State of California

State and Consumer Services Agency

MEDICAL BOARD OF CALIFORNIA

April 25-26, 2013

Executive Committee	**April 25**	**8:00 am – 9:30 am**
Panel A	**April 25**	**9:30 am – 12:30 pm**
Panel B	**April 25**	**10:30 am – 12:30 am**
Enforcement Committee	**April 25**	**1:30 pm – 3:00 pm**
Full Board	**April 25**	**3:00 pm – 5:30 pm**
Application Review Committee	**April 26**	**8:30 am – 9:00 am**
Full Board	**April 26**	**9:00 am – 3:00 pm**

MEDICAL BOARD OF CALIFORNIA

QUARTERLY BOARD MEETING AGENDA

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

Hilton LAX
Los Angeles Room
5711 W Century Blvd
Los Angeles, CA 90045
310-410-4000 (directions only)

Thursday April 25, 2013
3:00 p.m. – 5:30 p.m.
(or until the conclusion of Business)

Friday, April 26, 2013
9:00 a.m. – 3:00 p.m.
(or until the conclusion 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.

ORDER OF ITEMS IS SUBJECT TO CHANGE.

Thursday, April 25th

1. 3:00 p.m. Call to Order/Roll Call

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

3. Approval of Minutes from the January 31 – February 1, 2013 Meeting

4. Presentations by Approved Accreditation Agencies (pursuant to the relevant sections of the Business and Professions Code and Health and Safety Code section 1248) – Mr. Worden and Mr. Heppler
   A. Accreditation Association for Ambulatory Health Care (AAAHC)
   B. American Association for Accreditation of Ambulatory Surgery Facilities Inc. (AAAASF)
   C. Institute for Medical Quality (IMQ)
   D. The Joint Commission

5. CLOSED SESSION (5:15 p.m.)
Pursuant to section 11126(e)(1) of the Government Code, the Board will meet in closed session to confer with its counsel regarding the following litigation:
WALKER v. ZELIG, CASE # No. 1 CA-CV 12-0395 – Yuma County Superior Court; Case No. S1400CV201100655

RECESS

Friday, April 26, 2013

6. 9:00 a.m. Call to Order/Roll Call

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

8. Consideration of Revised Regulatory Language for CCR, Title 16, Division 13, Chapter 2, Article 1, Section 1355.45 – Physician Incarceration and Inactive License; Notice to Medical Board – Mr. Heppler

9. Enforcement Process Overview: Role/Responsibilities of Physicians in the Enforcement Process – Ms. Cady, Ms. Sweet, Ms. Castro and Mr. Heppler

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

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

12. Update on Executive Committee; Consideration of Committee Recommendations – Dr. Levine

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

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

15. President's Report – Dr. Levine

16. Executive Director's Report – Ms. Whitney
    A. Update on Staffing and Administration
    B. Budget Overview – Ms. Kirchmeyer
    C. BreEZe Update – Ms. Kirchmeyer
    D. 2014 Board Meeting Dates

17. Discussion and Consideration of Teleconferencing of Medical Board Meetings – Ms. Kirchmeyer and Ms. Dobbs

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

19. Special Faculty Permit Committee Recommendation; Approval of Applicant – Dr. Low

20. Update on Midwifery Advisory Council – Ms. Sparrevohn

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

22. Enforcement Chief's Report – Ms. Threadgill
    A. Approval of Orders Following Completion of Probation and Orders for License Surrender During Probation
    B. Expert Utilization Report
    C. Enforcement Program Update
    D. Program Statistics

23. Vertical Enforcement Program Report – Ms. Castro
    A. Program Update
    B. HQE Organization and Staffing

24. Report on History of Business and Profession Code section 2220.7 (Gag Clause) – Ms. Whitney and Ms. Threadgill

25. Update on Enforcement Committee; Consideration of Committee Recommendations – Dr. Low

26. Update on Education Committee – Ms. Yaroslavsky

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

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

29. Update on Physician Assistant Board – Mr. Schunke

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

31. Agenda Items for July 18-19, 2013 Meeting in the Sacramento Area

32. Adjournment

Meetings of the Medical Board of California are open to the public except when specifically noticed otherwise in accordance with the Open Meetings Act. The audience will be given appropriate opportunities to comment on any issue presented in open session before the Board, but the President may apportion available time among those who wish to speak.

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

NOTICE: The meeting is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Lisa Toof at (916) 263-2389 or lisa.toof@mbc.ca.gov or send a written request to Lisa Toof. Providing your request at least five (5) business days before the meeting will help ensure availability of the requested accommodation.

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.

MEDICAL BOARD OF CALIFORNIA
QUARTERLY BOARD MEETING

Embassy Suites
San Francisco Airport
Mendocino & Burlingame Rooms
150 Anza Blvd.
Burlingame, CA 94010

Thursday, January 31, 2013

DRAFT MEETING MINUTES

Due to timing for invited guests to provide their presentations, the agenda items below are listed in the order they were presented.

Agenda Item 1 Call to Order/Roll Call

Dr. Levine, M.D. called the meeting of the Medical Board of California (Board) to order on January 31, 2013 at 3:55 pm. A quorum was present and due notice was provided to all interested parties.

Members Present:
Sharon Levine, M.D., President
Barbara Yaroslavsky
David Serrano Sewell, J.D.
Denise Pines
Dev GnanaDev, M.D.
Janet Salomonson, M.D.
Michael Bishop, M.D.
Reginald Low, M.D.
Silvia Diego, M.D.

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

Staff Present:
Susan Cady, Enforcement Manager
Dianne Dobbs, Department of Consumer Affairs, Legal Counsel
Tim Einer, Administrative Assistant II
Kurt Heppler, Staff Counsel
Kimberly Kirchmeyer, Deputy Director
Natalie Lowe, Licensing Manager
Armando Melendez, Business Services Analyst
Regina Rao, Business Services Analyst
Vic Sandoval, Investigator
Kevin Schunke, Licensing Outreach Manager
Jennifer Simoes, Chief of Legislation

Renee Threadgill, Chief of Enforcement
Lisa Toof, Administrative Assistant II
See Vang, Business Services Analyst
Linda Whitney, Executive Director
Curt Worden, Chief of Licensing

Members of the Audience:
Teresa Anderson, California Academy of Physician Assistants
G.V. Ayers, Consultant, Senate Business, Professions, and Economic Development Committee
Yvonne Choong, California Medical Association
Zennie Coughlin, Kaiser Permanente
Frank Cuny, California Citizens for Health Freedom
Julie D'Angelo Fellmeth, Center for Public Interest Law
Hank Dempsey, Chief Consultant, Assembly Business, Professions, and Consumer Protection Committee
Karen Ehrlich, L.M., Midwifery Advisory Council
Jack French, Consumers Union Safe Patient Project
Faith Gibson, Midwifery Advisory Council
Carol Godstein
Terry Jones, Supervising Deputy Attorney General
Tina Minasian, Consumers Union Safe Patient Project
Dr. William Norcross, M.D., UCSD, PACE Program
Dr. William Perry, M.D., UCSD, PACE Program
Loren Reed, Department of Consumer Affairs, Public Affairs Office
Robert Rowan, California Citizens for Health Freedom
Carrie Sparrevohn, Midwifery Advisory Council
Diana Taylor, University of California, San Francisco

Agenda Item 2 Public Comments on Items not on the Agenda

Yvonne Choong, California Medical Association (CMA), spoke about an issue raised at the Enforcement Committee meeting related to the Medical Board of California's (Board) enforcement of physicians conducting utilization review that does not meet the standard of care. This item was approved to be added to the Enforcement Committees for a future meeting agenda. CMA agrees with the Board's previous position that utilization review does constitute the practice of medicine primarily because these decisions directly impact the treatment received within the professional sphere of physicians. She also requested that the Board place this item on the agenda for a future full Board meeting to clarify the Board's jurisdiction over violations related to utilization review and how the Board can better allocate resources to provide oversight to utilization review and to consider legislative or regulatory changes that can improve the Board's enforcement authority in this area.

Agenda Item 3 Designation of the *Decision In the Matter of the Accusation Against Edward Spencer*, (Case #12-210205496) as a Presidential Decision.

Ms. Dobbs presented the case to the Board. An accusation against Dr. Spencer went to Administrative hearing. The Board adopted the Administrative Law Judge's decision stating the relevant facts in this case are: 1) the Board filed a petition to order a psychiatric evaluation for respondent; 2) The petition alleged that respondent's ability to safely practice medicine was impaired due to mental illness; 3) The Boards documents included an 805 report that was received from respondent's employer; 4) The respondent was not provided a copy of the petition and was not offered an opportunity to present argument in opposition of the decision; 5) In the Administrative Hearing, it was raised, that the respondent did not make himself available to be interviewed by the Board's Investigators and did not comply with order for evaluation.

At the hearing the issue was raised that the entire petition process was unconstitutional as it did not offer respondent opportunity to see materials that were presented and an opportunity to object to it. This case can be adopted as a Presidential Decision because the Administrative Law Judge highlighted in the decision why 820 does not require the documents to be provided to the respondent ahead of time and why not allowing respondent to participate in the process at that stage of the case was not a violation of their constitutional rights. Ms. Dobbs explained that this decision would provide guidance to all involved in similar cases. Ms. Dobbs then introduced the Deputy Attorney General, Jane Zack Simon, who was assigned to the Spencer Case.

Ms. Simon expressed why this case would be good to adopt as a presidential decision. It makes clear several important points: 1) Failure to comply with a Board order is in and/of itself unprofessional conduct and cause for disciplinary action under Business and Profession Code 2224; 2) The provisions routinely put in orders requiring licensees to be evaluated as ordered, but also to cooperate and provide the evaluator any information or records that the evaluator deems necessary to conduct a thorough investigation; 3) The Board is not required to provide the licensee the investigation and they are not entitled to the petition that goes to Board Members to determine whether they have reason to order an evaluation. These reinforce the confidentiality nature of the investigation and help avoid any compromise to the investigation during the investigative stage. Ms. Dobbs requested the Board to designate certain sections of that decision to include factual finding #1, 2, 5, 6 and 7 and the legal conclusions 1 – 5. Ms. Dobbs asked for a motion to make these the Presidential Decision.

Ms. Yaroslavsky made a motion to make this a Presidential Decision; s/Ms. Salomonson. Motion Carried.

Ms. Yaroslavsky asked if there was a way to put a stop practice on a licensee for a certain number of days if evaluation was not completed as ordered. Ms. Simon stated there would have to be a statue change for that to be an option. Dr. Low requested a discussion on setting a time line for a plan to work on possibly changing the current statute. Ms. Yaroslavsky requested a three month update as to how many cases have been affected by accepting this as a precedential decision.

DRAFT

Agenda Item 4 Presentation on the Aging Physician – Dr. Perry & Dr, Norcross

Dr. Levine introduced Dr. Perry and Dr. Norcross who have worked with the PACE program since 1996 when it began. Dr. Perry is a neurologist and has done many neurological psychological exams on aging physicians. He spoke about and provided a power point presentation on different aspects of assessing the aging physician. His topics included: 1) The aging physician population; 2) concerns of the aging physician; 3) report that states that three to five percent of the aging physician have some type of an impairment; 4) how the aging brain works and reacts to changes in cognitive processing and their impact on medical practice; 5) the goals of a Neuropsychological/Fitness for duty evaluation, and, 6) impairment vs. cognitive weakness.

Public Comment was received for this agenda item.

Carol Godstein asked Dr. Norcross to explain why the suicide for female physicians is higher than that of male physicians and asked if anyone is working on that issue.

Dr. Norcross responded that it is believed that depression is a factor, but that truly no one knows why the suicide rate is so high in women physicians.

Darryl Hopkins, physician at Stanford, stated his institution has been looking at the aging physician from the perspective of screening. Screening is the approach to look at the risk of the whole population or a subset of the population and then supply a screening test to that group to see if there is any problem. If something is found, then it can be investigated further.

Agenda Item 5 Licensing Committee Report

Dr. Salomonson gave an update on the Licensing Committee meeting held on January 31, 2013. The Licensing Committee discussed a new issue that has been brought to the Board's attention. The Accreditation Council Graduate for Medical Education (ACGME) now has an international branch as does the Royal College of Canada International (RCCI). The Board has a pathway for recognizing international medical schools but have always required post graduate education to be either ACGME or RCCI. It is an evolving area and the Board is asking licensing staff to keep it apprised. The other issue is regarding the merging of the Osteopathic Association post graduate training (AOA) and the ACGME. The Board's statutes do not accommodate this because of the wording of the statute, thus a change is needed to accommodate this is to add "hospitals that are accredited by the American Osteopathic Association" to Section 2089.5 of the Business and Procedures Code. Dr. Diego recommended that the name be changed to The Joint Commission or by any entity CMS deems appropriate.

Ms. Whitney asked that the staff be asked to research any other items that may need to go into that revision of that particular statute to ensure that the complete issue has been addressed.

Dr. Salomonson agreed. Mr. Worden explained that this will be included in the Sunset process and the language has to be open to include future entities. Dr. Salomonson requested a motion for a change in the wording of statute Section 2089.5 of the Business and Procedures code.

Dr. Levin made a motion for the change in wording; s/Yaroslavsky; motion passed unanimously.

Agenda Item 6 Enforcement Committee Report

Dr. Low gave an update on the Enforcement Committee held on January 31, 2013. Dr. Low reported that an upcoming expert training program will be held on Saturday, February 9, 2013 at UC Irvine. Another one is planned in San Diego sometime in the summer or fall. Dr. Low stated that there has been significant progress in the Central Complaint Unit in case processing time. The processing time has been reduced by 20 days since the July meeting.

The Board has contracted with a transcription service to assist the consultants in the report writing to help in expediting the process.

The Enforcement Committee discussed Senate Bill 1441, which calls for uniform standards for the DCA licensees who are identified as substance abusers. There were 16 areas that had to be addressed and some of those were determined by staff to not be applicable because the Board does not have a diversion program. It was pointed out that the Board may not be in complete compliance and the issue will be put as an agenda item for the next meeting.

Public comment was received for this agenda item.

Tina Manasian urged the Board to come into full compliance with SB 1441 as soon as possible.

Agenda item 11 Closed Session

Dr. Levine asked for a motion to recess into closed session: Ms. Yaroslavsky moved; s/Diego.

The open meeting ended at 5:40 pm and went into closed session.

Closed session adjourned at 6:05 pm.

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Dr. Levine, M.D. called the meeting of the Medical Board of California (Board) to order on February 1, 2013 at 9:08 am. A quorum was present and due notice was provided to all interested parties.

Members Present:
Sharon Levine, M.D., President
Barbara Yaroslavsky
David Serrano Sewell, J.D.
Denise Pines

Dev GnanaDev, M.D.
Janet Salomonson, M.D.
Michael Bishop, M.D.
Reginald Low, M.D.
Silvia Diego, M.D.

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

Staff Present:
Susan Cady, Enforcement Manager
Dianne Dobbs, Department of Consumer Affairs, Legal Counsel
Tim Einer, Administrative Assistant II
Kurt Heppler, Staff Counsel
Kimberly Kirchmeyer, Deputy Director
Natalie Lowe, Licensing Manager
Armando Melendez, Business Services Analyst
Regina Rao, Business Services Analyst
Vic Sandoval, Investigator
Kevin Schunke, Licensing Outreach Manager
Jennifer Simoes, Chief of Legislation
Renee Threadgill, Chief of Enforcement
Lisa Toof, Administrative Assistant II
See Vang, Business Services Analyst
Linda Whitney, Executive Director
Curt Worden, Chief of Licensing

Members of the Audience:
G.V. Ayers, Consultant, Senate Business, Professions, and Economic Development Committee
Carol Godstein
Carrie Sparrevohn, Midwifery Advisory Council
Diana Taylor, University of California, San Francisco
Faith Gibson, Midwifery Advisory Council
Frank Cuny, California Citizens for Health Freedom
Hank Dempsey, Chief Consultant, Assembly Business, Professions, and Consumer Protection Committee
Jack French, Consumers Union Safe Patient Project
Julie D'Angelo Fellmeth, Center for Public Interest Law
Karen Ehrlich, L.M., Midwifery Advisory Council
Loren Reed, Department of Consumer Affairs, Public Affairs Office
Phyllida Burlingame, American Civil Liberties Union of California
Robert Rowan, California Citizens for Health Freedom
Teresa Anderson, California Academy of Physician Assistants
Terry Jones, Supervising Deputy Attorney General
Tina Minasian, Consumers Union Safe Patient Project
Yvonne Choong, California Medical Association

DRAFT

Zennie Coughlin, Kaiser Permanente

Agenda Item 12 Call to Order/Roll Call

Dr. Levine, M.D. called the meeting of the Medical Board of California (Board) to order on February 1, 2013 at 9:08 am. A quorum was present and due notice was provided to all interested parties.

Agenda Item 13 Public Comments on Items not on the Agenda

Dr. Barnett provided a power point presentation in regards to a reprimand against him related to the gag clause law. He requested a full review by the Board, a written report of the findings and remediation to the full extent possible. Dr. Levine requested that this issue be put on a future agenda for full discussion.

Agenda Item 14 Approval on Minutes from the October 25-26, 2013 Meeting

Dr. Levine asked for a vote to approve the minutes; approved unanimously.

Agenda Item 15 Update on Activities of the Board of Pharmacy

Ms. Herold stated the Board of Pharmacy is working on Implementation California; a system to secure the drug supply chain, so that counterfeit, adulterated drugs do not end up reaching patients. It tracks product from the manufacturer through every change of ownership down the chain to the pharmacy, or to the practitioner level. This process will make it so that a drug will not be able to be sold in California after July 2017 unless it has been tracked all the way through the process.

At the recent Pharmacy Board meeting DEA's proposed guidelines for the drug take back program were reviewed. There are three different ways for the public to get rid of controlled substances that they no longer want or need. One is to mail them back to a reverse distributor, community take back events, and also through pharmacies. None of these are required, they are all voluntary and there is a cost, since the cost of disposing of the drugs is expensive.

The Board of Pharmacy sponsored a bill that will impact ambulatory surgery clinics that took effect in January, 2013. It will allow groups of physicians to apply to the Pharmacy Board for a co-mingle drug permit, which means the clinic can have a single stock of medication from which they can work. Without this bill being in place, physicians were unable to have a large stock of drugs. This bill will allow a co-mingle drug stock through a permit with the Board.

Agenda Item 16 Update on Joint Forum to Promote Appropriate Prescribing and Dispensing

Ms. Whitney gave a brief update on the number of people registered for the forum and stated there is a long waiting list. There will be Board Members from both the Pharmacy Board and the Medical Board attending. There are several speakers scheduled to discuss promoting appropriate prescribing and dispensing.

Agenda item 17 Presentation and Consideration of the Organ Donor License Plate Sponsorship

Ms. Zettel, CEO of Donate Life California, gave a presentation on the basics of organ and tissue donation and how these donations can save lives and improve the lives of others. She asked that the Board be an official honorary state sponsor as they work to establish a specialized license plate to increase awareness and raise money for organ and tissue donation, education and outreach. They are not asking for the Board to sponsor monetarily, but to have a link on the Board's web site homepage to promote the license plate campaign and information on organ and tissue donation.

Public Comment was received on this agenda item;

Ms. Godstein commented that she recently renewed her drivers' license and found that the new license did not have the pink dot showing that she is an organ donor and is concerned that her wishes will not be carried out. It was explained to her that the DMV requires that an individual check the "donate" box each time he/she renews a license to get the pink dot and that the lack of the dot does not mean that she is not listed in the electronic registry. Dr. Levine asked for a motion to accept the Board becoming an official state sponsor.

Dr. Salomonson made a motion for the Board to become a state sponsor; s/Dr. Gnanadev. Motion Carried.

Agenda Item 7 Executive Committee Update: Consideration of Committee Recommendations

Dr. Levine provided an update on the Executive Committee meeting held on January 31, 2013. The Executive Committee reviewed the Board Member Administrative Procedure Manual and asked staff to make some additions to the manual. One addition being a section that explains in more detail what the Board Members duties and responsibilities are. The Committee asked staff to work on and bring back recommendations to the Board for discussion at the next committee meeting on; 1) rolls of Members when responding to the media; 2) Members meeting with the public and interested parties; and 3) options on the best way for the public who are not in attendance of the meeting to provide written comments to the Board.

Public comment was received on this agenda item;

Jack French, Consumer's Union requested that the Board meeting minutes be posted within one week following the Board meeting so the public would have time to review them in a timely manner. He also requested that the Board post on its Web site the meeting itself as soon as possible following the meeting. He would also like the public to be able to submit requested

agenda items to the Executive Director and/or Board President up to 30 days prior to the scheduled meeting date. If the Board decides not to allow the requested item on the agenda, that the requestor be notified and that the denial of such be read into the Board meeting minutes at the following meeting.

Agenda Item 8 Update on Health Professions Education Foundation

Ms. Yaroslavsky and Dr. Diego gave a brief update stating the Foundation is doing well especially with the Steven Thompson loan repayment program. The foundation awarded over four million dollars in loan repayments with the help of matching funds. In the year 2011 there were 185 applicants and the foundation was able to award approximately 75 loan repayments. Ms. Yaroslavsky thanked the Board as well as the federal government for extra funding that was disseminated.

Agenda Item 9 Physician Assistant Board Update

Mr. Schunke gave an update from the Physician Assistant Board (PAB). The Physician Assistants committee has transitioned and is now a fully authorized Board under the Department of Consumer Affairs (DCA). They have almost 9000 licensed physician assistants (PA) in California. There were two regulation packages to be brought to the Board's attention. The regulation on preceptors in PA training programs has been approved by the Office of Administrative Law and becomes effective April 1, 2013. The second rulemaking is the sponsored free health care events. The hearing was held the last week of October, 2012 and the regulations are being finalized. The next PAB meeting is scheduled for February 11, 2013. The Executive Officer of the PAB retired in December and one of its current staff members, Glenn Mitchell, was promoted and is now serving as the new Executive Officer of the PAB.

