide an update. 1/31/13 – Time does not allow for visits to the district offices during the Board meetings, thus Members will be invited to field offices when the Chief of Enforcement is on site for caseload reviews.
<ul style="list-style-type: none"> At the time of agenda mailing, Division Chiefs will arrange for a tour of facilities where appropriate. (Chiefs to arrange for a tour of district offices in areas outside of Sacramento, and a tour of headquarters when in Sacramento.) 	Begin 2012	Division Chiefs	c	5/3/12 – These tours will be conducted when the meeting locations are near the district offices, but may also need to be completed on an individual basis rather than during the full Board meeting.

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

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Continue the complaint survey and evaluate how it might be improved. 	Winter 2012 Ongoing	Research Program Specialist	B	9/19/12 – The Board will continue to send out the complaint survey form and will include information from it in the Sunset Review.
<ul style="list-style-type: none"> Establish a survey for newly licensed physicians about the application/licensing process 	Spring 2012 Ongoing	Research Program Specialist	B	9/19/12 – The Research Program Specialist has established a survey for newly licensed physicians using survey monkey. The results will be presented in the Sunset Review Report and will be presented to the Licensing Committee on an ongoing basis.
<ul style="list-style-type: none"> Establish a survey on the Web site on other areas, including the usefulness of the Web site 	Summer 2012 Ongoing	Research Program Specialist	B	9/19/12 – The Research Program Specialist has developed a survey for Web users and is working with the Public Affairs Office to finalize. A survey has also been developed for readers of the Board’s Newsletter. 4/5/13 – The survey will be placed on the Web site by the end of April.
<ul style="list-style-type: none"> Provide a report to the Board on the results at the time of the Annual report. 	Fall 2012 Ongoing	Research Program Specialist	B	1/31/13 – A report was provided at the October 2012 meeting to the appropriate Committees and will be provided on an annual basis.

Goal 6: Access to Care, Workforce, and Public Health: Understanding the implications of Health Care Reform and evaluating how it may impact access to care and issues surrounding healthcare delivery, as well as promoting public health, as appropriate to the Board's mission in exercising its licensing, disciplinary and regulatory functions.

Objective 6.1: Educate the Board on the new healthcare reform law and how it may impact physicians' practice, workforce (possible shortages), and utilization of allied healthcare professionals.

Activity	Date	Staff	Priority	Status
<ul style="list-style-type: none"> Invite appropriate speakers to address the Board about implementation of the Affordable Care Act in the State, and how it will impact care delivery in California. 	2011 Ongoing	Legislative	D	5/3/12 – Completed and ongoing. At the February Board meeting, a presentation was given by Catherine Dower, J.D. entitled “California’s Health Care Workforce – Are We Ready for the Affordable Health Care Act?” Future presentations will also be provided.
<ul style="list-style-type: none"> Ask appropriate associations to share their view of the changing practice environment due to healthcare reform (California Medical Association, California Hospital Association, California Association of Physician Groups, etc.) 	Summer 2012	Legislative	D	5/3/12 – Completed and ongoing. The California Medical Association provided a presentation at the July 2011 Board meeting entitled “Five Issues Facing California’s Physician Workforce”. Future presentations will also be provided.
<ul style="list-style-type: none"> Direct the Access to Care Committee to study the impact of healthcare reform and identify areas in which the Board can help, such as addressing shortages through telemedicine or publicizing programs to help those in underserved populations, etc. 	Spring 2013	Legislative	D	
<ul style="list-style-type: none"> Take appropriate action based on the remedies identified by the committee. 	Winter 2013	Legislative	D	