Agenda Item 10 Update of Licensing Outreach/Education Program

Mr. Schunke reported that travel for the outreach program has been approved for 2013. Outreach has already begun to teaching hospitals throughout California and outreach has been scheduled for much of the year starting in February through November. The 2013 matrix has begun with the teaching hospitals which asks them to let the Board know residents who need a license by July of this year.

Agenda Item 18 Update on Legislation

A. 2013 Legislation

Ms. Simoes reported that there are 40 newly elected members of the Legislature and meetings will be set up with each of them in the month of February. In addition 12 of the 13 members of the Assembly Business and Professions Committee are new. Meetings will be scheduled with them as well. Ms. Simoes reported several important legislative deadlines. The Governor released a proclamation that calls for the legislature to hold an extraordinary session for purposes of implementation of the affordable care act of California, this session commenced on Monday, January 28, 2013.

There are two bills that need a position taken on them. SB 62 (Price) would require a coroner to report deaths, that may be the result of prescription drug use, to the Board, the Osteopathic Medical Board, the Podiatric Board of Medicine, the Physician Assistant Board, and the Board of Pharmacy. Staff recommends that the Board take a "support", if amended position, narrowing it to schedule II and schedule III drugs. Ms. Simoes asked for a motion.

Ms. Yaroslavsky made a motion for the Board to take a "support", if amended position on this bill: s/Ms. Levine; motion carried.

GV Ayers, Senate Business and Professions Committee Consultant, spoke briefly on what the Legislature is doing to pursue the SB62 bill by talking with coroners, etc. He will take the Board's recommendations back to the legislature and will take them into consideration.

Public Comment was received on this agenda item;

Yvonne Choong, California Medical Association, stated her concerns about the current language in the bill as well as the issue of overburdening coroners.

Ms. Simoes discussed SCR8 (DeSaulnier.) This concurrent resolution would proclaim the month of March, each year, as Prescription Drug Abuse Awareness Month and would encourage all citizens to participate in prevention programs and activities.

Ms. Yaroslavsky made a motion to take a "support" position on this Concurrent Resolution; s/Bishop; motion carried.

Maria Garcia spoke on behalf of California State Assembly Member Ben Wesoe in regards to the proposal of a bill not yet established to provide access to safe alternative treatments to cancer in California.

Frank Cuny and Robert Rowan spoke on their support for this bill that would provide access to safe alternative treatments to cancer and the patient's right to choose.

Diana Taylor, professor of nursing at University of CA San Francisco spoke on clarification of the bill related to midwives performing first trimester aspiration abortions. They have two recent reports of findings that were recently published in national peer review journals. The first one is in this month's issue of the American Journal of Public Health and the second will be in next month's issue of the American Journal of Medical Quality.

Phyllida Burlingame, American Civil Liberties Union of CA spoke on AB154 (Atkins). This bill has six organizational sponsors. The Author has been working with these organizations to create actual language for the bill. The purpose of the bill is to increase woman's access to early abortion care in California by authorizing advanced practice clinicians, nurse practitioners, certified nurse midwives, and physician assistants to provide early aspiration abortion care within the scopes of their licenses.

B. <u>Status of Regulatory Action</u>

Ms. Simoes pointed out the regulatory matrix and asked if there were any questions.

Agenda Item 23 BreEZe Update

Ms. Kirchmeyer introduced Mr. Rutschmann who is from DCA and the project manager of the BreEZe project. Mr. Rutschmann gave a detailed presentation on how the BreEZe project.

Public Comment was received for this agenda item.

Julie D'Angelo Fellmeth, Center for Public Interest Law expressed her concerns about whether the BreEZe system would interface with the Attorney Generals' office. Ms. Kirchmeyer stated the system has the functionality, but the Attorney General's office has to allow that interaction.

Agenda Item 19 Board Member Communications with Interested Parties

Dr. Levine requested that Mr. Heppler explain in more detail what interested party communication means. Mr. Heppler stated that interested party communication means a meeting that entails discussing something that falls within the jurisdiction of the Board.

Dr. Levine called a recess for lunch at 11:40 am.

Meeting reconvened at 12:15 pm

Agenda Item 20 President's Report

Dr. Levine reported that Ms. Yaroslavsky, Ms. Whitney and she attended a meeting with the State and Consumer Services Agency (SCSA) and the Governor's Office Staff to discuss the Board's enforcement program and issues related to appropriate prescribing. Dr. Levine described the intent, of the upcoming joint forum on prescription drugs and what the Board can do to try and address the epidemic of opioid death.

Dr. Levine stated that at the last Board Meeting she was mentioned she was scheduled to attend two separate meetings looking at undergraduate and graduate medical education. Specifically whether or not we would need to look at a statutory change. As statute is currently written, it conforms to current practice of four years of undergraduate education, four years of medical school with the growing cost of medical education, there are schools around the country looking to see if curriculum changes could compress the total time of undergraduate and medical school educate without the sacrifice of quality of medical education and the preparedness of graduates to come out of those programs. There are not any answers at the moment and that there will be pilot efforts. The Board should follow this with interest.

Dr. Levine and Ms. Whitney attended a meeting sponsored by the Federation of State Medical Board (FSMB) that focused on the national licensure and whether the time is right for some kind of federal licensure. She reported that none of the people at the meeting from a state perspective felt there was a need for federal licensure. There was an interest in signing contracts between states under what

conditions a physician licensed in one state can care for patients in other states, particularly around border states and physicians who may have patients come from state border towns.

Agenda Item 25 Review and Consideration of Request for Recognition; Medical University of Warsaw – English Language Program

Mr. Worden reported that the University of Warsaw had requested recognition by the Board for their English Language Program. The Board has already recognized the University of Warsaw for their Polish Language Program. Mr. Worden gave a brief detailed background and history of the school and then introduced Dr. Silva who gave a detailed evaluation of how this school meets the criteria for recognition.

Ms. Yaroslavsky made a motion to the Board to recognize this school; s/Levine. Motion carried.

Agenda Item 21 Update of Federation of State Medical Boards

Ms. Whitney reported that the Federation of State Medical Boards (FSMB) sent out a draft white paper policy brief regarding licensing models to facilitate the multi-state practice of medicine meeting they held. Comments were provided to the FSMB and as it develops its final position paper, it will be shared with the state Boards for the April FSMB meeting. Ms. Whitney continues to serve on the committee that is developing model data sets for state Boards to track work force data.

The committee will survey all state Boards in the near future to determine who collects what data, and is looking at cost to implement such a system for states that do not collect that data. This information will be presented at the April FSMB meeting.

Ms. Whitney reported that the executive staff participated in a round table conference regarding the Federal Trade Commission activity around the scope of practice issue. As updates are available, they will be presented to the Board.

Agenda Item 22 Executive Director's Report

A. Update of Staffing and Administration

Ms. Whitney recognized and thanked Tim Einer for his excellent work with the Medical Board as he is leaving the Board. Ms. Whitney announced Mr. Einer's replacement as Lisa Toof who came from the High Speed Rail where she supported the CEO and Board Members.

Ms. Simoes has been acting as the Board's public information officer and hopes to have that vacant position filled by the end of February. Mr. Heppler has moved to a position at DCA and the Board is in the process of backfilling his position. Approval for his position is pending. Monthly update meetings have been set up with the DCA's Director's Office to keep them informed of emerging policy issues related to the Board and medicine. Executive staff is participating in weekly calls with DCA related to the launch of the BreEZe program. Ms. Whitney and Ms. Kirchmeyer attended the quarterly executive officer meeting in November, 2012. Issues at this meeting included pension reform and the impact on current and future employees. Another topic

was the Franchise Tax Board top 100 delinquent tax payers and how the DCA is implementing that legislation for the Board because some individuals might be suspended. The BreEZe project and its upcoming launch date was discussed. The next meeting is scheduled for March, 2013.

Ms. Whitney and Ms. Threadgill met twice with the SCSA in regards to enforcement issues related to ISO's, excessive prescribing, vehicles and staffing. These meetings were in addition to the meeting that Dr. Levine attended and mentioned earlier. Mr. Terry Jones was named acting Sr. Assistant Attorney General upon the retirement of Carlos Ramirez in December 2012. Ms. Whitney continues her bi-weekly calls with Mr. Jones to discuss cases, processes and issues that have come up within the past two weeks.

Dr. Levine announced that International Association of Medical Regulatory Authorities, which is the sister agency of the FSMB has asked Ms. Whitney to assist them in identifying physicians for a newly formed international academy for Continuing Medical Education and Consumer Professional Development accreditation.

B. Budget Overview

Ms. Kirchmeyer reported on staffing issues currently taking place at the Board. The Board is in the process of hiring seasonal employees and permanent intermittent staff to replace the loss of the student assistants and retired annuitants. The Board is recruiting for the Consumer Protection Enforcement Initiative position which is still going through the process at DCA.

Ms. Kirchmeyer announced that the April, 2013 Board meeting will be held at the Hilton at LAX. Staff is working on securing the Marriott in Sacramento for the July, 2013 meeting.

Staff is working with the University of California, San Francisco on a survey regarding electronic health records that will be sent to all licensees who renew in June and July of this year. This will be the second survey that has been sent out on electronic health records. Once information is gathered, a presentation will be made to the Board with the findings.

Ms. Kirchmeyer reported on budget issues. The Board's fund reserve at the end of the fiscal year is projected to be 4.3 months. The Board has one augmentation request moving forward and that is for the BreEZe system. Per this projection, the Board will be very close to its mandated 2-4 months reserve at the end of this year and within mandate next fiscal year, therefore it is not prudent at this time to consider any reduction in licensing fees at this time as previously recommended by the Bureau of State Audits. The Board's spending is currently in line with its budget.

Mr. Kirchmeyer announced that the Board received a letter from the Reserve Officer Training Corp. program in Ramona, CA. The letter thanked the Board for its donation of computers to its cyber warfare team. Due to the Board receiving new computers, the old computers were donated to a high school ROTC program.

Agenda Item 24 Licensing Chief's Report

A. Staffing

Mr. Worden thanked the licensing staff for doing an outstanding job these past several months. He then gave a brief report on staffing stating that there are only three vacancies. Staff is working on interviewing and hiring permanent intermittent positions to replace the student assistants and retired annuitants that were no longer able to work.

B. Program Statistics

Mr. Worden discussed the licensing program statistic. The licensing staff answered 20,578 phone calls and the Board received 1,715 new physician and surgeon applications for the quarter. The Board completed initial review on 1,791 applications and there were 1,264 new licenses issued. The Board is meeting the strategic plan goal.

C. Status of International Medical School Programs

Mr. Worden gave a brief update on status of the International Medical School Program stating that the Board has a list of schools that are currently being reviewed and these schools are on the list because they have applicants who have attended those schools or the Board has self-assessment from those schools. There are 98 international schools in pending status, 9 self-assessment reports which must have a medical consultant review. The Board has been able to recognize 33 international medical schools in the quarter that met the definitions of 1314.(A)(1).

D. Status of Free Health Care Event Program

Mr. Worden gave an update of the Free Health Care Event Program. The Board is the first Board to pass regulations for this program. The Board is ready to start accepting applications. It has been notified by DCA that there are two free health care events coming up in California; one in Riverside county April 4-7, the other in Santa Ana April 11-14.

Agenda Item 26 Midwifery Advisory Council Update and Consideration of Council Recommendations

Ms. Sparrevohn gave a detailed update on the Midwives Alliance of North America (MANA) statistics project. The report included how data is collected and how data is compared to other like databases that are used nationwide. A legislative change in Business and Professions Code section 2516 would be required to make the MANA system available to midwives. She asked that the Board request a change in the statute during the Sunset Review process.

Public Comment was received on this agenda item.

Shannon Smith-Crowley, American Congress of Obstetricians and Gynecologists expressed her concerns about changing over and/or merging the two databases together.

Karen Erhlich, Midwife Advisory Council (MAC), stated that she is the one who brought this project to the table because she feels the way things are being reported now is not the quality that is should be.

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The MANA system will offer much more detailed information because registration will happen prospectively.

Yvonne Choong, CMA stated she believes that the current system does have issues, but contracting it out to a non-state entity may not be the solution. She recommends that the Board consider mechanisms for improving the database system.

Faith Gibson, Midwifery Advisory Council (MAC) gave some brief history of how this issue began. She stated there were some conversations at the Board regarding reporting by midwives in order to have statistics on the practice of midwifery. She assisted in creating the current reporting mechanism that is in law now. She encouraged the Board to approve the use of the MANA system and said it will give the members the information that they need.

Ms. Yaroslavsky recommended to the Board that they consider amending the Business and Professions Code section 2516 to use the MANA prospective data collection taking into account the funding as well as the advice they have heard today.

Ms. Yaroslavsky made a motion to amend the Business and Professions Code; s/Serrano-Sewell. Motion carried.

Ms. Sparrevohn also reported the MAC is hoping to get an amendment to Business and Professions Code section 2514, to allow Certified Nurse Midwives (CNM) to supervise midwife students. Currently, physicians and licensed midwives are allowed to supervise but CNM's are not included.

Public comment was heard on this agenda item;

Yvonne Choong, CMA recommended that it be clear the intent is to have the CNM who is supervising midwife student would be acting in lieu of the physician or licensed midwife.

Ms. Sparrevohn clarified that the statute right now reads that it is either physicians or licensed midwives who can act as a supervisor, the MAC just wants to add that CNM's can also act in a supervisory role.

Ms. Yaroslavsky made a motion to include Nurse Midwives as supervisors of midwifery students; s/Pines. Motion carried.

Ms. Sparrevohn provided the items the MAC is requesting for the March meeting. In addition to normal "housekeeping" type items, she would like to continue an ongoing discussion on the students and assistants issue and hear from interested parties on those issues. Also continue discussion on the MANA statistics in order to discuss in which the Board has questions. Lastly, the MAC would like an update on the Sunset Review process by staff. Ms. Sparrevohn would also like to create some written material on licensed midwives that can be distributed to new Board Members.

At this time, Dr. Levine took a moment to welcome and introduce the Board's newest member, Felix Yip, M.D.. Dr. Levine also swore in Dr. Yip.

Agenda Item 27 Update on Outpatient Surgery Centers Program

Mr. Worden provided some general information and background on outpatient surgery centers, including accreditation requirements. Some centers are not required to be owned by licensed physicians or surgeons; however, an outpatient surgery center that is not owned by licensed physicians or surgeons may not employ physicians or surgeons. Minimum requirements for outpatient surgery centers are set in statute. Accreditation agencies may require additional minimum requirements to meet the specific requirements for that specific agency. Accreditation agencies are required to inspect an outpatient surgery center at least once every three years. Accreditation agencies are required to report to the Board when the accreditation agency denies an existing surgery center's accreditation. A complaint against an outpatient surgery center is not necessarily a complaint against a physician.

The Board's licensing, enforcement, and legal staff met with California Department of Public Health (CDPH) in November, 2012 by telephone regarding outpatient surgery center's adverse action reports and complaints received by CDPH. In December, the Board's Executive Director sent correspondence to the CDPH's Director informing him that the Board had not received any adverse actions or complaints from the CDPH and requested that CDPH send all adverse actions or complaints that are not within its jurisdiction to the Board's Central Complaint Unit Manager.

Licensing is continuing to work with the four accreditation agencies to provide the necessary information to be in compliance with the current statutes. Three of the four agencies have met most of the requirements. The Board will continue to work with these agencies. Licensing will be focusing most of its attention on the accreditation agency that has not proceeded with meeting the minimum requirements. The Board's Web site is updated when the Board receives new information from the accreditation agency. The Board also receives a monthly update from each accreditation agency. The Board will not be posting information that happened prior to January 1, 2012 on the Web site as the statute is not retroactive. As of December 31, 2012, there are 1,181 accredited outpatient surgery centers.

Dr. Salomonson requested that each accreditation agency give a brief presentation at a future Board meeting to help the Board understand how vigorous the accreditation process is.

Ms. Threadgill reported that the Central Complaint unit would process the complaints that are received from the outpatient surgery centers; to date, however, the Board has not received any adverse action reports from CDPH. The Board has received two complaints regarding possible unaccredited outpatient surgery centers. The Board does not monitor the length or complexity of surgeries performed in the outpatient surgery centers.

Public comment was received on this agenda item.

Tina Manasian, Consumers Union, expressed her concerns on physician owned ambulatory surgery centers. She is pleased that the Board has chosen to post final inspection reports on the Web site. She urged the Board to require staff to update the Web site so that the section on accreditation of physician owned ambulatory surgery centers contains the information required by state law. She noted that on 18 of the first 25 surgery centers that came up when one enters the phrase "surgery center", no physician owned is listed. Also seven of the 25 indicated "non-reported" for accreditation. She stated

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the missing data occurs with each accrediting agency. She asked how the Board is planning on working with the CDPH to keep informed regarding accreditation issues such as violating standards of care, and reported about adverse events. She stated that on a recent call between the Consumers Union, CDPH and the Board, there seemed to be a misunderstanding between the two agencies about where the responsibility lies for notification of physicians of new responsibilities regarding reporting of adverse events and for imposing required fines for non-reporting. She requested the Board provide a link on the Web site home page to information about physician-owned ambulatory surgery centers and their related accredited information. Also the page that does link to the information required by SB100 should be more consumer friendly.

Agenda Item 28 Enforcement Chief's Report

Ms. Threadgill requested a motion from the Board for approval to restore 10 licenses to clear status following completion of probation.

Ms. Threadgill requested a motion to restore 10 licenses to clear status. Mr. Serrano Sewell moved; s:GnanaDev. Motion Carried.

Ms. Threadgill also asked for a motion for three orders for license surrenders during probation and/or administrative action.

Ms. Threadgill requested a motion for three order for license surrenders. Dr. Levine moved; s:Yaroslavsky. Motion Carried.

Ms. Threadgill discussed the expert reviewer utilization report. She reported that the number of active experts is 964, which is slightly higher than the 953 reported at last meeting. The total number of experts utilized in calendar year 2012 was 349. During the Enforcement Committee meeting, Ms. Sweet provided an update regarding the second presentation of the revised expert reviewer training, which will be held in Irvine at the UC Irvine Medical Center on February 9, 2013 from 8:00 am – 5:00 pm.

The Board continues to support medical related training for Administrative Law Judges. On February 19, 2013, PACE will be doing some presentations and training from 9:00 am – 12:00 pm on the following topics: physician choice, clinical judgments, clinical guidelines, and the rise of evidence-based medicine. On February 21, 2013, training will be presented from 1:30 pm – 4:30 pm on topics of addiction, addiction medicine, and the addicted physician. Dr. Low is scheduled to present cardiology 101 training on Friday, March 15, 2013 during the lunch hour.

The current vacancy rate for investigators is 7%, taking into consideration identified candidates and those in background, the vacancy rate is only 1%. The percentage for supervisor vacancies however is 19%, which makes the overall vacancy rate for sworn personnel 9%. In calendar year 2012, the Board was interviewing and hiring a significant amount of staff. The Boards office of Standards and Training Unit completed 33 background investigations and the newly hired investigators attended their POST training in October, 2012. This 16 week training will be ending and graduation will be on February 14, 2013.

To date the Board has hired three additional staff that will be required to attend the next scheduled POST training. Additionally, the Board has begun to advertise six additional investigator positions; two for district offices, and the additional four staff, as well as a supervising investigator position to staff a new Operations Safe Medicine unit in Northern California. These additional positions will further assist in lowering the case load and current average investigation time. The Board only has one analyst vacancy in the CCU and one inspector vacancy in the Probation Unit.

Ms. Threadgill then reported on the progress of the CCU in meeting its goals of reducing complaint processing time, as this is one of the goals of the Strategic Plan. The CCU continues to do an outstanding job of reducing the timeline and the current information from receipt of complaint to closure or referral are down to 63 days, with 50% of the complaints being under 50 days. The enforcement time frame continues to improve; the total average days for the complaint investigation time is 334 days or .92 years. This is not just the investigations but includes the CCU time as well.

Ms. Threadgill then referred to the suspension orders issued. In this fiscal year to date, there have been 42 different types of suspension orders issued. Of these, 17 are Interim Suspension Orders (ISO). Ms. Threadgill then provided some information on ISOs and discussed what it takes to get this order. An ISO is considered extraordinary relief and pursuant to Government Code Section 11529, standard of proof must be met in order for an ISO to be granted. The standard of proof must be consistent with the burden and standards of proof applicable to a preliminary injunction entered into under section 2527 of the Code of Civil Procedure. Since every case is different, it is difficult to generalize why an ISO is not in place for a particular licensee. Before an ISO can be requested there are a number of steps that must be taken such as gathering medical records, obtaining patient consents, medical consultant and expert review, etc., in order to prove that the licensee's continued practice presents an imminent danger to public health, safety or welfare. Once the Attorney General's Office reviews the case, a determination is made as to whether there is enough evidence to warrant requesting an ISO. Even after the ISO is requested, if an Administrative Law Judge determines there is insufficient evidence, the request can be denied. Also due to a 15 day time restraint to file an accusation after granting an ISO and a 30 day time restraint between the accusation being filed and a hearing being scheduled, an investigation must be nearly complete in order to request an ISO. Depending on the case, gathering the appropriate materials necessary to complete the investigation and request an ISO can be a time consuming process. Due diligence must be taken to ensure that seeking the ISO is the correct course of action.

During October's Board meeting, a Member requested the development of an outreach plan. In response to that request, the Board staff contacted the California Medical Association, Director of Education, and has been invited to present at the local county medical societies Executive Directors' meeting held in Sacramento on April 15, 2013. During this meeting, the Board hopes to identify information that the county societies are interested in receiving from the Board and develop a plan based on their interests.

Dr. Bishop requested the Enforcement Program work on a self-assessment and report back to the Board.

Public comment was heard on this agenda item:

Carol Godstein, a health care consumer, reported on a complaint filed on two different physicians with the CCU, where she was unhappy with the handling and outcome of the complaint. She was referred to Ms. Threadgill.

Agenda Item 29 Vertical Enforcement Program Report

Mr. Jones introduced himself to the Board as the current acting Senior Assistant Attorney General for the Health Quality Enforcement Section due to Carlos Ramirez's retirement. Mr. Jones gave a summary of the preliminary report and a January 24, 2013 letter sent to the Board regarding the Sunset Review Report. As of the date the letter was sent out to the Board, Mr. Jones had not received any type of data from the Board. To summarize the report, he stated that the Vertical Enforcement Prosecution (VEP) is working and that it has resulted in lowered timelines over the course of the implementation of VEP since 2006. He stated that it has significantly resulted in more serious discipline in settings where the VEP is actively pursued during the course of the investigation. He has set forth in his report that the AG's office has improved at producing accusations in a timely manner, though they still have further improvements to meet their goal of 30 days, but over the period that VEP has been in effect, it has garnered a 32% increase in effectiveness in getting accusations timely filed. The most significant statistic that he wanted to mention is the measure of disciplinary outcomes. He referred to a chart that described results in the filing of accusations `and the types of disciplines that have come out of the filings over the last three fiscal years. He reported that during the past three years, the disciplinary action in cases handled by the Los Angeles office, which covers approximately 25% of the physician population in the state and where attorneys have greater involvement during the investigation stage, has been significantly higher than offices in Northern California.

With these statistics, Mr. Jones feels that the active involvement of the Attorney General's office does result in greater public protection and should be continued. He feels that there are still improvements that can be made and his office will work Ms. Threadgill and her staff in putting together mechanisms to improve further performance of the VEP. A few suggestions can be made to improve timelines; including taking certain cases out of the VEP, specifically conviction cases. These cases can be handled without the assistance of the Attorney General's Office and could be removed from VEP by way of agreement between the Attorney General's office and the Board. There are a few other types of cases that may be able to be removed from the VEP, such as petitions for early termination or modification of probation. A decrease in processing time could be achieved by decreasing the Deputy Attorney General the same amount of time to approve a case closure as for accepting a case for prosecution which is 5 days. There are a couple of programmatic improvements that might be addressed, specifically, getting an accusation case onto the calendar at the Office of Administrative Hearings in a more expeditious manner. The Government Code requires that the Office of Administrative Hearings give preference to the Board cases, and that historically has not happened. If that was to be implemented at this time, the Board could get 60 days or more removed from the timeline. Another area where improvement could be made is in the enforcement of subpoenas. That would address a relatively small subset of cases, but it is an area where a lot of time is spent which might be able to be reduced.

Dr. GnanaDev requested a breakdown of timelines for each district office. Mr. Jones agreed to that request.

Dr. Bishop requested that the Board instruct Board staff to evaluate each of Mr. Jones suggestions and get back to the Board at the next meeting with implementation strategies for discussion.

Dr. Low asked which of the two entities, the Board or the Attorney General's office is in the best position to negotiate with Office of Administrative Hearings to prioritize the Board's cases.

Mr. Jones responded saying the Office of Administrative Hearings contracts with the board to perform the hearings, and he believes that the Board should be dealing with the Office of Administrative Hearings Director on this issue.

Mr. Serrano Sewell asked Mr. Jones if he thought that getting everyone involved together at a summit to problem solve the issues that are causing delays in timelines would be beneficial. Mr. Jones agreed that discussion and communication taking place in person can be much more effective than emails.

Dr. Levine noted that the Board has a VEP report due to the Legislature in March via the Sunset Review report and asked Dr. Low and Mr. Serrano Sewell to review the report before it gets submitted to the Legislature.

Agenda Item 30 Discussion and Consideration of the Supplemental Sunset Review Report

Ms. Kirchmeyer reported that at the last Board meeting, the Board approved the Sunset Review Report with the understanding that there will be a supplemental report that would also include updates on specific items as well as the VEP review. Today's discussion will only include items that the Board would like to have added to or removed from the report.

The first section provided an update on the work staff continues to do on the Breeze project, an update on the elimination of the Board's retired annuitants and the recruitment to obtain staff in place of those positions, and an overview on the Board's forum on appropriate prescribing and dispensing.

Ms. Kirchmeyer asked for a motion to approve this section of the report.

Ms. Yaroslavsky made the motion to approve this section of the report/s: Dr. Levine. Motion carried.

Ms. Robinson provided an update on the Licensing Section. There are seven updates in this section, four are additional information or updates and three are new items. The first is the update on the applicant satisfaction survey. The initial report included 77 responses and to date there are 242. The second update is on the outpatient surgery center accreditation which Mr. Worden covered in his review of the outpatient surgery centers. The third update is the international medical graduates and the implementation of recently enacted SB122. To date, the Board has received two applications, thus it is too early to determine whether regulations are necessary until more applications are received. The Board will continue to review this process as new factors are discovered and will develop regulations as necessary. The fourth update is on the Maintenance of Licensure. The initial report discussed the Board's past efforts and the Federation of State Medical Boards' (FSMB) current efforts on the Maintenance of Licensure. This report discusses the FSMB's five pilot programs of which nine state boards are participating. The Board looks forward to receiving the outcomes of these pilots and will

evaluate the data and decide how to move forward with Maintenance of Licensure to improve consumer protection.

The fifth issue is international postgraduate training, which was discussed yesterday at the Licensing Committee Meeting and then presented to the Full Board. The Board has agreed to watch the evolution of this program. This information will be added to the Sunset Report to inform the Legislature that the Board is monitoring this issue. The sixth item is the addition of the Allopathic and Osteopathic postgraduate training programs to the supplemental report as an issue for legislation. The seventh issue is on the Midwifery Program. The Board has added in the report the issue of certified nursing midwives supervising students in addition to physicians and licensed midwives. Lastly, the issue of the MANA statistics and program to be used instead of, or in addition to the current statistics reported to OHSPD. Ms. Robinson requested a motion to approve the licensing section.

Ms. Yaroslavsky made the motion to approve the items in the licensing section; s/Dr. GnanaDev. Motion Carried.

Ms. Kirchmeyer provided an update of the Enforcement Section. An update on the expert reviewer training was provided. This section will be amended after the training scheduled for next week is completed. The next addition is a section identifying how the Board plans to hire the CPEI positions, which is the exact same information that was provided in the Executive Committee meeting. Another item the Board identified at the meeting was a possible legislative change to suspend an individual who fails to comply with a petition for a mental/physical examination. That would require a legislative change and is something the Board may want to consider it in the Sunset Report.

Ms. Yaroslavsky requested that the Board look into a possible legislative change in regards to removing a Public Letter of Reprimand from the Boards Web site prior to the ten year requirement, so that in extreme cases, the Board has the final determination on posting.

Dr. Salomonson would like to have a legislative mechanism to review cases as more data becomes available.

Mr. Heppler recommended that the Board consider legislation for a physician who may have been disciplined, but through subsequent judicial review or judicial consideration, found they were not at fault. Dr. Levine asked for a motion.

Ms. Yaroslavsky made a motion to include these updates in the Sunset Review Report: s/Salomonson. Motion carried.

Ms. Kirchmeyer then reported on the VEP. Ms. Kirchmeyer discussed how important statistics are for the Board. The Board takes statistics very seriously. In order to ensure consistency, the Board currently only has the supervising investigators enter information in the Board's database. Additionally, the Board's staff reviews entries to ensure that accurate codes are placed on the system when cases are completed by the district office and when they are transmitted to the Attorney General's Office. Staff also cross references information provided in the physical files with the information posted into the database.

The Board also has a data validation individual who reviews these reports and statistics to ensure the data has been entered correctly. The Board has identified reports that are run on a monthly basis to determine if the codes are being entered correctly and these reports are reviewed and analyzed to ensure the statistics at the end of the fiscal year are accurate.

To measure the effectiveness of the VEP, the Board ran numerous reports that showed time frames for certain activities. For all reports, staff analyzed which cases would be considered as part of the VEP and excluded those that were not part of the VEP, such as criminal cases, petition cases, etc. This report was run to see where the improvements were comparing VEP cases with pre-VEP cases.

Ms. Kirchmeyer discussed the Boards' methodology for the time frames. The Board runs statistics from the date of the event back to whenever the beginning date was, no matter when that beginning date occurred. In the time frame from when the investigation was initiated to when an accusation was filed in the fiscal year 11/12, the Board took all accusations filed in 11/12 and went back and found the date the investigation was assigned, no matter which fiscal year it occurred in to determine how many days there were between those two data markers. The Board does remove any days that the case was closed from the overall time frame.

The Board analyzed statistics to help provide a recommendation for the Board to consider. A chart was provided to the Members which shows the investigation times from 2004/2005, prior to the VEP, to 2011/2012. Although there was a decrease in some years and an increase in others, overall from 04/05 to 11/12 there was a two day decrease in the time it took to investigate a complaint. For those that were referred to discipline, there was a 12 day reduction with VEP.

There was a significant decrease in the time it took to obtain a suspension. The time decreased by almost a hundred days and all categories showed improvement.

- The timeframe from when an investigation was initiated until the time an accusation was filed. In this category there was a decrease of 32 days.

- The timeframe from when an investigation was initiated until when a stipulation for disciplinary action is received. In this category there was a decrease of 8 days.

- The timeframe from when a case was initiated until the time the matter was submitted to an ALJ or until a proposed decision was received. The time decrease for all cases was a 77 day decrease.

- The timeframe from when an investigation was initiated until the Board received a proposed decision. In this category, there was an increase in 213 days.

In reviewing all of the data, it appears that having the DAG involved earlier in cases resulted in a decrease in the timeframe to issue a suspension order.

However, the overall statistics do not find that the VEP has dramatically improved the timeframes to discipline physicians found in violation of the law. With the decrease in investigative time in the last year, decreases should be reflected in the disciplinary timeframes in the next fiscal year.
The Board has also noted that it takes a significant amount of time to have subpoenas enforced. Therefore, based upon all of the statistics, Board staff is recommending that the VEP model be modified. If the VEP was modified to only have certain cases remain in the VEP model and have others outside of the VEP model, it is believed that the DAGs would have time to work on subpoenas as well as move the disciplinary cases through the process more expeditiously. 60% of the cases the DAGs are involved in do not result in disciplinary action. The statistics do not indicate that having the DAG involved in these cases has decreased the time to investigate these cases, therefore it is recommended that these cases be removed from the VEP model. It is also recommended that the most urgent cases, which have the most potential to result in a suspension, to remain in the VEP model. These cases would include sexual misconduct, physical or mental illness and peer review or 805 cases. In all other cases, designation to VEP should be jointly considered by Board staff and AG's staff as the case is assigned at the district office. This assignment could be regularly re-considered as the case progresses to assure appropriate use of AG resources and also to be sure a DAG is brought into the case when necessary.

Mr. Serrano Sewell recommended having a joint recommendation to the legislature on this issue, both from the AG's office and from the Board.

Dr. Levine asked for a volunteer to work with her as a subcommittee member to review the Supplemental Sunset Review report before it goes to the Legislature. Dr. Salomonson volunteered.

Dr. Levine asked for a motion to delegate the two committees to make the final decision on the language to be put into supplemental sunset review report that is being sent to the Legislature.

Public comment was heard on this agenda item.

Julie D'Angelo Fellmeth, CPIL spoke on her concerns about the suggested changes to VEP.

She stated that the Sunset Review Supplemental Report focuses on the main goal of VE being expedited case processing cycles, but that fast is not necessarily better.
People are looking for better, higher quality decision making by earlier involvement by the attorneys.

She stated that the Board and HQE have been working to implement VE since January 2006 and that during that time frame, the Board experienced significant vacancies in its investigator positions.

When VE started in 2006, the Board had almost 20% fewer investigators than it had 5 years earlier. By October of 2011, the Board had a 25% vacancy rate in its investigative staff. The hiring freeze was lifted in 2011 and the Board has begun to fill most of these vacancies, but it is important to recognize that devastating vacancy rate and the VE today is being evaluated in the context of that vacancy rate.

She noted the supplemental report contains detailed data and charts comparing times frames for various kinds of cases and various stages of the enforcement process and this data is seemingly being presented to the Board and to the Legislature to convince them that the Board's use of VE should

either be eliminated or confined to a very narrow set of sub cases. These cases being sexual misconduct cases, physical and mental illness cases and peer review cases where the Board has received an 805 report.

She believes there are some inconsistencies in the Sunset report. It states that the use of VE has increased the investigative time frames in three kinds of cases including cases alleging physical or mental illness. Yet those are the kinds of cases that the Board would leave with the VE.

She stated that believes that VEP should not be eliminated or confined to only specific types of cases.

GV Ayers, Senate Business and Professions Committee explained the process of the Sunset review hearing and confirmed the date of March 11, 2013.

Ms. Yaroslavsky made a motion to appoint a subcommittee to review the final draft to ensure edits discussed were included in the final version of the Supplemental report; s/Salomonson. Motion carried.

Dr. Levine deferred agenda item 31 (Discussion and Consideration of Teleconferencing of Medical Board Meetings) to the April Board Meeting.

Agenda Item 33 – Adjournment

Dr. Levine asked for a motion to adjourn the meeting. Dr. Salomonson made a motion/ s:Ms. Yaroslavsky. Motion carried.

Meeting adjourned at 4:15 pm.

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

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MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: April 16, 2013
ATTENTION: Board Members
SUBJECT: Outpatient Surgery Settings
STAFF CONTACT: Curtis J. Worden, Chief of Licensing

PURPOSE:

To provide the Board members with more detailed information to supplement the: April 25 2013, PowerPoint Presentations on Outpatient Surgery Settings.

BACKGROUND:

California Business and Professions Code (B&P) Sections 2215, 2216 and 2217 were added to statutes in 1994 and became effective January 1, 1995. B&P Sections 2216.1 and 2216.2 were added to statutes in 1999 (AB271) and became effective January 1, 2000. These statutes (B&P Sections 2215-2217) identify surgery in certain outpatient settings, restrictions on use of anesthesia, minimum staffing and security requirements (Attachment 1- B&P Sections 2215 - 2217).

California Health and Safety Code (H&S) Sections 1248 – 1248.85 were added to statutes in 1994 (AB595) and became effective January 1, 1995. H&S Section 1248.4 was amended in 1997 (AB219) and became effective October 8, 1997. H&S Section 1248.15 was amended in 1999 (AB271) and became effective January 1, 2000. H&S Sections 1248, 1248.15, 1248.2, 1248.25, 1248.35, 1248.5, 1248.7, and 1248.85 were amended in 2011 (SB100) and became effective in January 2012. H&S Section 1248.35 was amended in 2012 (SB1095) and became effective January 1, 2013 (Attachment 2 – H&S Sections 1248 – 1248.85)

The Board authored language for the California Code of Regulations regarding Outpatient Surgery Settings and the Office of Administrative Law approved the following: California Code of Regulations, Title 16, Division 1, (CCR) Sections 1313.2 – 1313.6, that became operative February 17, 1996 (Attachment 3 – CCR Sections 1313.2 – 1313.6). These regulations further define statutes regarding Outpatient Surgery Setting Accreditation Agencies.

SUMMARY:

On January 1, 1995 the Board received statutory authority to approve Outpatient Surgery Setting Accreditation Agencies. In order to implement new statutes created by the passage of AB595, the Board drafted the language for CCR Sections 1313.2 - 1313.6, held hearings regarding the language, voted to approve the language and submitted the language for approval by the Office of Administrative Law. The Office of Administrative Law approved the proposed regulations and the regulations became operative on February 17, 1996.

The above referenced statutes and regulations define the specific authority for the Medical Board of California (Board), and the California Department of Public Health regarding Outpatient Surgery Settings. In addition, the above referenced statutes and regulations specify the following Outpatient Surgery Setting and Accreditation Agency requirements, and define:

- What is an Outpatient Surgery Setting
- Who may own an Outpatient Surgery Setting
- Accreditation Agency minimum requirements
- Exemptions from requiring an accreditation from an Accreditation Agency
- Minimum requirements to receive accreditation by an Accreditation Agency
- Levels of anesthesia used in an Outpatient Surgery Setting requiring accreditation

This report will focus on the Board's responsibilities.

Business and Professions Code Sections 2215 – 2217:

B&P Section 2215 states the Legislative findings and declarations, and intent regarding certain Outpatient Surgery Settings, effective on January 1, 1995.

B&P Section 2216 restricts the use of anesthesia in certain Outpatient Surgery Settings.

B&P Section 2216.1 "On or after July 1, 2001, it is unprofessional conduct for a physician and surgeon to perform procedures in any outpatient setting except in compliance with Section 2216, unless the setting has a minimum of two staff persons on the premises…"

B&P Section 2216.2 (a) "It is unprofessional conduct for a physician and surgeon to fail to provide adequate security by liability insurance, or by participation in an interindemnity trust, for claims by patients arising out of surgical procedures performed outside of a general acute care hospital as defined in subdivision (a) of Section 1250 of the Health and Safety Code…"

B&P Section 2217 The Division of Licensing of the Medical Board of California may adopt regulations to implement this article and Chapter 1.3 (commencing with Section 1248) of Division 2 of the Health and Safety Code.

Note: Please see Attachment 1 for copies of B&P Sections 2215 - 2217

Health and Safety Code Sections 1248 – 1248.85:

H&S Section 1248 defines for the Board what an Outpatient Surgery Setting is and what is an Accreditation Agency.

What is an Outpatient Surgery Setting?

H&S Section 1248(b)(1) "Outpatient setting" means any facility, clinic, unlicensed clinic, center, office, or other setting that is not part of a general acute care facility, as defined in Section 1250, and where anesthesia, except local anesthesia or peripheral nerve blocks, or both, is used in compliance with the community standard of practice, in doses that, when administered have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes.

H&S Section 1248(b)(2) "Outpatient setting" also means facilities that offer in vitro fertilization, as defined in subdivision (b) of Section 1374.55.

What is not an Outpatient Surgery Setting?

H&S Section 1248(b)(3) "Outpatient setting" does not include, among other settings, any setting where anxiolytics and analgesics are administered, when done so in compliance with the community standard of practice, in doses that do not have the probability of placing the patient at risk for loss of the patient's life-preserving protective reflexes.

What is an Accreditation Agency?

H&S Section 1248(b)(c) "Accreditation agency" means a public or private organization that is approved to issue certificates of accreditation to outpatient settings by the board pursuant to Sections 1248.15 and 1248.4.

Who can own an Outpatient Surgery Setting?

H&S Section 1248. identifies the following acceptable owners:

- An Association
- Corporation
- Firm
- Partnership
- Individual Person

When is an Outpatient Surgery Setting exempt from accreditation?

H&S Section 1248.1 (a) - (f) and (h) identifies the following exemptions from accreditation requirements:

- An ambulatory surgical center that is certified to participate in Medicare program…
- Any clinic conducted, maintained, or operated by a federally recognized Indian tribe or tribal organization…
- Any clinic directly conducted, maintained or operated by the United States…
- Any primary care clinic or surgical clinic licensed under section 1204
- Any health facility licensed as a general acute care hospital
- Outpatient surgical setting where anxiolytics and analgesics are administered in compliance with the community standard of practice, in doses that do not have the probability of placing the patient at risk for loss of life preserving protective reflexes
- A setting, including, but not limited to, a mobile van, in which equipment is used to treat patients admitted to a facility described in subdivision (a), (d), or (e), and in which the procedures performed are staffed by the medical staff of, or other healthcare practitioners with clinical privileges at, the facility and are subject to the peer review process of the facility but which setting is not a part of a facility described in subdivision (a), (d), or (e).

H&S Section 1248.15 defines minimum standards for accreditation of Outpatient Surgery Settings and approving accreditation agencies. The following are some of the accreditation standards:

- Outpatient setting allied health staff shall be licensed or certified …
- Outpatient settings shall have a system for facility safety and emergency training…
- Onsite equipment, medication, and trained personnel to handle services sought or provided and to facilitate handling of any medical emergency….
- Have a written transfer agreement with a local accredited or licensed acute care hospital…
- Permit surgery only by a licensee who has admitting privileges at a local accredited or licensed acute care hospital, with the exception that licensees who may be precluded from having admitting privileges by their professional classification…
- Submit for approval by an accrediting agency a detailed procedural plan for handling medical emergencies…
- Submit for approval by an accrediting agency a detailed plan, standardized procedures, and protocols to be followed in the event of serious complications…
- Plan shall include at a minimum:
    - Notify individual designated by the patient in case of an emergency
    - Ensure that the mode of transfer is consistent with the patient's medical condition
    - Ensure all relevant clinical information is documented and accompanies the patient
    - Continue to provide appropriate care to the patient until the transfer is effectuated
- All physicians and surgeons transferring patients from an outpatient setting shall agree to cooperate with medical staff peer review process on the transfer case…
- Outpatient setting shall permit surgery by a dentist, physician and surgeon, an osteopathic physician and surgeon or podiatrist acting within his or her scope of practice…
- Outpatient setting may, in its discretion, permit anesthesia service by a certified registered nurse anesthetist acting within his or her scope of practice…
- Outpatient setting shall have a system for:
    - Maintaining clinical records
    - Patient care and monitoring procedures
    - Quality assessment
- Members of medical staff and other practitioners who are granted clinical privileges shall be professionally qualified and appropriately credentialed ….
- Outpatient setting shall grant privileges in accordance with recommendations from qualified health professionals, and credentialing standards established by the outpatient setting
- Clinical privileges shall be periodically reappraised…
- Outpatient settings that have multiple service locations shall have all of the sites inspected
- Outpatient settings shall post the certificate of accreditation in a location readily visible to patients …
- Outpatient settings shall post the name and telephone number of the accrediting agency with instructions on submission of complaints in a location readily visible to patients…
- Outpatient settings shall have a written discharge criteria

- Outpatient settings shall have a minimum of two staff persons on the premises, one of whom shall either be a licensed physician and surgeon or a licensed health care professional with current certification in advanced cardiac life support (ACLS)…
- Transfer to an unlicensed setting of a patient who does not meet the written discharge criteria shall constitute unprofessional conduct
- An accreditation agency may include additional standards in its determination to accredit outpatient settings…
- No accreditation standard adopted or approved by the board, and no standard included in any certification program of any accreditation agency approved by the board, shall serve to limit the ability of any allied health care practitioner to provide services within his or her full scope of practice…
- Notwithstanding this or any other provision of law, each outpatient setting may limit the privileges, or determine the privileges, within the appropriate scope of practice, that will be afforded to physicians and allied health care practitioners who practice at the facility…
- Privileges may not be arbitrarily restricted based on category of licensure
- The Board shall adopt regulations that it deems necessary for outpatient settings that offer in vitro fertilization
- The board may adopt regulations it deems necessary to specify procedures that should be performed in an accredited outpatient setting for facilities or clinics that are outside the definition of outpatient setting…
- As part of the accreditation process, the accrediting agency shall conduct a reasonable investigation of the prior history of the outpatient setting, including all licensed physicians and surgeons who have an ownership interest therein, to determine whether there have been any adverse accreditation decisions rendered against them…
- An outpatient setting shall be subject to the reporting requirements in Section 1279.1 and the penalties for failure to report specified in Section 1280.4

H&S Section 1248.2 specifies certificate of accreditation requirements. The following are some of the requirements:

- Any outpatient setting may apply to an accreditation agency for a certificate of accreditation…
- The board shall obtain and maintain a list of accredited outpatient settings from the information provided by the accreditation agencies approved by the board, and shall notify the public, by placing the information on its Internet Web site, whether an outpatient setting is accredited or the setting's accreditation has been revoked, suspended, or placed on probation, or the setting has received a reprimand by the accreditation agency
- The list of outpatient settings shall include:
    - Name, address, and telephone number of any owners, and their medical license numbers.
    - Name and address of the facility.
    - The name and telephone number of the accreditation agency.
    - The effective and expiration dates of the accreditation.
- Accrediting agencies shall notify the board and update the board on all outpatient settings that are accredited.

H&S Section 1248.25 specifies the criteria for denial of accreditation.

H&S Section 1248.3 specifies the terms of certificates; Notification of change of ownership; Disclosure of information by agency. The following are some of the requirements:

- Certificates of accreditation shall be valid for not more than three years
- The outpatient setting shall notify the accreditation agency within 30 days of any significant change in ownership…
- The outpatient setting shall notify the accreditation agency within 30 days of any significant change in change in scope of services, additional services, or change in locations
- Except for disclosures to the division or to the Division of Medical Quality under this chapter, an accreditation agency shall not disclose information obtained in the performance of accreditation activities under this chapter that individually identifies patients, individual medical practitioners, or outpatient settings
- Neither the proceedings nor the records of an accreditation agency or the proceedings and records of an outpatient setting related to performance of quality assurance or accreditation activities under this chapter shall be subject to discovery, nor shall the records or proceedings be admissible in a court of law
- The prohibition relating to discovery and admissibility of records and proceedings does not apply to any outpatient setting requesting accreditation in the event that denial or revocation of that outpatient setting's accreditation is being contested
- Nothing… shall prohibit the accreditation agency from making discretionary disclosures of information to an outpatient setting pertaining to the accreditation of that outpatient setting

H&S Section 1248.35 identifies inspections by agency or the Board. The following are some of the requirements:

- Every outpatient setting which is accredited shall be inspected by the accreditation agency and may also be inspected by the Medical Board of California
- The Medical Board of California shall ensure that accreditation agencies inspect outpatient settings.
- The frequency of inspection shall depend upon the type and complexity of the outpatient setting to be inspected.
- Inspections shall be conducted no less often than once every three years by the accreditation agency and as often as necessary by the Medical Board of California…
- The Medical Board of California or the accreditation agency may enter and inspect any outpatient setting that is accredited by an accreditation agency at any reasonable time…
- If an accreditation agency determines, as a result of its inspection, that an outpatient setting is not in compliance with the standards under which it was approved, the accreditation agency may do any of the following:
    - Require correction of any identified deficiencies within a set timeframe…
    - Failure to comply shall result in the accrediting agency issuing a reprimand or suspending or revoking the outpatient setting's accreditation
    - Place the outpatient setting on probation...
    - Suspend or revoke the outpatient setting's certification of accreditation

- Except as is otherwise provided in this subdivision, before suspending or revoking a certificate of accreditation under this chapter, the accreditation agency shall provide the outpatient setting with notice of any deficiencies…
- The outpatient setting shall agree with the accreditation agency on a plan of correction that shall give the outpatient setting reasonable time to supply information demonstrating compliance with the standards of the accreditation agency…
- During the allotted time to correct the deficiencies, the plan of correction, which includes the deficiencies, shall be conspicuously posted by the outpatient setting in a location accessible to public view
- Within 10 days after the adoption of the plan of correction, the accrediting agency shall send a list of deficiencies and the corrective action to be taken to the board…
- The accreditation agency may immediately suspend the certificate of accreditation before providing notice and an opportunity to be heard, but only when failure to take the action may result in imminent danger to the health of an individual…
- If an outpatient setting does not comply with a corrective action within a timeframe specified by the accrediting agency, the accrediting agency shall issue a reprimand, and may either place the outpatient setting on probation or suspend or revoke the accreditation of the outpatient setting, and shall notify the board of its action…
- The accreditation agency shall, within 24 hours, report to the board if the outpatient setting has been issued a reprimand or if the outpatient setting's certification of accreditation has been suspended or revoked or if the outpatient setting has been placed on probation. ..
- The accreditation agency, upon receipt of a complaint from the board that an outpatient setting poses an immediate risk to public safety, shall inspect the outpatient setting and report its findings of inspection to the board within five business days.
- If an accreditation agency receives any other complaint from the board, it shall investigate the outpatient setting and report its findings of investigation to the board within 30 days.
- Reports on the results of any inspection shall be kept on file with the board and the accreditation agency along with the plan of correction and the comments of the outpatient setting…
- All final inspection reports, which include the lists of deficiencies, plans of correction or requirements for improvements and correction, and corrective action completed, shall be public records open to public inspection
- If one accrediting agency denies accreditation, or revokes or suspends the accreditation of an outpatient setting, this action shall apply to all other accrediting agencies.
- An outpatient setting that is denied accreditation is permitted to reapply for accreditation with the same accrediting agency.
- The outpatient setting also may apply for accreditation from another accrediting agency, but only if it discloses the full accreditation report of the accrediting agency that denied accreditation…

H&S Section 1248.4 identifies accreditation agency approval and requirements. The following are some of requirements:

- Each accreditation agency approved by the division shall, on and after January 1, 1995, promptly forward to the division a list of each outpatient setting to which it has granted a

certificate of accreditation, as well as settings that have lost accreditation or were denied accreditation…

- Submit an application, supporting documentation and fess to apply for approval by the Board.
- The division shall approve an accreditation agency that applies for approval if the accreditation agency meets the following:
    - Includes within its accreditation program, at a minimum, the standards for accreditation of outpatient settings approved by the Board
    - Submits its current accreditation standards to the division every three years, or upon request for continuing approval by the Board
    - Maintains internal quality management programs to ensure quality of the accreditation process.
    - Has a process by which accreditation standards can be reviewed and revised no less than every three years.
    - Maintains an available pool of allied health care practitioners to serve on accreditation review teams as appropriate
    - Has accreditation review teams…
        - Review teams consist of at least one physician and surgeon who practices in an outpatient setting; any other members shall be practicing actively in these settings
        - Participate in formal educational training programs provided by the accreditation agency in evaluation of the certification standards…
    - The accreditation agency shall demonstrate that professional members of its review team have experience …
    - Standards for accreditation shall be developed with the input of the medical community…
    - Accreditation reviewers shall be credentialed and screened by the accreditation agency
    - The accreditation agency shall not have an ownership interest in nor be involved in the operation of a freestanding outpatient setting nor in the delivery of health care services to patients.

H&S Section 1248.5 is regarding the evaluation of approved accreditation agencies.

H&S Section 1248.55 is regarding the termination of approval of an approved accreditation agency. The following are some of the requirements:

- The Board shall notify the accreditation agency with a notice of deficiencies and a reasonable time to supply the information….
- If approval of an accreditation agency is terminated, outpatient settings accredited by the that agency shall be notified by the Board…
- This may require an outpatient setting that has been accredited by an accreditation agency whose approval has been terminated to cease operations immediately…

H&S Section 1248.6 identifies the fees for application of approval by the Board

H&S Section 1248.65 identifies unprofessional conduct by a physician and surgeon regarding outpatient settings.

H&S Section 1248.7 is regarding complaints against an outpatient setting. The following are some of the requirements:

- The board shall investigate all complaints concerning a violation of this chapter…

H&S Section 1248.75 is regarding notice of deficiencies.

H&S Section 1248.8 is regarding violations of this chapter as a misdemeanor.

H&S Section 1248.85 is regarding the adoption of additional standards by an approved accreditation agency.

Note: Please see Attachment 2 for copies of H&S Code Sections 1248 - 1248.85

The California Code of Regulations, Title 16, Division 13, Sections 1313.2 – 1313.6 further define some of the above statutes, specifically:

CCR Section 1313.2 relates to H&S Section 1248

CCR Section 1313.3 relates to H&S Sections 1248.15 and 1248.4

CCR Section 1313.4 relates to H&S Sections 1248.15 and 1248.4

CCR Section 1313.5 relates to H&S Section 1248.4

CCR Section 1313.6 relates to H&S Section 1248.6

Note: Please see Attachment 3 for copies of CCR Sections 1313.2 - 1313.6

The Board is authorized by statute to accept applications from Accreditation Agencies that are requesting the Board's approval to accredit an outpatient surgery setting. The Board currently has four approved Accreditation Agencies:

- American Association for Accreditation of Ambulatory Surgery Facilities Inc. (AAAASF)
- Accreditation Association for Ambulatory Health Care (AAAHC)
- Institute for Medical Quality (IMQ)
- The Joint Commission (JC)

ATTACHMENTS:

1. California Business and Professions Code Sections: 2215 – 2217
2. California Health and Safety Code Sections: 1248 – 1248.85
3. California Code of Regulations, Title 16, Division 13, Sections: 1313.2 – 1313.6

ATTACHMENT - 1

Business and Professions Code - BPC

DIVISION 2. HEALING ARTS [500. - 4999.129.]
(Division 2 enacted by Stats. 1937, Ch. 399.)

CHAPTER 5. Medicine [2000. - 2521.]
(Chapter 5 repealed and added by Stats. 1980, Ch. 1313, Sec. 2.)

ARTICLE 11.5. Surgery in Certain Outpatient Settings [2215. - 2217.]
(Article 11.5 added by Stats. 1994, Ch. 1276, Sec. 1.)

2215.
The Legislature finds and declares that in this state, significant surgeries are being performed in unregulated out-of-hospital settings. The Legislature further finds and declares that without appropriate oversight, some of these settings may be operating in a manner which is injurious to the public health, welfare, and safety. Although the health professionals delivering health care services in these settings are licensed, further quality assurance is needed to ensure that health care services are safely and effectively performed in these settings. The Legislature further recognizes that there is a wide range of surgical procedures safely performed in a myriad of outpatient settings, and the degree of patient risk varies greatly. It is the intent of the Legislature to create regulations that directly impact patient safety. It is not the intent of the Legislature to require standards in excess of those requirements in Section 1248.15, or to require physical modifications to facilities unless the modifications or standards directly impact patient safety and are cost-effective. The cost effectiveness of any modifications shall be taken into consideration by the Division of Licensing of the Medical Board of California, and shall ensure that the least costly and effective method of achieving patient safety is required.
(Added by Stats. 1994, Ch. 1276, Sec. 1. Effective January 1, 1995.)

Business and Professions Code - BPC

DIVISION 2. HEALING ARTS [500. - 4999.129.]
(Division 2 enacted by Stats. 1937, Ch. 399.)

CHAPTER 5. Medicine [2000. - 2521.]
(Chapter 5 repealed and added by Stats. 1980, Ch. 1313, Sec. 2.)

ARTICLE 11.5. Surgery in Certain Outpatient Settings [2215. - 2217.]
(Article 11.5 added by Stats. 1994, Ch. 1276, Sec. 1.)

2216.
On or after July 1, 1996, no physician and surgeon shall perform procedures in an outpatient setting using anesthesia, except local anesthesia or peripheral nerve blocks, or both, complying with the community standard of practice, in doses that, when administered, have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes, unless the setting is specified in Section 1248.1. Outpatient settings where anxiolytics and analgesics are administered are excluded when administered, in compliance with the community standard of practice, in doses that do not have the probability of placing the patient at risk for loss of the patient's life-preserving protective reflexes.

The definition of "outpatient settings" contained in subdivision (c) of Section 1248 shall apply to this section.
(Added by Stats. 1994, Ch. 1276, Sec. 1. Effective January 1, 1995.)

Business and Professions Code - BPC

DIVISION 2. HEALING ARTS [500. - 4999.129.]
(Division 2 enacted by Stats. 1937, Ch. 399.)

CHAPTER 5. Medicine [2000. - 2521.]
(Chapter 5 repealed and added by Stats. 1980, Ch. 1313, Sec. 2.)

ARTICLE 11.5. Surgery in Certain Outpatient Settings [2215. - 2217.]
(Article 11.5 added by Stats. 1994, Ch. 1276, Sec. 1.)

2216.1.
On and after July 1, 2000, it is unprofessional conduct for a physician and surgeon to perform procedures in any outpatient setting except in compliance with Section 2216, unless the setting has a minimum of two staff persons on the premises, one of whom shall either be a licensed physician and surgeon or a licensed health care professional with current certification in advanced cardiac life support (ACLS), as long as a patient is present who has not been discharged from supervised care.
(Added by Stats. 1999, Ch. 944, Sec. 2. Effective January 1, 2000.)

Business and Professions Code - BPC

DIVISION 2. HEALING ARTS [500. - 4999.129.]
(Division 2 enacted by Stats. 1937, Ch. 399.)

CHAPTER 5. Medicine [2000. - 2521.]
(Chapter 5 repealed and added by Stats. 1980, Ch. 1313, Sec. 2.)

ARTICLE 11.5. Surgery in Certain Outpatient Settings [2215. - 2217.]
(Article 11.5 added by Stats. 1994, Ch. 1276, Sec. 1.)

2216.2.
(a) It is unprofessional conduct for a physician and surgeon to fail to provide adequate security by liability insurance, or by participation in an interindemnity trust, for claims by patients arising out of surgical procedures performed outside of a general acute care hospital as defined in subdivision (a) of Section 1250 of the Health and Safety Code.

(b) For purposes of this section, the board shall determine what constitutes adequate security.

(c) Nothing in this section shall require an insurer admitted to transact liability insurance in this state to provide coverage to a physician and surgeon.

(d) The security required by this section shall be acceptable only if provided by any one of the following:

(1) An insurer admitted pursuant to Section 700 of the Insurance Code to transact liability insurance in this state.

(2) An insurer that is eligible pursuant to Section 1765.1 of the Insurance Code.

(3) A cooperative corporation authorized by Section 1280.7 of the Insurance Code.

(4) An insurer licensed to transact liability insurance in at least one state of the United States.
(Amended by Stats. 2011, Ch. 83, Sec. 1. Effective July 15, 2011. Operative July 21, 2011, by Sec. 34 of Stats. 2011, Ch. 83.)

Business and Professions Code - BPC

DIVISION 2. HEALING ARTS [500. - 4999.129.]
(Division 2 enacted by Stats. 1937, Ch. 399.)

CHAPTER 5. Medicine [2000. - 2521.]
(Chapter 5 repealed and added by Stats. 1980, Ch. 1313, Sec. 2.)

ARTICLE 11.5. Surgery in Certain Outpatient Settings [2215. - 2217.]
(Article 11.5 added by Stats. 1994, Ch. 1276, Sec. 1.)

2217.
The Division of Licensing of the Medical Board of California may adopt regulations to implement this article and Chapter 1.3 (commencing with Section 1248) of Division 2 of the Health and Safety Code.
(Added by Stats. 1994, Ch. 1276, Sec. 1. Effective January 1, 1995.)

ATTACHMENT - 2

Health and Safety Code - HSC

DIVISION 2. LICENSING PROVISIONS [1200. - 1795.]
(Division 2 enacted by Stats. 1939, Ch. 60.)

CHAPTER 1.3. Outpatient Settings [1248. - 1248.85.]
(Chapter 1.3 added by Stats. 1994, Ch. 1276, Sec. 2.)

HSC § 1248.
For purposes of this chapter, the following definitions shall apply:

(a) "Division" means the Medical Board of California. All references in this chapter to the division, the Division of Licensing of the Medical Board of California, or the Division of Medical Quality shall be deemed to refer to the Medical Board of California pursuant to Section 2002 of the Business and Professions Code.

(b) (1) "Outpatient setting" means any facility, clinic, unlicensed clinic, center, office, or other setting that is not part of a general acute care facility, as defined in Section 1250, and where anesthesia, except local anesthesia or peripheral nerve blocks, or both, is used in compliance with the community standard of practice, in doses that, when administered have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes.

(2) "Outpatient setting" also means facilities that offer in vitro fertilization, as defined in subdivision (b) of Section 1374.55.

(3) "Outpatient setting" does not include, among other settings, any setting where anxiolytics and analgesics are administered, when done so in compliance with the community standard of practice, in doses that do not have the probability of placing the patient at risk for loss of the patient's life-preserving protective reflexes.

(c) "Accreditation agency" means a public or private organization that is approved to issue certificates of accreditation to outpatient settings by the board pursuant to Sections 1248.15 and 1248.4.

(Amended by Stats. 2011, Ch. 645, Sec. 2. Effective January 1, 2012.)

HSC § 1248.1.
No association, corporation, firm, partnership, or person shall operate, manage, conduct, or maintain an outpatient setting in this state, unless the setting is one of the following:

(a) An ambulatory surgical center that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. Sec. 1395 et seq.) of the federal Social Security Act.

(b) Any clinic conducted, maintained, or operated by a federally recognized Indian tribe or tribal organization, as defined in Section 450 or 1601 of Title 25 of the United States Code, and located on land recognized as tribal land by the federal government.

(c) Any clinic directly conducted, maintained, or operated by the United States or by any of its departments, officers, or agencies.

(d) Any primary care clinic licensed under subdivision (a) and any surgical clinic licensed under subdivision (b) of Section 1204.

(e) Any health facility licensed as a general acute care hospital under Chapter 2 (commencing with Section 1250).

(f) Any outpatient setting to the extent that it is used by a dentist or physician and surgeon in compliance with Article 2.7 (commencing with Section 1646) or Article 2.8 (commencing with Section 1647) of Chapter 4 of Division 2 of the Business and Professions Code.

(g) An outpatient setting accredited by an accreditation agency approved by the division pursuant to this chapter.

(h) A setting, including, but not limited to, a mobile van, in which equipment is used to treat patients admitted to a facility described in subdivision (a), (d), or (e), and in which the procedures performed are staffed by the medical staff of, or other healthcare practitioners with clinical privileges at, the facility and are subject to the peer review process of the facility but which setting is not a part of a facility described in subdivision (a), (d), or (e).

Nothing in this section shall relieve an association, corporation, firm, partnership, or person from complying with all other provisions of law that are otherwise applicable.

(Added by Stats. 1994, Ch. 1276, Sec. 2. Effective January 1, 1995.)

HSC § 1248.15.
(a) The board shall adopt standards for accreditation and, in approving accreditation agencies to perform accreditation of outpatient settings, shall ensure that the certification program shall, at a minimum, include standards for the following aspects of the settings' operations:

(1) Outpatient setting allied health staff shall be licensed or certified to the extent required by state or federal law.

(2) (A) Outpatient settings shall have a system for facility safety and emergency training requirements.

(B) There shall be onsite equipment, medication, and trained personnel to facilitate handling of services sought or provided and to facilitate handling of any medical emergency that may arise in connection with services sought or provided.

(C) In order for procedures to be performed in an outpatient setting as defined in Section 1248, the outpatient setting shall do one of the following:

(i) Have a written transfer agreement with a local accredited or licensed acute care hospital, approved by the facility's medical staff.

(ii) Permit surgery only by a licensee who has admitting privileges at a local accredited or licensed acute care hospital, with the exception that licensees who may be precluded from having admitting privileges

by their professional classification or other administrative limitations, shall have a written transfer agreement with licensees who have admitting privileges at local accredited or licensed acute care hospitals.

(iii) Submit for approval by an accrediting agency a detailed procedural plan for handling medical emergencies that shall be reviewed at the time of accreditation. No reasonable plan shall be disapproved by the accrediting agency.

(D) In addition to the requirements imposed in subparagraph (C), the outpatient setting shall submit for approval by an accreditation agency at the time of accreditation a detailed plan, standardized procedures, and protocols to be followed in the event of serious complications or side effects from surgery that would place a patient at high risk for injury or harm or to govern emergency and urgent care situations. The plan shall include, at a minimum, that if a patient is being transferred to a local accredited or licensed acute care hospital, the outpatient setting shall do all of the following:

(i) Notify the individual designated by the patient to be notified in case of an emergency.

(ii) Ensure that the mode of transfer is consistent with the patient's medical condition.

(iii) Ensure that all relevant clinical information is documented and accompanies the patient at the time of transfer.

(iv) Continue to provide appropriate care to the patient until the transfer is effectuated.

(E) All physicians and surgeons transferring patients from an outpatient setting shall agree to cooperate with the medical staff peer review process on the transferred case, the results of which shall be referred back to the outpatient setting, if deemed appropriate by the medical staff peer review committee. If the medical staff of the acute care facility determines that inappropriate care was delivered at the outpatient setting, the acute care facility's peer review outcome shall be reported, as appropriate, to the accrediting body or in accordance with existing law.

(3) The outpatient setting shall permit surgery by a dentist acting within his or her scope of practice under Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code or physician and surgeon, osteopathic physician and surgeon, or podiatrist acting within his or her scope of practice under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or the Osteopathic Initiative Act. The outpatient setting may, in its discretion, permit anesthesia service by a certified registered nurse anesthetist acting within his or her scope of practice under Article 7 (commencing with Section 2825) of Chapter 6 of Division 2 of the Business and Professions Code.

(4) Outpatient settings shall have a system for maintaining clinical records.

(5) Outpatient settings shall have a system for patient care and monitoring procedures.

(6) (A) Outpatient settings shall have a system for quality assessment and improvement.

(B) Members of the medical staff and other practitioners who are granted clinical privileges shall be professionally qualified and appropriately credentialed for the performance of privileges granted. The outpatient setting shall grant privileges in accordance with recommendations from qualified health professionals, and credentialing standards established by the outpatient setting.

(C) Clinical privileges shall be periodically reappraised by the outpatient setting. The scope of procedures performed in the outpatient setting shall be periodically reviewed and amended as appropriate.

(7) Outpatient settings regulated by this chapter that have multiple service locations shall have all of the sites inspected.

(8) Outpatient settings shall post the certificate of accreditation in a location readily visible to patients and staff.

(9) Outpatient settings shall post the name and telephone number of the accrediting agency with instructions on the submission of complaints in a location readily visible to patients and staff.

(10) Outpatient settings shall have a written discharge criteria.

(b) Outpatient settings shall have a minimum of two staff persons on the premises, one of whom shall either be a licensed physician and surgeon or a licensed health care professional with current certification in advanced cardiac life support (ACLS), as long as a patient is present who has not been discharged from supervised care. Transfer to an unlicensed setting of a patient who does not meet the discharge criteria adopted pursuant to paragraph (10) of subdivision (a) shall constitute unprofessional conduct.

(c) An accreditation agency may include additional standards in its determination to accredit outpatient settings if these are approved by the board to protect the public health and safety.

(d) No accreditation standard adopted or approved by the board, and no standard included in any certification program of any accreditation agency approved by the board, shall serve to limit the ability of any allied health care practitioner to provide services within his or her full scope of practice. Notwithstanding this or any other provision of law, each outpatient setting may limit the privileges, or determine the privileges, within the appropriate scope of practice, that will be afforded to physicians and allied health care practitioners who practice at the facility, in accordance with credentialing standards established by the outpatient setting in compliance with this chapter. Privileges may not be arbitrarily restricted based on category of licensure.

(e) The board shall adopt standards that it deems necessary for outpatient settings that offer in vitro fertilization.

(f) The board may adopt regulations it deems necessary to specify procedures that should be performed in an accredited outpatient setting for facilities or clinics that are outside the definition of outpatient setting as specified in Section 1248.

(g) As part of the accreditation process, the accrediting agency shall conduct a reasonable investigation of the prior history of the outpatient setting, including all licensed physicians and surgeons who have an ownership interest therein, to determine whether there have been any adverse accreditation decisions rendered against them. For the purposes of this section, “conducting a reasonable investigation” means querying the Medical Board of California and the Osteopathic Medical Board of California to ascertain if either the outpatient setting has, or, if its owners are licensed physicians and surgeons, if those physicians and surgeons have, been subject to an adverse accreditation decision.

(h) An outpatient setting shall be subject to the reporting requirements in Section 1279.1 and the penalties for failure to report specified in Section 1280.4.

(Amended by Stats. 2011, Ch. 645, Sec. 3. Effective January 1, 2012.)

HSC § 1248.2.
(a) Any outpatient setting may apply to an accreditation agency for a certificate of accreditation. Accreditation shall be issued by the accreditation agency solely on the basis of compliance with its standards as approved by the board under this chapter.

(b) The board shall obtain and maintain a list of accredited outpatient settings from the information provided by the accreditation agencies approved by the board, and shall notify the public, by placing the information on its Internet Web site, whether an outpatient setting is accredited or the setting's accreditation has been revoked, suspended, or placed on probation, or the setting has received a reprimand by the accreditation agency.

(c) The list of outpatient settings shall include all of the following:

(1) Name, address, and telephone number of any owners, and their medical license numbers.

(2) Name and address of the facility.

(3) The name and telephone number of the accreditation agency.

(4) The effective and expiration dates of the accreditation.

(d) Accrediting agencies approved by the board shall notify the board and update the board on all outpatient settings that are accredited.

(Amended by Stats. 2011, Ch. 645, Sec. 4. Effective January 1, 2012.)

HSC § 1248.25.
If an outpatient setting does not meet the standards approved by the board, accreditation shall be denied by the accreditation agency, which shall provide the outpatient setting notification of the reasons for the denial. An outpatient setting may reapply for accreditation at any time after receiving notification of the denial. The accreditation agency shall report within three business days to the board if the outpatient setting's certificate for accreditation has been denied.

(Amended by Stats. 2011, Ch. 645, Sec. 5. Effective January 1, 2012.)

HSC § 1248.3.
(a) Certificates of accreditation issued to outpatient settings by an accreditation agency shall be valid for not more than three years.

(b) The outpatient setting shall notify the accreditation agency within 30 days of any significant change in ownership, including, but not limited to, a merger, change in majority interest, consolidation, name change, change in scope of services, additional services, or change in locations.

(c) Except for disclosures to the division or to the Division of Medical Quality under this chapter, an accreditation agency shall not disclose information obtained in the performance of accreditation activities under this chapter that individually identifies patients, individual medical practitioners, or outpatient settings. Neither the proceedings nor the records of an accreditation agency or the proceedings and records of an outpatient setting related to performance of quality assurance or accreditation activities under this chapter shall be subject to discovery, nor shall the records or proceedings be admissible in a court of law. The prohibition relating to discovery and admissibility of records and proceedings does not apply to any outpatient setting requesting accreditation in the event that denial or revocation of that outpatient setting's accreditation is being contested. Nothing in this section shall prohibit the accreditation agency from making discretionary disclosures of information to an outpatient setting pertaining to the accreditation of that outpatient setting.

(Added by Stats. 1994, Ch. 1276, Sec. 2. Effective January 1, 1995.)

HSC § 1248.35.
(a) Every outpatient setting which is accredited shall be inspected by the accreditation agency and may also be inspected by the Medical Board of California. The Medical Board of California shall ensure that accreditation agencies inspect outpatient settings.

(b) Unless otherwise specified, the following requirements apply to inspections described in subdivision (a).

(1) The frequency of inspection shall depend upon the type and complexity of the outpatient setting to be inspected.

(2) Inspections shall be conducted no less often than once every three years by the accreditation agency and as often as necessary by the Medical Board of California to ensure the quality of care provided.

(3) The Medical Board of California or the accreditation agency may enter and inspect any outpatient setting that is accredited by an accreditation agency at any reasonable time to ensure compliance with, or investigate an alleged violation of, any standard of the accreditation agency or any provision of this chapter.

(c) If an accreditation agency determines, as a result of its inspection, that an outpatient setting is not in compliance with the standards under which it was approved, the accreditation agency may do any of the following:

(1) Require correction of any identified deficiencies within a set timeframe. Failure to comply shall result in the accrediting agency issuing a reprimand or suspending or revoking the outpatient setting's accreditation.

(2) Issue a reprimand.

(3) Place the outpatient setting on probation, during which time the setting shall successfully institute and complete a plan of correction, approved by the board or the accreditation agency, to correct the deficiencies.

(4) Suspend or revoke the outpatient setting's certification of accreditation.

(d) (1) Except as is otherwise provided in this subdivision, before suspending or revoking a certificate of accreditation under this chapter, the accreditation agency shall provide the outpatient setting with notice

of any deficiencies and the outpatient setting shall agree with the accreditation agency on a plan of correction that shall give the outpatient setting reasonable time to supply information demonstrating compliance with the standards of the accreditation agency in compliance with this chapter, as well as the opportunity for a hearing on the matter upon the request of the outpatient setting. During the allotted time to correct the deficiencies, the plan of correction, which includes the deficiencies, shall be conspicuously posted by the outpatient setting in a location accessible to public view. Within 10 days after the adoption of the plan of correction, the accrediting agency shall send a list of deficiencies and the corrective action to be taken to the board and to the California State Board of Pharmacy if an outpatient setting is licensed pursuant to Article 14 (commencing with Section 4190) of Chapter 9 of Division 2 of the Business and Professions Code. The accreditation agency may immediately suspend the certificate of accreditation before providing notice and an opportunity to be heard, but only when failure to take the action may result in imminent danger to the health of an individual. In such cases, the accreditation agency shall provide subsequent notice and an opportunity to be heard.

(2) If an outpatient setting does not comply with a corrective action within a timeframe specified by the accrediting agency, the accrediting agency shall issue a reprimand, and may either place the outpatient setting on probation or suspend or revoke the accreditation of the outpatient setting, and shall notify the board of its action. This section shall not be deemed to prohibit an outpatient setting that is unable to correct the deficiencies, as specified in the plan of correction, for reasons beyond its control, from voluntarily surrendering its accreditation prior to initiation of any suspension or revocation proceeding.

(e) The accreditation agency shall, within 24 hours, report to the board if the outpatient setting has been issued a reprimand or if the outpatient setting's certification of accreditation has been suspended or revoked or if the outpatient setting has been placed on probation. If an outpatient setting has been issued a license by the California State Board of Pharmacy pursuant to Article 14 (commencing with Section 4190) of Chapter 9 of Division 2 of the Business and Professions Code, the accreditation agency shall also send this report to the California State Board of Pharmacy within 24 hours.

(f) The accreditation agency, upon receipt of a complaint from the board that an outpatient setting poses an immediate risk to public safety, shall inspect the outpatient setting and report its findings of inspection to the board within five business days. If an accreditation agency receives any other complaint from the board, it shall investigate the outpatient setting and report its findings of investigation to the board within 30 days.

(g) Reports on the results of any inspection shall be kept on file with the board and the accreditation agency along with the plan of correction and the comments of the outpatient setting. The inspection report may include a recommendation for reinspection. All final inspection reports, which include the lists of deficiencies, plans of correction or requirements for improvements and correction, and corrective action completed, shall be public records open to public inspection.

(h) If one accrediting agency denies accreditation, or revokes or suspends the accreditation of an outpatient setting, this action shall apply to all other accrediting agencies. An outpatient setting that is denied accreditation is permitted to reapply for accreditation with the same accrediting agency. The outpatient setting also may apply for accreditation from another accrediting agency, but only if it discloses the full accreditation report of the accrediting agency that denied accreditation. Any outpatient setting that has been denied accreditation shall disclose the accreditation report to any other accrediting agency to which it submits an application. The new accrediting agency shall ensure that all deficiencies have been corrected and conduct a new onsite inspection consistent with the standards specified in this chapter.

(i) If an outpatient setting's certification of accreditation has been suspended or revoked, or if the accreditation has been denied, the accreditation agency shall do all of the following:

(1) Notify the board of the action.

(2) Send a notification letter to the outpatient setting of the action. The notification letter shall state that the setting is no longer allowed to perform procedures that require outpatient setting accreditation.
(3) Require the outpatient setting to remove its accreditation certification and to post the notification letter in a conspicuous location, accessible to public view.

(j) The board may take any appropriate action it deems necessary pursuant to Section 1248.7 if an outpatient setting's certification of accreditation has been suspended or revoked, or if accreditation has been denied.

(Amended by Stats. 2012, Ch. 454, Sec. 5. Effective January 1, 2013.)

HSC § 1248.4.
(a) It is the intent of the Legislature that an accreditation agency operating on or before January 1, 1995, or a successor thereof, or an accreditation agency thereafter operating as part of a joint program granted temporary certification as an accreditation agency by the division, whether operating as part of a joint program or independently, and meeting the standards set forth in this chapter, as determined by the division, not be required to go through the entire application process with the division. Therefore, the division may grant a temporary certificate of approval to such an accreditation agency. The temporary approval issued to an accreditation agency under this subdivision shall expire on January 1, 1998. In order to continue its status as an accreditation agency, an accreditation agency approved by the division under this subdivision shall apply for renewal of approval by the division on or before January 1, 1998, and shall establish that it is in compliance with the standards set forth in this chapter and any regulations adopted pursuant thereto.

(b) Each accreditation agency approved by the division shall, on and after January 1, 1995, promptly forward to the division a list of each outpatient setting to which it has granted a certificate of accreditation, as well as settings that have lost accreditation or were denied accreditation.

(c) The division shall approve an accreditation agency that applies for approval on a form prescribed by the division, accompanied by payment of the fee prescribed by this chapter and evidence that the accreditation agency meets the following criteria:

(1) Includes within its accreditation program, at a minimum, the standards for accreditation of outpatient settings approved by the division as well as standards for patient care and safety at the setting.

(2) Submits its current accreditation standards to the division every three years, or upon request for continuing approval by the division.

(3) Maintains internal quality management programs to ensure quality of the accreditation process.

(4) Has a process by which accreditation standards can be reviewed and revised no less than every three years.

(5) Maintains an available pool of allied health care practitioners to serve on accreditation review teams as appropriate.

(6) Has accreditation review teams that shall do all of the following:

(A) Consist of at least one physician and surgeon who practices in an outpatient setting; any other members shall be practicing actively in these settings.

(B) Participate in formal educational training programs provided by the accreditation agency in evaluation of the certification standards at least every three years.

(7) The accreditation agency shall demonstrate that professional members of its review team have experience in conducting review activities of freestanding outpatient settings.

(8) Standards for accreditation shall be developed with the input of the medical community and the ambulatory surgery industry.

(9) Accreditation reviewers shall be credentialed and screened by the accreditation agency.

(10) The accreditation agency shall not have an ownership interest in nor be involved in the operation of a freestanding outpatient setting, nor in the delivery of health care services to patients.

(d) Accreditation agencies approved by the division shall forward to the division copies of all certificates of accreditation and shall notify the division promptly whenever the agency denies or revokes a certificate of accreditation.

(e) A certification of an accreditation agency by the division shall expire at midnight on the last day of a three-year term if not renewed. The division shall establish by regulation the procedure for renewal. To renew an unexpired approval, the accreditation agency shall, on or before the date upon which the certification would otherwise expire, apply for renewal on a form, and pay the renewal fee, as prescribed by the division.

(Amended by Stats. 1997, Ch. 769, Sec. 1. Effective October 8, 1997.)

HSC § 1248.5.
The board shall evaluate the performance of an approved accreditation agency no less than every three years, or in response to complaints against an agency, or complaints against one or more outpatient settings accreditation by an agency that indicates noncompliance by the agency with the standards approved by the board.

(Amended by Stats. 2011, Ch. 645, Sec. 7. Effective January 1, 2012.)

HSC § 1248.55.
(a) If the accreditation agency is not meeting the criteria set by the division, the division may terminate approval of the agency.

(b) Before terminating approval of an accreditation agency, the division shall provide the accreditation agency with notice of any deficiencies and reasonable time to supply information demonstrating compliance with the requirements of this chapter, as well as the opportunity for a hearing on the matter in compliance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) (1) If approval of the accreditation agency is terminated by the division, outpatient settings accredited by that agency shall be notified by the division and, except as provided in paragraph (2), shall be authorized to continue to operate for a period of 12 months in order to seek accreditation through an approved accreditation agency, unless the time is extended by the division for good cause.

(2) The division may require that an outpatient setting, that has been accredited by an accreditation agency whose approval has been terminated by the division, cease operations immediately in the event that the division is in possession of information indicating that continued operation poses an imminent risk of harm to the health of an individual. In such cases, the division shall provide the outpatient setting with notice of its action, the reason underlying it, and a subsequent opportunity for a hearing on the matter. An outpatient setting that is ordered to cease operations under this paragraph may reapply for a certificate of accreditation after six months and shall notify the division promptly of its reapplication.

(Added by Stats. 1994, Ch. 1276, Sec. 2. Effective January 1, 1995

HSC § 1248.6.
(a) The Division of Licensing shall establish by regulation a reasonable fee for an application for approval as an accreditation agency in an amount that is reasonably necessary to recover the cost of implementing and administering this chapter, and not to exceed five thousand dollars ($5,000). The division shall establish by regulation a reasonable fee for a temporary certificate of approval, as outlined in subdivision (a) of Section 1248.4, not to exceed two thousand dollars ($2,000). The division shall also establish a reasonable fee for renewal. The renewal fee shall be proportionate to the number of outpatient settings accredited by the approved accrediting body seeking renewal, and shall not exceed one hundred dollars ($100) per outpatient setting accreditation reviewed.

(b) All fees paid to and received by the division or the Medical Board of California under this chapter shall be paid into the State Treasury and shall be credited to a special fund that is hereby created as the Outpatient Setting Fund of the Medical Board of California. Funds in the Outpatient Setting Fund of the Medical Board of California shall be expended by the board for the purpose of implementing and administering this chapter upon appropriation by the Legislature. No surplus in the fund shall be deposited in or transferred to the General Fund or any other fund.

(Added by Stats. 1994, Ch. 1276, Sec. 2. Effective January 1, 1995.)

HSC § 1248.65.
It shall constitute unprofessional conduct for a physician and surgeon to willfully and knowingly violate this chapter.

(Added by Stats. 1994, Ch. 1276, Sec. 2. Effective January 1, 1995.)

HSC § 1248.7.
(a) The board shall investigate all complaints concerning a violation of this chapter. With respect to any complaints relating to a violation of Section 1248.1, or upon discovery that an outpatient setting is not in compliance with Section 1248.1, the board shall investigate and, where appropriate, the board, through or in conjunction with the local district attorney, shall bring an action to enjoin the outpatient setting's operation. The board or the local district attorney may bring an action to enjoin a violation or threatened violation of any other provision of this chapter in the superior court in and for the county in which the violation occurred or is about to occur. Any proceeding under this section shall conform to the requirements of Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure, except that the Division of Medical Quality shall not be required to allege facts necessary to show or tending to show lack of adequate remedy at law or irreparable damage or loss.

(b) With respect to any and all actions brought pursuant to this section alleging an actual or threatened violation of any requirement of this chapter, the court shall, if it finds the allegations to be true, issue an order enjoining the person or facility from continuing the violation. For purposes of Section 1248.1, if an outpatient setting is operating without a certificate of accreditation, this shall be prima facie evidence that a violation of Section 1248.1 has occurred and additional proof shall not be necessary to enjoin the outpatient setting's operation.

(Amended by Stats. 2011, Ch. 645, Sec. 8. Effective January 1, 2012.)

HSC § 1248.8.
(a) Any person or entity that willfully violates this chapter or any rule or regulation adopted under this chapter shall be guilty of a misdemeanor and subject to a fine not to exceed one thousand dollars ($1,000) per day of violation.

(b) In determining the punishment to be imposed under this section, the court shall consider all relevant facts, including, but not limited to, the following:

(1) Whether the violation exposed a patient or other individual to the risk of death or serious physical harm.

(2) Whether the violation had a direct or immediate relationship to health, safety, or security of a patient or other individual.

(3) Evidence, if any, of willfulness in the violation.

(4) The presence or absence of good faith efforts by the outpatient setting to prevent the violation.

(c) For purposes of this section, "willfully" or "willful" means that the person doing an act or omitting to do an act intends the act or omission, and knows the relevant circumstances connected with the act or omission.

(d) The district attorney of every county shall, upon application by the Division of Medical Quality or its authorized representative, institute and conduct the prosecution of any action or violation within the county of any provisions of this chapter.

(Added by Stats. 1994, Ch. 1276, Sec. 2. Effective January 1, 1995.)

HSC § 1248.85.
This chapter shall not preclude an approved accreditation agency from adopting additional standards consistent with Section 1248.15, establishing procedures for the conduct of onsite inspections, selecting onsite inspectors to perform accreditation onsite inspections, or establishing and collecting reasonable fees for the conduct of accreditation onsite inspections.

(Amended by Stats. 2011, Ch. 645, Sec. 9. Effective January 1, 2012.)

ATTACHMENT - 3

16 CCR § 1313.2

Cal. Admin. Code tit. 16, § 1313.2

Barclays Official California Code of Regulations Currentness
Title 16. Professional and Vocational Regulations
Division 13. Medical Board of California [FNA1]
Chapter 1. Division of Licensing
Article 3.5. Outpatient Setting Accreditation Agencies (Refs & Annos)
[FNa1] For disposition of former Sections 1370-1375.45, see Table of Parallel Reference, Chapter 13.2, Title 16, California Code of Regulations.
§ 1313.2. Definitions.

(a) “Accredited” shall include, for purposes of section 1248.1(g) of the Health and Safety Code, not only full accreditation but also provisional accreditation granted by an accreditation agency to an outpatient setting, provided that (1) the outpatient setting is in substantial compliance with the accreditation agency's standards; (2) the deficiencies in compliance do not affect the quality of patient care; and (3) the deficiencies will be corrected within six months of the date on which the outpatient setting was granted provisional accreditation.

(b) “Accreditation agency” has the meaning given to it in section 1248(d) of the Health and Safety Code.

Note: Authority cited: Sections 2018 and 2217, Business and Professions Code. Reference: Section 1248, Health and Safety Code.

HISTORY

1. New Article 3.5 and section filed 1-18-96; operative 2-17-96 (Register 96, No. 3).

16 CCR § 1313.2, 16 CA ADC § 1313.2

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16 CCR § 1313.3

Cal. Admin. Code tit. 16, § 1313.3

Barclays Official California Code of Regulations Currentness
Title 16. Professional and Vocational Regulations
Division 13. Medical Board of California [FNA1]
Chapter 1. Division of Licensing
Article 3.5. Outpatient Setting Accreditation Agencies (Refs & Annos)
[FNa1] For disposition of former Sections 1370-1375.45, see Table of Parallel Reference, Chapter 13.2, Title 16, California Code of Regulations.
§ 1313.3. Applications; Processing Times.

(a) An application for approval as an accreditation agency shall be filed with the division at its principal office and shall be accompanied by the fee prescribed by this article.

(b) An application shall include the following information and documents:

(1) Name and address of applicant;

(2) Date applicant began to operate as as accreditation agency;

(3) Copy of applicant's current accreditation standards;

(4) A list of all outpatient settings accredited or certified by applicant;

(5) Information to establish the applicant's compliance with sections 1248.15 and 1248.4 of the Health and Safety Code and section 1313.4.

(c) The division shall inform an applicant for approval as an accreditation agency in writing within 30 days of receipt of an application whether the application is complete and accepted for filing or is deficient and what specific information or documentation is required to complete the application.

(d) The division shall inform an applicant as an accreditation agency within 120 days after completion of the application of its decision whether the applicant meets the requirements for approval. An application is considered complete if it is in compliance with the requirements of sections 1248.15 and 1248.4 of the Health and Safety Code and section 1313.4.

Note: Authority cited: Sections 2018 and 2217, Business and Professions Code; and Section 15376, Government Code. Reference: Sections 1248.15 and 1248.4, Health and Safety Code; and Section 15376, Government Code.

HISTORY

1. New section filed 1-18-96; operative 2-17-96 (Register 96, No. 3).

16 CCR § 1313.3, 16 CA ADC § 1313.3

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16 CCR § 1313.4

Cal. Admin. Code tit. 16, § 1313.4

Barclays Official California Code of Regulations Currentness
Title 16. Professional and Vocational Regulations
Division 13. Medical Board of California [FNA1]
Chapter 1. Division of Licensing
Article 3.5. Outpatient Setting Accreditation Agencies (Refs & Annos)
[FNa1] For disposition of former Sections 1370-1375.45, see Table of Parallel Reference, Chapter 13.2, Title 16, California Code of Regulations.
§ 1313.4. Standards.

(a) An accreditation agency shall meet the standards set forth in sections 1248.15 and 1248.4 of the Health and Safety Code.

(1) With respect to section 1248.15(a)(2)(C)(i), a written transfer agreement shall include a mechanism for patient transport; a plan for transfer of the patient's records; policies defining the role of each person in handling an emergency; and a plan for continuity of the patient's care upon transfer of that care.

(2) With respect to section 1248.15(a)(6), the required system for quality assessment and improvement shall include, in addition to chart review, actions that utilize information derived through quality assessment to improve systems to maximize patient protection.

(3) With respect to section 1248.15(a)(7), the actual sample size shall be determined by the accreditation agency.

(b) An accreditation agency shall send to the division any change in its accreditation standards within 30 calendar days after making the change.

(c) An accreditation agency shall, within fourteen calendar days after issuance, provide to the division a copy of any certificates of accreditation it issues and any denial or revocation of a certificate of accreditation. For each setting whose accreditation it denies or revokes, the accreditation agency shall also provide to the division in writing the reasons for its action.

Note: Authority cited: Sections 2018 and 2217, Business and Professions Code; and Section 1248.15, Health and Safety Code. Reference: Sections 1248.15 and 1248.4, Health and Safety Code.

HISTORY

1. New section filed 1-18-96; operative 2-17-96 (Register 96, No. 3).

2. New subsection (a)(1), subsection renumbering, amendment of subsection (c) and amendment of Note filed 12-5-2000; operative 1-4-2001 (Register 2000, No. 49).

16 CCR § 1313.4, 16 CA ADC § 1313.4

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16 CCR § 1313.5

Cal. Admin. Code tit. 16, § 1313.5

Barclays Official California Code of Regulations Currentness
Title 16. Professional and Vocational Regulations
Division 13. Medical Board of California [FNA1]
Chapter 1. Division of Licensing
Article 3.5. Outpatient Setting Accreditation Agencies (Refs & Annos)
[FNa1] For disposition of former Sections 1370-1375.45, see Table of Parallel Reference, Chapter 13.2, Title 16, California Code of Regulations.
§ 1313.5. Renewal.

An application for renewal of approval shall be filed with the division at its principal office prior to expiration of the approval. It shall include all of the information required by section 1313.3(b) and shall be accompanied by the renewal fee prescribed by this article.

Note: Authority cited: Sections 2018 and 2217, Business and Professions Code; and Section 1248.4(e), Health and Safety Code. Reference: Section 1248.4, Health and Safety Code.

HISTORY

1. New section filed 1-18-96; operative 2-17-96 (Register 96, No. 3).

16 CCR § 1313.5, 16 CA ADC § 1313.5

This database is current through 3/8/13 Register 2013, No. 10

END OF DOCUMENT

16 CCR § 1313.6

Cal. Admin. Code tit. 16, § 1313.6

Barclays Official California Code of Regulations Currentness
Title 16. Professional and Vocational Regulations
Division 13. Medical Board of California [FNA1]
Chapter 1. Division of Licensing
Article 3.5. Outpatient Setting Accreditation Agencies (Refs & Annos)
[FNa1] For disposition of former Sections 1370-1375.45, see Table of Parallel Reference, Chapter 13.2, Title 16, California Code of Regulations.
§ 1313.6. Fees.

(a) The fee for temporary approval as an accreditation agency is $2,000.

(b) The fee for approval as an accreditation agency is $5,000.

(c) The fee for renewal of approval is $100 for each outpatient setting accredited or reaccredited during the three years immediately preceding the filing of the renewal application.

Note: Authority cited: Sections 2018 and 2217, Business and Professions Code; and Section 1248.6, Health and Safety Code. Reference: Section 1248.6, Health and Safety Code.

HISTORY

1. New section filed 1-18-96; operative 2-17-96 (Register 96, No. 3).

16 CCR § 1313.6, 16 CA ADC § 1313.6

This database is current through 3/8/13 Register 2013, No. 10

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MEDICAL BOARD OF CALIFORNIA

OUTPATIENT SURGERY SETTING INFORMATIONAL PRESENTATION

April 25, 2013

OUTPATIENT SURGERY SETTING INFORMATIONAL PRESENTATION

Business and Professions Code Section 2215

"The Legislature finds and declares that in this state, significant surgeries are being performed in unregulated out-of-hospital settings. The Legislature further finds and declares that without appropriate oversight, some of these settings may be operating in a manner which is injurious to the public health, welfare and safety…"

(Added Stats. 1994, ch. 1276, § 1 (AB 595.)

OUTPATIENT SURGERY SETTING INFORMATIONAL PRESENTATION

Business and Professions Code Section 2216

"On or After July 1, 1996, no physician and surgeon shall perform procedures in an outpatient setting using anesthesia, except local anesthesia or peripheral nerve blocks, or both, complying with the community standard of practice, in doses that when administered, have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes, unless the setting is specified in Section 1248.1…"

(Added Stats. 1994, ch. 1276, § 1 (AB 595.)

OUTPATIENT SURGERY SETTING INFORMATIONAL PRESENTATION

Health and Safety Code Section 1248

(b)(1) "Outpatient setting" means any facility, clinic, unlicensed clinic, center, office, or other setting that is not part of a general acute care facility, as defined in Section 1250, and where anesthesia, except local anesthesia or peripheral nerve blocks, or both, is used in compliance with the community standard of practice, in doses that, when administered have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes...

OUTPATIENT SURGERY SETTING INFORMATIONAL PRESENTATION

Required Settings

Health and Safety Code Section 1248.1 specifies them as:

"(d) Any primary care clinic licensed under subdivision (a) and any surgical clinic licensed under subdivision (b) of Section 1204.

* * *

(g) An outpatient setting accredited by an accreditation agency approved by the division pursuant to this chapter."

OUTPATIENT SURGERY SETTING INFORMATIONAL PRESENTATION

Outpatient Surgery Settings are "authorized" in the following ways :

1) Licensed by California Department of Public Health;
2) Accredited by an agency approved by the Medical Board of California; or
3) Fit another statutory classification.

OUTPATIENT SURGERY SETTING INFORMATIONAL PRESENTATION

- A court decision (*Capen v. Shewry*) altered the landscape relating to the operation of these settings.
- After *Capen*, the Department of Public Health will not license Outpatient Surgery Settings that are owned in whole or part by physicians
- If these sites don't fit within a statutory classification, they need to be accredited

OUTPATIENT SURGERY SETTING INFORMATIONAL PRESENTATION

- To implement these laws, MBC has adopted regulations specifying approval and renewal criteria for Accreditation Agencies

- These criteria may be found at California Code of Regulations, Title 16, Division 13, Sections 1313.2 – 1313.6

OUTPATIENT SURGERY SETTING INFORMATIONAL PRESENTATION

Important Concept

- An Outpatient Surgery Setting is a place
- A fixed location with an address
- If we had a vehicle with a GPS device, we could drive there

OUTPATIENT SURGERY SETTING INFORMATIONAL PRESENTATION

Contrast A Personal License

- Physician's and Surgeon's Certificate
- Law License
- These licenses follow you around

OUTPATIENT SURGERY SETTING INFORMATIONAL PRESENTATION

Q. Does the Medical Board of California License Outpatient Surgery Settings?

A. No. The Medical Board of California indirectly oversees Outpatient Surgery Settings

Q. How does it do that?

A. The Board approves the agencies that accredit Outpatient Surgery Settings

OUTPATIENT SURGERY SETTING INFORMATIONAL PRESENTATION

Who can operate, manage, conduct or maintain an Outpatient Surgery Setting?

- An Association
- Corporation
- Firm
- Partnership
- Individual Person

(Health and & Safety Code, § 1248.1)

OUTPATIENT SURGERY SETTING INFORMATIONAL PRESENTATION

Exemptions from accreditation:

An ambulatory surgical center that is certified to participate in Medicare program…

Any clinic conducted, maintained, or operated by a federally recognized Indian tribe or tribal organization,…

Any clinic directly conducted, maintained or operated by the United States…

OUTPATIENT SURGERY SETTING INFORMATIONAL PRESENTATION

Any primary care clinic or surgical clinic licensed under section 1204

Any health facility licensed as a general acute care hospital

Outpatient surgical setting where anxiolytics and analgesics are administered in compliance with the community standard of practice, in doses that do not have the probability of placing the patient at risk for loss of life preserving protective reflexes

OUTPATIENT SURGERY SETTING INFORMATIONAL PRESENTATION

Powers of the Board

The Board Approves Accreditation Agencies

The Board may inspect outpatient settings and shall investigate complaints

The Board shall evaluate approved accreditation agencies not less than every three years

The Board may terminate the approval of an accrediting agency

The Board, under certain circumstances, may seek injunctive relief

OUTPATIENT SURGERY SETTING INFORMATIONAL PRESENTATION

The Board grants approval to an Accreditation Agency upon the Accreditation Agency submitting the application and necessary fee, the required supporting documentation, and the Board determining that the materials submitted indicate the Accreditation Agency meets the minimum requirements set forth in the relevant sections of the California Health and Safety Code and the California Code of Regulations.

OUTPATIENT SURGERY SETTING INFORMATIONAL PRESENTATION

Outpatient Surgery Setting Accreditation Requirements

Outpatient Surgery Settings must meet the minimum requirements pursuant to Health and Safety Code Section 1248.15 and California Code of Regulations Section 1313.4 to be eligible for accreditation by a Medical Board of California approved Accreditation Agency.

OUTPATIENT SURGERY SETTING INFORMATIONAL PRESENTATION

The Medical Board of California currently has approved four Accreditation Agencies:

American Association for Accreditation of Ambulatory Surgery Facilities Inc. (AAAASF)

Accreditation Association for Ambulatory Health Care (AAAHC)

Institute for Medical Quality (IMQ)

The Joint Commission (JC)

AAAHC
ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

AAAHC Accreditation Process

Thursday, April 25, 2013

IMPROVING HEALTH CARE QUALITY THROUGH ACCREDITATION

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Presenter

Carolyn Kurtz, JD

General Counsel & Vice President, Public/ Government Affairs

Mary Wei

Assistant Director, Accreditation Services

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Session objectives

- Outline activities:
  - Before the survey
  - During the survey
  - After the survey

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Before the survey

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Preparing to Apply for AAAHC Survey

Review Handbook

Determine Survey Eligibility

- In order to qualify for survey an organization requesting a AAAHC survey must
  - Provide Health Care services ≥ 6 mo prior to survey

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Preparing to Apply for AAAHC Survey (cont'd)

- Be a formally organized and legally constituted entity
- In compliance with applicable laws and regulations
- Licensed by the state, if applicable

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Preparing to Apply for AAAHC Survey (cont'd)

- Provides health care services under direction of
  - MD, DO, DDS, DMD, DPM, OD, DC, APRN (practicing in compliance with state law and regulation), and licensed clinical behavioral health professional

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Preparing to Apply for AAAHC Survey (cont'd)

- Shares facilities, records, equipment, and business management among its members
- Complies with US EEOC law
- Submits a completed application for survey
- Pays the appropriate fees
- Acts in good faith in providing information to AAAHC

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Application for Survey

For California outpatient settings, the application includes questions related to

- Ownership
- Anesthesia provision
- Any previous denial of accreditation

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Survey Scheduling

- Organization provides available timeframes for survey, including dates not available
- If Medicare, 5 days not available
- Appropriately privileged surveyors are scheduled
- Written confirmation of scheduled survey (if Medicare, the survey will be unannounced)

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On-site survey

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While we're on-site

During the on-site visit, surveyors will

1. Review documents such as (but not limited to)
   - Policies and Procedures
   - Records (Credential, Personnel, Clinical)
   - Quality Improvement Program
   - Infection Prevention Program
   - Risk Management Program

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While we're on-site (cont'd.)

During the on-site visit, surveyors will

2. Interview staff to determine understanding of policies
3. If necessary, allow for members of the public to share information

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While we're on-site (cont'd.)

During the on-site visit, surveyors will

4. Review compliance for previously cited deficiencies
5. For Medicare, follow the process from admission to discharge
6. Share findings with leadership members of the organization

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While we're on-site (cont'd.)

For California Outpatient Settings, surveyors review

- Compliance with the requirements of Section 2216, Section 61638.2 and 2259.8
- Compliance with previously cited deficiencies

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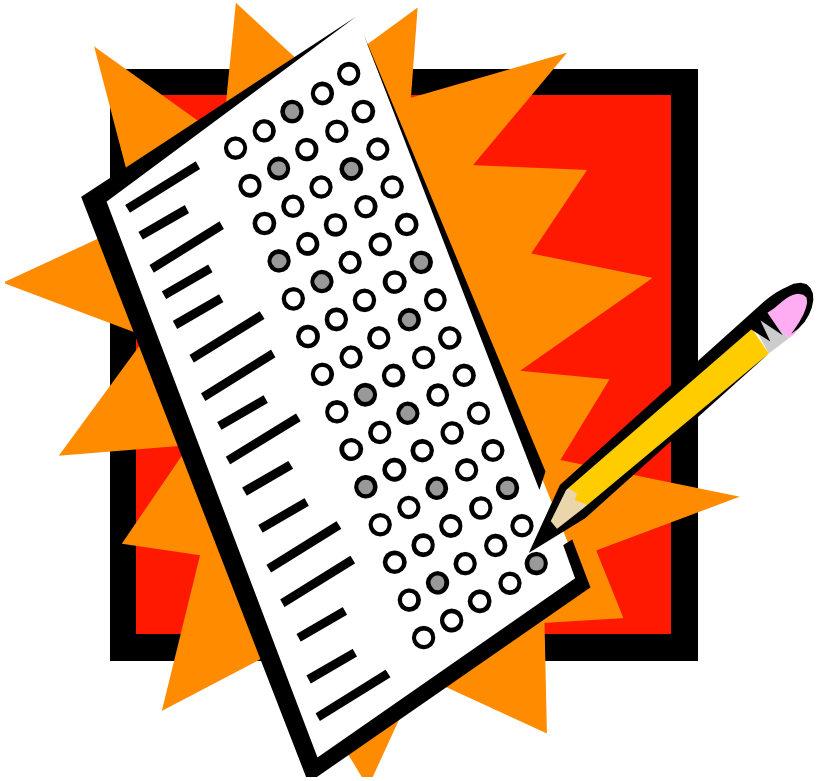
After the survey



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After the survey

AAAHC surveyors submit the survey report to AAAHC.

Report is reviewed internally and by the Accreditation Committee

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After the survey (cont'd.)

If Medicare, and deficiencies identified during the survey, organization receives a request for a plan of correction

An accreditation decision is granted by the Accreditation Committee.

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Reporting

Every month

- A list of outpatient settings accredited by AAAHC during the previous month
- Accreditation Expiration list for Outpatient Settings

More immediate reports

- Denial of accrediation
- Actions related to complaints

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During the accreditation term

AAAHC expects organizations to maintain compliance with AAAHC standards as they change from year to year

- Random surveys
- Discretionary surveys (complaints)
- Interim surveys

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Questions?

Contact AAAHC at (847)853-6060 or info@aaahc.org

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The Accreditation Process

Presented by: Thomas Terranova, MA
AAAASF Director of Accreditation
847-775-1970
tom@aaaasf.org
http://www.aaaasf.org

Mission

Patient Safety is the Mission of the American Association for Accreditation of Ambulatory Surgery Facilities, Inc (AAAASF)

About AAAASF

- Established in 1980
- Peer based inspection process
- Educational not punitive
- 100% compliance with standards
- Board certified or eligible medical specialists
- Hospital privileges for procedures performed in facility

Why Accreditation?

- Self-regulation reduces the need for government regulation
- Statistical data indicates accreditation improves outcomes
- Better informed patients demand higher standards of care

Collaboration with State Legislators

- 27 States have guidelines or regulations
- Recognize accreditation in lieu of state licensure
- Cost containment-takes burden from state agencies
- Established program proven effective
- Adequate inspector pool and reporting system

Accreditation Program

3 Year Accreditation Cycle

Initial On-site Inspection Survey

2nd Year and 3rd Year Self Evaluation

Re-inspection On-site Inspection Survey

No reciprocal inspections

No concurrent inspections

AAAASF # 1 Goal: Patient Safety

- Collaborative efforts
- Physician Credentialing
- Standardized Care
- Safe Environment
- Continuing Education

Puts patient safety first & achieves a common goal.

Accreditation Programs

- ASC/OBS Surgical Accreditation
- ASC/OBS Procedural Accreditation
- ASC/OBS Oral & Maxillofacial Surgery
- Medicare Ambulatory Surgery Centers
- Medicare Outpatient Physical Therapy
- Medicare Rural Health Clinics

Facility Classification

Classified by type of anesthesia

- A = Local Anesthesia
- B = IV anesthesia
- Cm = IV anesthesia (including propofol)
- C = General anesthesia

Process

- Submission of application
- All materials checked by staff
- Inspector assigned
- Inspection performed
  - Meeting with key staff
  - Walk through the environment
  - File review
  - Interviews with staff and medical director
  - Summation conference
- Report submitted
- Deficiencies corrected
- Accreditation conferred

Accreditation Program

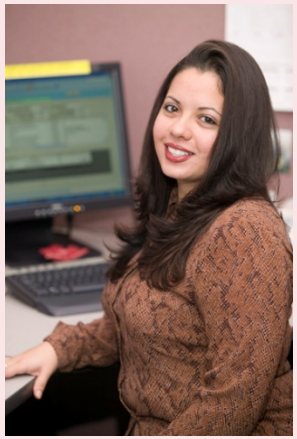
Ten Areas of Inspection include:

1. General Environment
2. Operating Room Environment, Policy & Procedures
3. Recovery Room Environment, Policy & Procedures
4. General Safety in the Facility
5. Blood and Medications
6. Medical Records
7. Quality Assessment/Quality Improvement
8. Personnel
9. Governance (Medicare only)
10. Anesthesia

Personalized Services

- Online option
- Assigned accreditation specialist assistance
- Floor plan review for new facilities
- Clear explanation of deficiencies
- Published transparent rates

Accreditation Assistance



Inspector Training Program

- Certified Surveyors receive ongoing updates
- Written Examination
- Performance evaluation by QA Committee
- Surveyor Mentoring for Medicare Program

Patient Safety Initiatives and Statistics

- AAAASF mission is to ensure the highest quality of patient care through an accreditation program that serves both the medical community and the public interest
- Peer review reporting system collects statistical data for quality assurance measures
- Good data improves patient care
- AAAASF accredited facilities are associated with a low incidence of unanticipated sequelae

MOST COMMON DEFICIENCIES

1. NO BOUND NARCOTIC LOG
2. NO CONSENT FOR PEER REVIEW OF MEDICAL RECORDS
3. NO TIMELY H&P OR OR REPORT ON CHART
4. NO PROTOCOL FOR DISABLED SURGEON OR ANESTHESIOLOGIST
5. INADEQUATE OR NON-EXISTENT PEER REVIEW
6. NO WEEKLY SPORE TEST OF STERILIZER
7. INADEQUATE OR NON-EXISTENT PERSONNEL FILES
8. NO YEARLY UPDATE OF EXPOSURE CONTROL OR HAZARD COMMUNICATION PLAN
9. INADEQUATE NARCOTIC STORAGE
10. IMPROPER SEPARATION OF DIRTY – CLEAN AREAS IN UTILITY ROOM

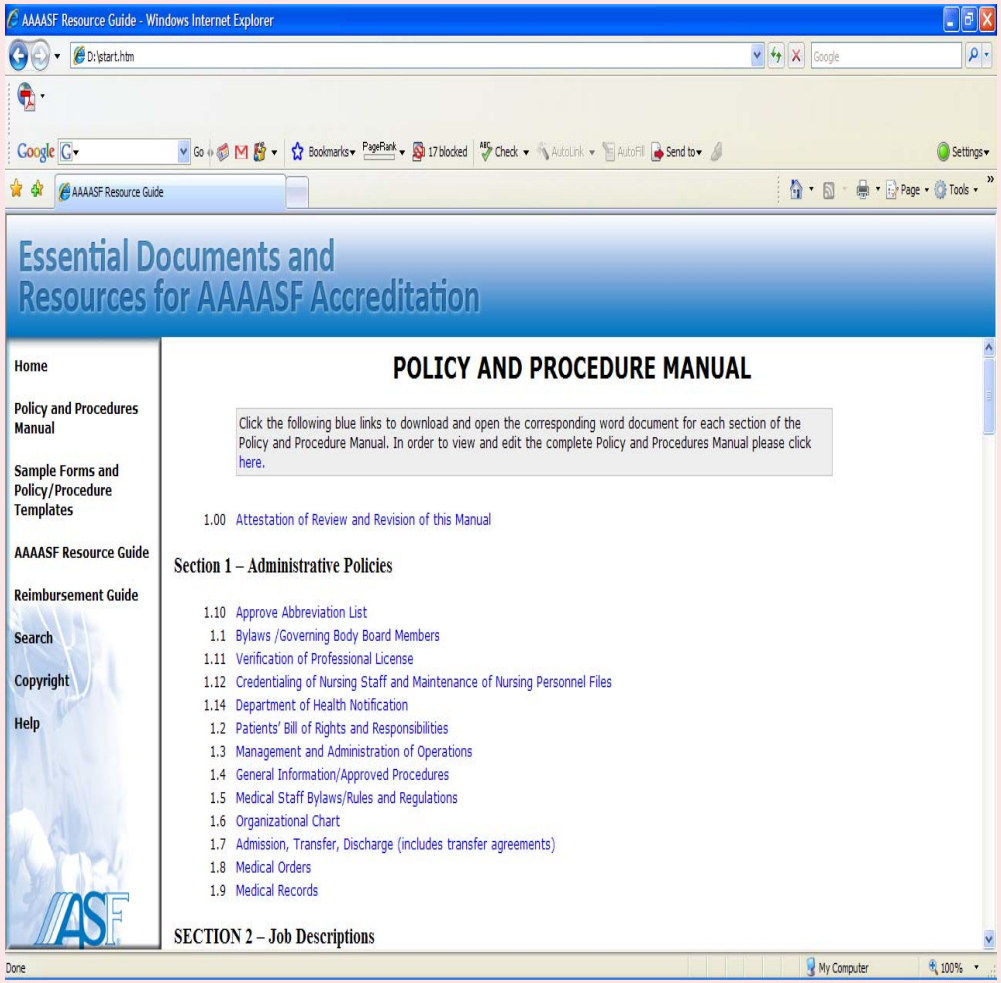
- NO ADA COMPATIBLE BATHROOM; NO EMERGENCY PROTOCOL; OUTDATED FIRE EXTINGUISHERS; NO EMERGENCY LIGHTING; NO EXIT SIGNAGE; INADEQUATE INSPECTION OF EQUIPMENT

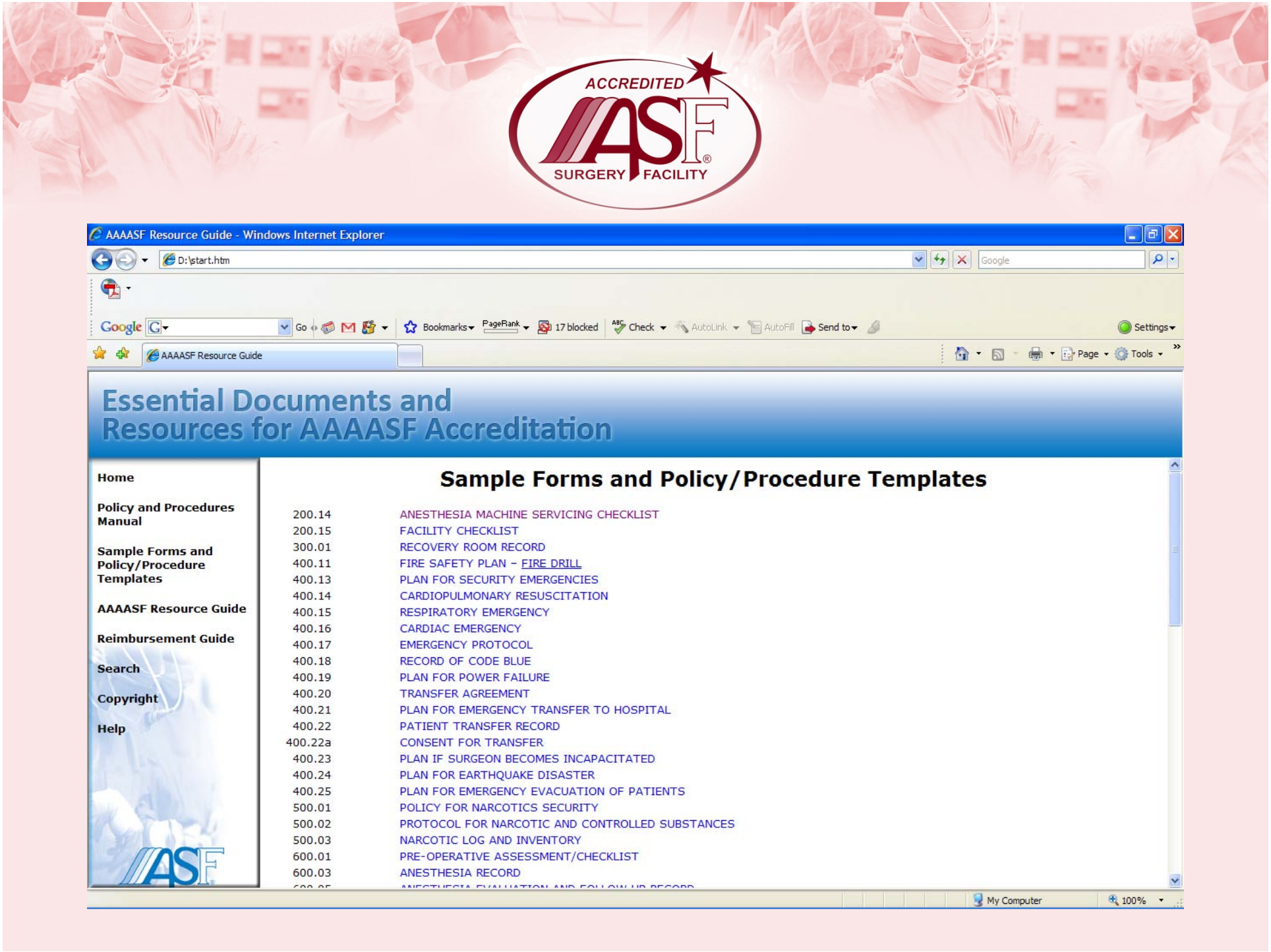
ADDITIONAL MEDICARE PROGRAM REQUIREMENTS

- DEAL PRIMARILY WITH PHYSICAL PLANT
- INFECTION CONTROL and QAPI REQUIREMENTS

- Policy and documentation requirements can seem daunting
- Essential documents and resources for AAAASF accreditation on CD

- 14 SECTION POLICY AND PROCEDURES MANUAL:
- Administrative Policies
- Job Descriptions
- Infection Control
- Quality Assurance
- Surgical Services
- Anesthesia Services
- Ancillary Services
- Nursing Services
- Environmental Services
- Fire, Safety and Disaster
- Supplies and Equipment
- Personnel Procedures
- Pre\Post Operative Procedures
- Operative Procedures

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SURGERY FACILITY
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PageRank
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AutoLink
AutoFill
Send to
Settings
AAAASF Resource Guide
Page
Tools
Essential Documents and
Resources for AAAASF Accreditation
Home
Policy and Procedures Manual
Sample Forms and Policy/Procedure Templates
AAAASF Resource Guide
Reimbursement Guide
Search
Copyright
Help
Sample Forms and Policy/Procedure Templates
200.14 ANESTHESIA MACHINE SERVICING CHECKLIST
200.15 FACILITY CHECKLIST
300.01 RECOVERY ROOM RECORD
400.11 FIRE SAFETY PLAN – FIRE DRILL
400.13 PLAN FOR SECURITY EMERGENCIES
400.14 CARDIOPULMONARY RESUSCITATION
400.15 RESPIRATORY EMERGENCY
400.16 CARDIAC EMERGENCY
400.17 EMERGENCY PROTOCOL
400.18 RECORD OF CODE BLUE
400.19 PLAN FOR POWER FAILURE
400.20 TRANSFER AGREEMENT
400.21 PLAN FOR EMERGENCY TRANSFER TO HOSPITAL
400.22 PATIENT TRANSFER RECORD
400.22a CONSENT FOR TRANSFER
400.23 PLAN IF SURGEON BECOMES INCAPACITATED
400.24 PLAN FOR EARTHQUAKE DISASTER
400.25 PLAN FOR EMERGENCY EVACUATION OF PATIENTS
500.01 POLICY FOR NARCOTICS SECURITY
500.02 PROTOCOL FOR NARCOTIC AND CONTROLLED SUBSTANCES
500.03 NARCOTIC LOG AND INVENTORY
600.01 PRE-OPERATIVE ASSESSMENT/CHECKLIST
600.03 ANESTHESIA RECORD
My Computer
100%

- RESOURCE GUIDE

AAAASF Resource Guide - Windows Internet Explorer

D:\start.htm

Essential Documents and Resources for AAAASF Accreditation

Home

Policy and Procedures Manual

Sample Forms and Policy/Procedure Templates

AAAASF Resource Guide

Reimbursement Guide

Search

Copyright

Help

RESOURCE GUIDE INDEX

100. GENERAL ENVIRONMENT:

1. ADA Checklist for Existing Facilities
   a. ADA Guide for Small Businesses
2. ADA Act: Additional Informational Sources
4. Questions And Answers: The Americans With Disabilities Act And Persons With HIV/AIDS
5. ADA Information Services
6. Americans with Disabilities Act Questions and Answers

200. OPERATING ROOM GENERAL ENVIRONMENT:

1. Instrumentation Cleaning Protocol
   a. AORN Guidance Statement: Preoperative Patient Care in the Ambulatory Surgery Setting
2. Storage of Sterilized Supplies
   a. AORN Guidance Statement: Postoperative Patient Care in the Ambulatory Surgery Setting
3. Sterilization Compliance Information
4. Steam Sterilization: "Sterility Assurance in Office-Based Practices"
   a. Sterilization of health care products-Requirements for validation and routine control of moist heat sterilization in health care facilities
6. Reprint: "Disinfection Standards-Whose Should You Follow?"
7. Asepsis
8. A Plan for Cleaning the OR

Thank you!

Institute *for* Medical Quality

180 Howard Street, Suite 210
San Francisco, CA 94105

phone: (415) 882-5151 ▪ fax: (415) 882-5149 website: www.imq.org

MEDICAL BOARD OF CALIFORNIA

Thursday, April 25, 2013

Los Angeles, California

Overview

- IMQ's Ambulatory Program began in 1996
- Response to passage of California Law AB 595 (Health and Safety Code § 1248)
- Non-profit subsidiary of the California Medical Association
- IMQ is the only California based accrediting entity recognized by the California Medical Board

Overview, cont'd

- IMQ's program developed to accommodate specific needs of California ambulatory facilities.
  - All IMQ surveys are conducted by California physicians meeting certain pre-requisites
  - Two surveyor teams may include a second physician or a California administrator or registered nurse with expertise in ambulatory facility practice
- Focus is on quality care and patient safety
- Standards are based on specific needs of California facilities
- Separate Standards for solo/small practices and larger or group practices

Areas Covered by IMQ Standards

- Administration
- Personnel and Credentialing
- Quality Programs and Peer Review
- Medical Records
- Care and Treatment
- Facility and Environmental Safety
- Surgery, Anesthesia and Invasive Diagnostic Procedures

Types of Facilities Accredited by IMQ

- **Ambulatory Surgery Centers**
- **Endoscopy Centers**
- **Fertility Clinics**
- **Medical Groups**
- **Managed Care Organizations**
- **Office-Based Surgery Practices**
- **OMS/Dental Practices**
- **Pain Management Centers**
- **Student Health Centers**
- **Urgent Care Centers**
- **Women's Health Centers**

Types of Surveys

- Initial Readiness Review
  - Designed for facilities that are just becoming operational.
    - Physical plant, Policies, Procedures, Staffing, Credentials, Privileges
    - Six-month Accreditation with a follow-up survey resulting in a one-year or three-year accreditation

Types of Surveys, con't

- Survey
  - For facilities that are operational but have not been accredited by IMQ
- One-year resurvey or Three-year resurvey
  - Full survey for facilities that have been accredited with with IMQ
- For-Cause survey
  - In response to complaints, when warranted

Survey Process

- Self Assessment and Review
  - Facilitated by use of IMQ's comprehensive standards manual
- Application and Pre-survey Forms
  - All facilities complete IMQ's application and submit required documentation
  - Submitted documentation is reviewed by the IMQ surveyor prior to the survey, resulting in increased feedback and reducing on-site time

Survey Process, Cont'd

- Application and pre-survey process, cont'
  - Pre- survey assistance provided by IMQ staff
    - Written pre-survey analysis of materials submitted by the applicant facility pointing out potentially problematic areas and suggesting corrections
- Scheduling
  - Surveyor selected by IMQ from a credentialed and trained surveyor panel
  - Survey scheduled at a mutually agreeable time

Survey Process, con't.

- Surveyor spends a full day at the facility
  - Interviews key staff
  - Reviews polices and procedures
  - Reviews Credential files and HR files
  - Reviews Quality Assurance and peer review documents
  - Medical record review
  - Billing review
  - Observes a procedure
  - Conducts a final meeting with physicians and staff to review findings and recommendations.

Our Surveyors

- All physician surveyors are or have been in active ambulatory practice in California
- Attend a mandatory yearly surveyor training
- Are evaluated routinely by peers and the facilities they survey

Our Surveyors, Cont'd

- **Application Process**

  All applicants submit curriculum vitae along with the application form to be reviewed by the IMQ staff and the ACRC for their suitability to become a surveyor. Those with appropriate background, experience, credentials, references, and qualifications are then appointed to observer status to continue with the training.

Our Surveyors, Cont'd

- **Training**

  IMQ ambualtroy surveyors complete a designated surveyor training prior to becoming a surveyor, and every year henceforth. Those in observer status also are required to attend two observation surveys.

Our Surveyors, Cont'd

- **Peer Review**

  Each surveyor participating in an accreditation survey is required to complete Peer Review Forms, in which he/she evaluates performance and competencies of other surveyors on the Survey Team. The Peer Review Forms are returned to IMQ office, and any notable feedback is reported to the surveyors. The Ambulatory Chair counsels any surveyors requiring education or redirection.

Our Surveyors, Cont'd

- **Annual Credentialing**

  Each active ambulatory surveyor is required to annually submit a reappointment request form. IMQ staff and ACRC review their requests, training histories, and any notable findings from the peer reviews and facility feed back forms and determine the continuation of surveyorship into the succeeding year. Any surveyors who are found to be not suitable to continue surveys are asked to reapply when their issues are resolved or corrected. The credentialing recommendations are presented to IMQ's Board of Directors for approval.

Program Staff

- The program staff undergo annual performance reviews, which include facility feedback forms, self-evaluation, and the comprehensive performance review by the manager and IMQ executive staff. During this process, any issues and weaknesses are assessed, and performance goals are set for the following year.

- Regular performance feedback is given to the program staff on an ongoing basis.

Accreditation Decision

- Made by the Ambulatory Care Review Committee (ACRC)
  - Composed of surveyors
  - Meets monthly
- **Six-month** accreditation to facilities having and initial readiness review survey
  - Followed in six months by a second survey
- **One-year accreditation** granted to facilities that meet the requirements but have room for improvement
  - Facilities asked to submit interim reports Corrective Actions Plans (CAP) in problem areas which are reviewed by the surveyor

Accreditation Decision, Cont'd

- **Three-year accreditation** awarded to facilities that meet all standards and demonstrate a higher level of compliance.
- Deferral may occur if additional information is needed
- **Non-accreditation** occurs if a facility does not meet the minimum mandatory standards and/or does not meet a significant number of the non-mandatory standards

Facility Notification

- The facility will receive notice of the decision within 15 days of ACRC meeting.
- When a facility has standards that have not been met or are partially met, Interim Reports (CAP) will be required to maintain their accreditation, and will be noted in the Accreditation Report (AR)/CAP that is sent to the facility.
- The **MEDICAL BOARD OF CALIFORNIA** is notified of the accreditation decision and accreditation period.

Facility Notification, Cont'd

- Upon receipt of the Accreditation Report (AR)/CAP the facility must:
  - Identify the person responsible (by title, not by name) for each corrective action listed in the "Accreditation Report and Corrective Action Plan" (AR/CAP).
  - Have the medical director sign and date that s/he agrees to this plan of correction.
  - Fax the document to IMQ within one week of the date on the letter.

Facility Notification, Cont'd

- Once IMQ receives the Corrective Action Plan identifying the person responsible for each of the corrections and signed by the Medical Director, the **MEDICAL BOARD OF CALIFORNIA** is sent a copy of the Accreditation Report and Corrective Action Plan.

Facility Notification, Cont'd

- The facility must post the CAP with this added information in public view, and
- Submit to IMQ interim reports as indicated in the AR/CAP.

Facility Notification, Cont'd

- Once all interim reports have been submitted and approved by the ACRC, the facility will receive a letter stating that all requirements of accreditation have been met. At that time, the facility may remove the AR/CAP from public view.

- The **MEDICAL BOARD OF CALIFORNIA** is notified when all the items in the Corrective Action Plan have been approved by the ACRC.

Re-accreditation

- Three to six months before a facility's expiration date (depending on the accreditation period) IMQ sends a letter and application packet to the facility.

Questions

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Joint Commission Overview

Medical Board of California
April 25, 2013

James L. Bersot, MD
Ambulatory Care Surveyor
The Joint Commission

Jennifer M. Hoppe, MPH
Senior Associate Director
State & External Relations
The Joint Commission

The Joint Commission

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Today's Discussion

- Overview of Joint Commission
- Accreditation Requirements
- Onsite survey process
- Post Survey Activities
- Complaint Process

The Joint Commission

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About The Joint Commission

- The Joint Commission evaluates and accredits more than 20,000 health care organizations and programs in the United States

- An independent, not-for-profit organization, The Joint Commission is the nation's oldest and largest standards-setting and accrediting body in health care

The Joint Commission

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Mission and Vision

- Mission: Continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.

- Vision: All people always experience the safest, highest quality, best-value health care across all settings

The Joint Commission

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Governance

- The Joint Commission is governed by a 32-member Board of Commissioners including physicians, administrators, nurses, employers, a labor representative, quality experts, a consumer advocate, and educators

- The Joint Commission's corporate members are the: American College of Physicians, American College of Surgeons, American Dental Association, American Hospital Association, and American Medical Association

The Joint Commission

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Accreditation Services

- The Joint Commission provides accreditation services for more than 4,000 hospitals and more than 13,000 other health care organizations including:
  - General, psychiatric, children's, rehabilitation, and critical access hospitals
  - Home care organizations, including medical equipment services and hospice services
  - Nursing homes and other long term care facilities
  - Independent or freestanding clinical laboratories
  - Behavioral health care organizations and addiction services
  - **Ambulatory care providers, including ambulatory surgery centers and office-based surgery practices**

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Goals of Accreditation Process

- Emphasizes direct on-site observations, staff and patient interviews
- Evaluates staff effectiveness and organization-wide performance
- Focuses on integration of systems across the organization
- Fosters team-building
- Provides education and consultative feedback

The Joint Commission

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Initial accreditation surveys

- Application for survey
  - questions specific to California law included
- Early Survey Option process
  - Two onsite surveys conducted
  - 1st survey prior to services being offered – limited set of standards
    - Preliminary Accreditation awarded
  - 2nd survey (full) conducted approximately 4 – 6 months

The Joint Commission

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Renewal Process

- Accreditation cycle is 36 month
- Triennial survey could occur anywhere between 18-36 months
- Intra-cycle monitoring requirement
  - Focus Standard Assessments
  - Unannounced Compliance Validation Survey
  - For-cause surveys
  - Extension Surveys

The Joint Commission

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Standards and Survey Process

The Joint Commission

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Standards Development

- The Joint Commission develops its standards in consultation with health care experts, providers, measurement experts, purchasers and consumers
- The standards are designed to
  - address the organization's level of performance in key functional areas such as patient rights, patient treatment, medication safety, and infection control
  - focus on setting expectations for an organization's actual performance and for assessing its ability to provide safe, high quality care

The Joint Commission

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Accreditation Requirements

- Accreditation Participation Requirements
- Environment of Care
- Emergency Management
- Human Resources
- Infection Control
- Information Management
- Leadership
- Life Safety
- Medication Management
- National Patient Safety Goals
- Performance Improvement
- Provision of Care
- Record of Care
- Rights of the Individual
- Sentinel Events
- Transplant Safety
- Waived Testing

The Joint Commission

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On-Site Survey Process

- The objectives of the on-site survey process are to evaluate the organization, and provide education and good practice guidance to help staff continually improve the organization's performance

- The on-site survey process
  - is data-driven, patient-centered, and focused on evaluating actual care processes
  - is designed to be organization-specific, consistent, and support the organization's effects to improve performance
  - includes tracer methodology, an evaluation method in which surveyors select a patient, resident or client and use that individual's record as a roadmap to move through an organization to assess and evaluate the organization's compliance with selected standards and the organization's systems of providing care and services

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Tracer Methodology

- Individual Tracers
  - Surveyors trace by observing and talking to staff in areas where the patient received care.
- System Tracers
  - Interactive session that explores important organization-wide processes/functions related to safety and quality of care.
  - Key system tracers: Medication Management, Data Use, Infection control
- Program Specific Tracers
  - Targeted tracers that explore high priority issues for each of the accreditation programs (AHC: Continuity of Care and Imaging Services)

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Additional Survey Components

- Competence Assessment and Credentialing & Privileging
- Leadership Session
- Environment of Care and Emergency Management
  - Life Safety Code Building Assessment (when applicable)

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Post Survey Activities

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Post Survey Findings

- Following the survey, the organization is provided with a report of preliminary findings
- The preliminary findings will undergo a comprehensive review by TJC central office staff
- Accreditation reports are posted to the organization w/in 10 days
- Organizations are afforded the opportunity to request a clarification
- Accreditation decisions are not final until all noncompliant standards are resolved*

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*except for adverse accreditation decisions

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Follow Up Activities

- Majority of organization will have Requirements for Improvement (RFI)
- Organization must submit Evidence of Standards Compliance (ESC) for all standards that were less than fully compliant
- Based on the critically of the finding the ESC is due within 45 days or 60 days
- If compliance is not resolved with the established timeframes, a progressively more adverse accreditation decision may result

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Adverse Accreditation Decisions

- Central office staff may recommend an adverse accreditation decision if:
  - The findings at the time of survey meet one the Joint Commission rules for adverse decisions
  - Based on findings that demonstrate systemic patterns, trends, or repeat findings from previous surveys
  - The organization is not able to submit an acceptable ESC within the established timeframe
- All adverse decisions are reviewed and approved by a sub-committee of the Board

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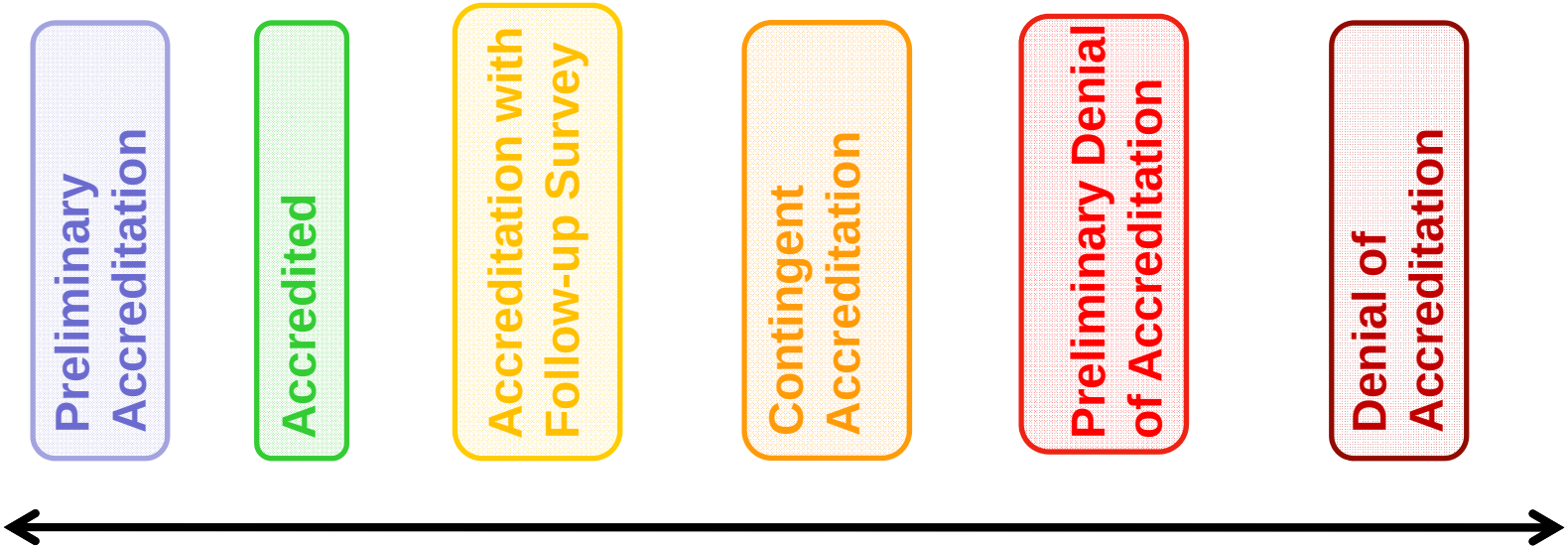
Continuum of the 2013 Joint Commission Accreditation Decisions



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Complaint Process

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How The Joint Commission Responds to Complaints

- Depending on the nature of the complaint, The Joint Commission will take one of the following actions:
  - Conduct an unannounced on-site evaluation of the organization
  - Ask the organization to provide a written response to the complaint.
  - Review the complaint and compliance with related standards at the time of the organization's next accreditation survey, if it is scheduled in the near future.
  - Incorporate the complaint into the quality monitoring database that is used to track health care organizations over time to identify trends or patterns in their performance.

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Complaint Review Process

- The Joint Commission has established objective criteria to guide its analysis of complaints:
  - An initial review is conducted to determine if the complaint information is relevant to Joint Commission standards and relates to the organization's performance within the past three years.
  - The complaint is categorized into one of three incident levels

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Complaint Priority Incident Levels

- **Low Priority Incidents**
  - Because of the importance of all complaints, low priority complaints are acknowledged as having been received and maintained on file, but not pursued actively.
- **Medium Priority Incidents**
  - These complaints are processed within 10 business days
- **High Priority Incidents**
  - Processed within 2 business days of receipt and a determination of appropriate action is made

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Onsite Review of Complaint

- Focus of survey is on the nature of the complaint, but other areas of concern may be identified
- Depending on nature of complaint
  - Review records for type of procedure
  - Review record over a specified date range
  - Focus on organization process for a specific issue (IC, EC, HR etc)
- Post survey requirements are consistent with full accreditation process

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Questions?

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Medical Board of California
Inactive License – Misdemeanor Convictions
Specific Language

Modified Text

Changes to the originally proposed language are shown by double underline for new text and double strikeout for deleted text.

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

Section 1355.45. (a) For purposes of subdivision (b) of section 2236.2 of the Code, "notice" means a ~~certified copy of a release issued by the applicable local jurisdiction where the licensee was incarcerated which is provided by the licensee either by regular mail or by personal service, at the option of the licensee.~~ statement signed under penalty of perjury and dated by the licensee and provided to the board by means of a facsimile transmission, regular mail, or personal service at the option of the licensee. The statement shall include the date and time of the licensee's release, his or her physician's and surgeon's certificate number, and the name and location of the facility at which the licensee was formerly incarcerated.

(b) Whenever a license is placed on inactive status pursuant to section 2236.2 of the Code, the ~~B~~board shall display the status of the license as follows: "Inactive License - Misdemeanor Conviction. Licensee was convicted of a misdemeanor and is currently incarcerated. No practice is permitted."

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

TITLE 16. Medical Board of California

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

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

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

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

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

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

The specific benefits of this proposal are two-fold: 1) By identifying the type of notice (certified copy of release), public protection is enhanced because the Board will have good basis for returning an inactive license to its prior status, instead of simply relying on the verbal or written statement of the licensee, and 2) by defining the type of statement that will accompany

the change in license status, the public will know the reason a physician's license was placed on inactive status.

This proposed regulation is not inconsistent or incompatible with existing state regulations. Additionally, providing notice to the Board of a release from incarceration if consistent with the reporting of criminal information to the Board (B&P Sections 803.5, 803.6).

FISCAL IMPACT ESTIMATES

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

Nondiscretionary Costs/Savings to Local Agencies: None

Local Mandate: None

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

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

Impact on Jobs/New Businesses: The Board has determined that this regulatory proposal will not have a significant adverse economic impact on the creation of jobs or new businesses or the elimination of jobs or existing businesses or the expansion of businesses in the State of California. The benefit to the health and welfare of California residents is the enhanced notice to the consumer so the public will know the reason a physician's license was placed on inactive status. This regulation has no benefit to worker safety and to the State's environment.

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

Effects on Housing Costs: None

EFFECT ON SMALL BUSINESS

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

CONSIDERATION OF ALTERNATIVES

The Board must determine that no reasonable alternative considered by the Board or that has otherwise been identified and brought to the attention of the Board would be more effective in carrying out the purpose for which the action is proposed, would be as effective and less burdensome to affected private persons than the proposed action, or would be more cost-

effective to affected private persons and equally effective in implementing the statutory policy or to other provision of law. Any interested person may present statements or arguments orally or in writing relevant to the above determinations at the above-mentioned hearing.

INITIAL STATEMENT OF REASONS AND INFORMATION

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

TEXT OF PROPOSAL

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

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

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

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

CONTACT PERSON

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

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

The backup contact person is:

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

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

ENFORCEMENT PROCESS OVERVIEW

ROLE/RESPONSIBILITIES OF THE PHYSICIANS IN THE ENFORCEMENT PROCESS

SELECTION CRITERIA FOR ALL MEDICAL REVIEWERS

MBC HISTORY

- **Possess a current California medical license in good standing**
- No prior discipline
- No accusations pending
- No complaint history within the last 3 years

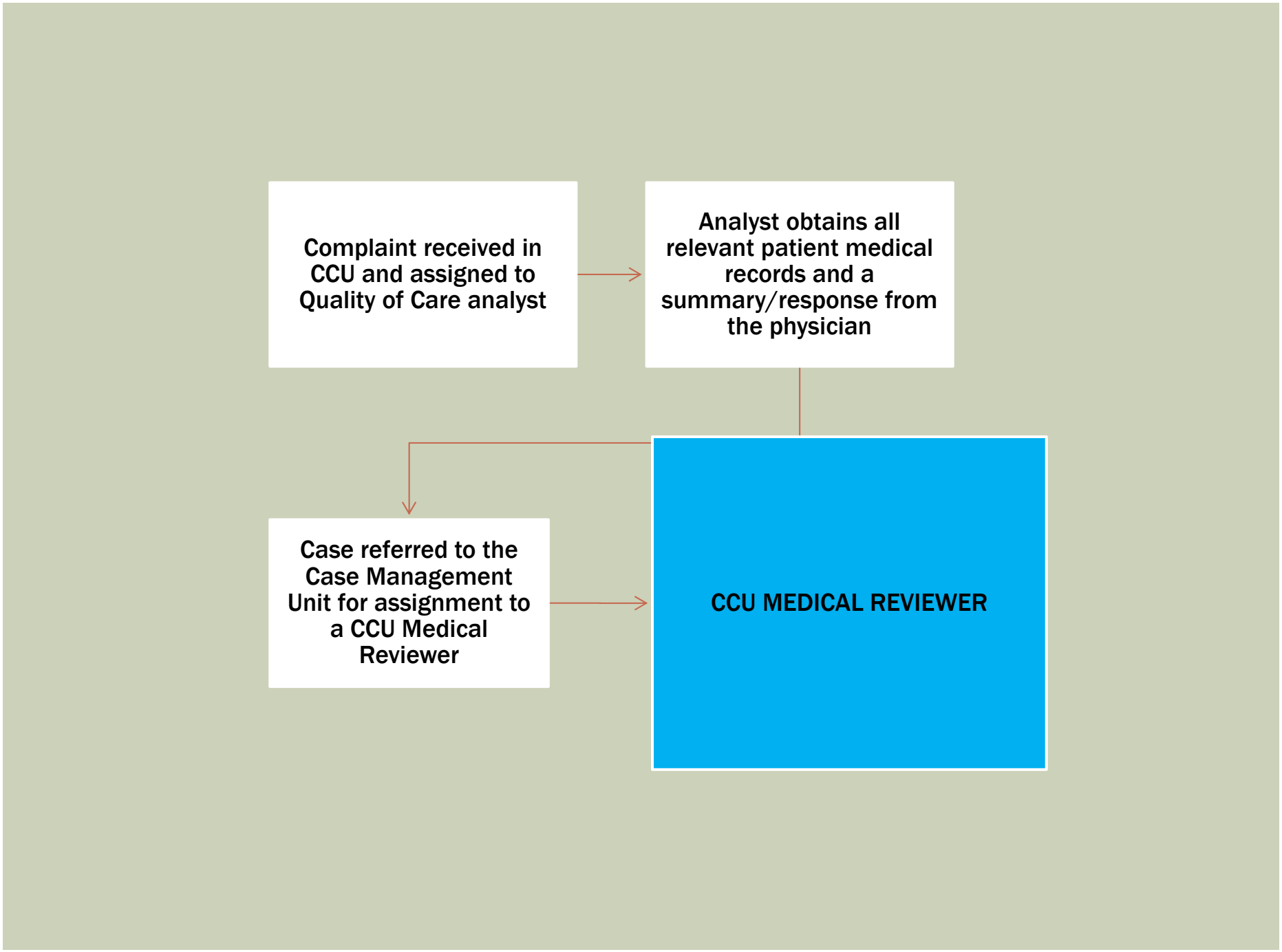
SPECIALTY EXPERTISE

- Board certification in one of the 24 ABMS specialties

PRACTICE REQUIRED

- Active practice or retired within the last 2-3 years

CENTRAL COMPLAINT UNIT


Complaint received in CCU and assigned to Quality of Care analyst
Analyst obtains all relevant patient medical records and a summary/response from the physician
Case referred to the Case Management Unit for assignment to a CCU Medical Reviewer
CCU MEDICAL REVIEWER

Case Management

Initial Review

- The case file and the physician's CV are reviewed to identify the physician's practice specialty. The analyst must also identify the type of treatment that was provided to ensure the CCU Reviewer has expertise in that area

Reviewer Identification

- The case management analyst reviews the CCU database to identify if any CCU Medical Reviewers are available with the requisite experience or expertise.
- When an available CCU Medical Reviewer with the requisite expertise is identified, the prospective reviewer is contacted by phone or email to discuss the assignment
- Most reviewers receive at least 2 cases per assignment

Follow-Up

- Case file is shipped to the CCU Medical Reviewer through overnight delivery service
- Analyst follows up with Medical Reviewer if case is not returned within 3 weeks.
- Total Number of cases reviewed in 2011/2012:
- Average number of days to complete review:

Pursuant to Business and Professions Code Section 2220.08

(a) Except for report received by the board pursuant to Section 805 that may be treated as complaints by the board and new complaints relating to a physician and surgeon who is the subject of a pending accusation or investigation or who is on probation, any complaint determined to involve quality of care, before referral to a field office for further investigation, shall meet the following criteria:

(1) It shall be reviewed by one or more medical experts with the pertinent education, training, and expertise to evaluate the specific standard of care issues raised by the complaint to determine if further field investigation is required.

Composition of CCU Expert Pool

Medical Specialty	No. of consultants
Anesthesiology	14
Cardiology	13
Dermatology	4
ENT/Otolaryngology	3
Gastroenterology	4
Family Practice	16
Hematology/Oncology	7
Internal Medicine	31
Midwife	1
Obstetrics/Gynecology	12
Ophthalmology	7
Orthopedics	6
Neurology	5
Neurological Surgery	4
Pathology	2
Pediatrics	11
Plastic Surgery	2
Psychiatry	12
Radiology (interventional)	4
Radiology (diagnostic)	5
Surgery	15
Urology	6
Total No. of Consultants	184

CCU MEDICAL REVIEWER

No Violation/ No Departure

- No departure from the standard of practice or any other misconduct by the physician. The complaint is closed by CCU without further investigation.

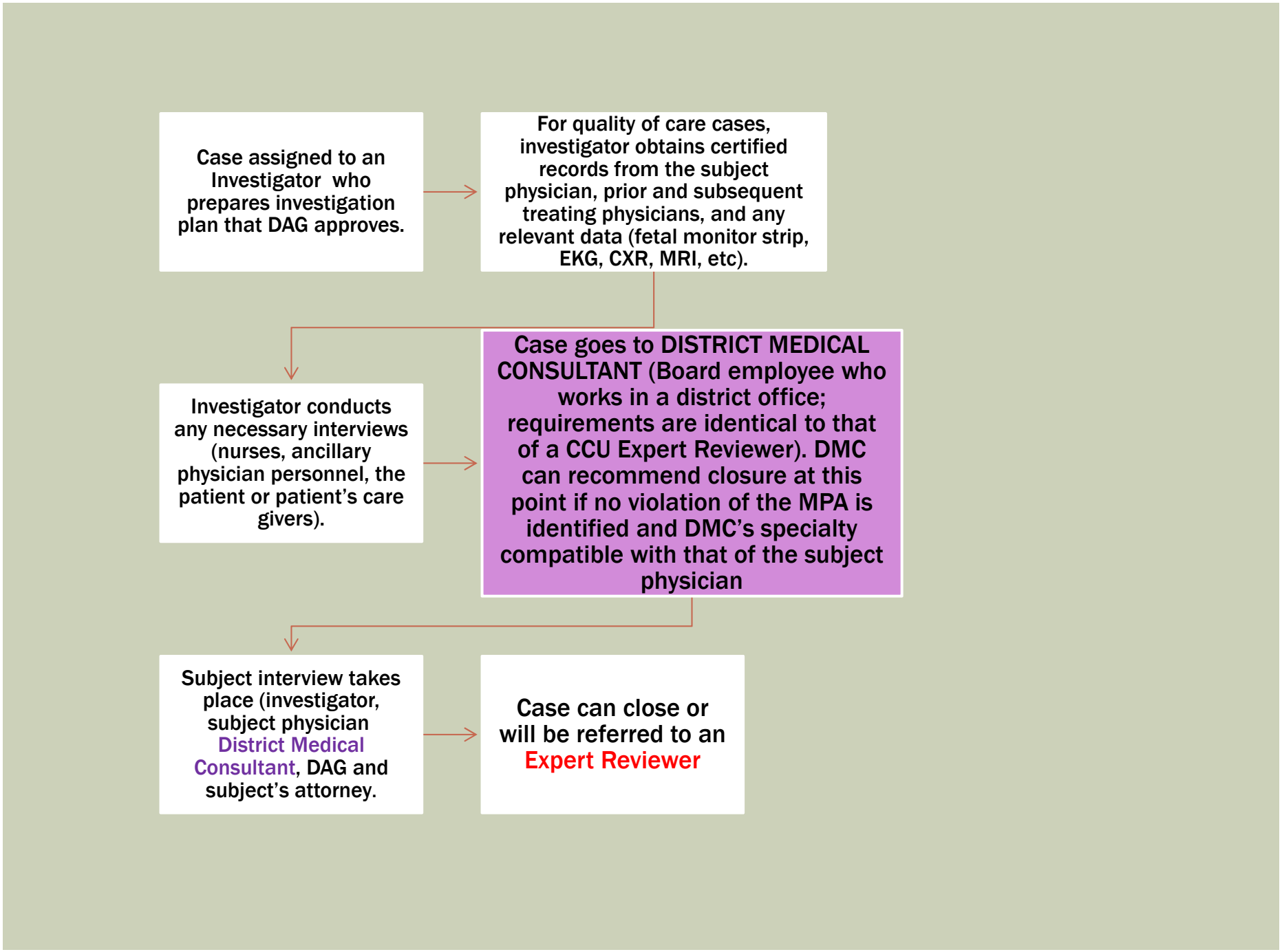
Simple Departure

- Physician's conduct deviated from the standard of practice but does not warrant further investigation. The complaint is closed by CCU and retained for 5 years.

Refer for further investigation

- Care found to potentially represent an extreme departure from the standard of practice. The complaint is referred for further investigation.

THE FIELD INVESTIGATION


Case assigned to an Investigator who prepares investigation plan that DAG approves.
For quality of care cases, investigator obtains certified records from the subject physician, prior and subsequent treating physicians, and any relevant data (fetal monitor strip, EKG, CXR, MRI, etc).
Investigator conducts any necessary interviews (nurses, ancillary physician personnel, the patient or patient's care givers).
Case goes to DISTRICT MEDICAL CONSULTANT (Board employee who works in a district office; requirements are identical to that of a CCU Expert Reviewer). DMC can recommend closure at this point if no violation of the MPA is identified and DMC's specialty compatible with that of the subject physician
Subject interview takes place (investigator, subject physician District Medical Consultant, DAG and subject's attorney.
Case can close or will be referred to an Expert Reviewer

SELECTION OF EXPERT REVIEWER

http://165.235.24.248/ExpertReviewerProgram/

Expert Reviewer Master Page

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STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

Medical Board of California
Expert Reviewer Program

Search By Last Name

Primary Specialties

- ADDICTION MEDICINE
- AEROSPACE MEDICINE
- ALLERGY & IMMUNOLOGY
- ANESTHESIOLOGY
- BIOETHICS
- CARDIOLOGY
- COLON & RECTAL SURGERY
- COMPLEMENTARY/ ALTERNATIVE/ INTEGRATIVE MEDICINE
- CORRECTIONAL MEDICINE/HEALTHCARE
- DERMATOLOGY
- EMERGENCY MEDICINE
- ENDOCRINOLOGY, DIABETES & METABOLISM
- ETHICS
- FAMILY MEDICINE
- Forensic Document Examiner
- GASTROENTEROLOGY- HEPATOLOGY

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Expert Reviewer Master Page

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STATE OF CALIFORNIA
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DEPARTMENT OF CONSUMER AFFAIRS

Medical Board of California
Expert Reviewer Program

Search By Last Name

Clear Results

Primary Specialties

- PEDIATRIC HEMATOLOGY-ONCOLOGY
- PEDIATRIC NEPHROLOGY
- PEDIATRIC PULMONOLOGY
- PEDIATRIC SURGERY
- PEDIATRICS
- PHYSICAL MEDICINE & REHABILITATION
- PLASTIC SURGERY
  - ACLS CERTIFIED
  - AESTHETIC SURGERY
  - BREAST SURGERY
  - BURN RECONSTRUCTION/BURN CARE
  - CO2 LASER
  - COSMETIC SURGERY
  - ENDOSCOPY/ENDOSCOPIC COSMETIC SURGERY
  - FACIAL PLASTIC & RECONSTRUCTIVE SURGERY
  - HAIR TRANSPLANTS

Profile Info	County	Last Name	First Name	In Use	Flagged	Rating AVG	Cases	License	License Status	Zip
Click Here	Los Angeles	Vipond	Gregory	Available	OK TO USE			A100020	License Renewed & Current	910
Click Here	San Diego	Hilinski	John	Available	OK TO USE		2	A63027	License Renewed & Current	921
Click Here	Los Angeles	Anastas...	John	Available	OK TO USE	5	6	A92907	License Renewed & Current	902
Click Here	Los Angeles	Oyama	Mark	Unavaila...	OK TO USE	4	4	G 61877	License Renewed & Current	900
Click Here	El Dorado	Rice, Jr.	Reginald	Available	OK TO USE	3	2	G 70357	License Renewed & Current	956
Click Here	San Francisco	Maas	Corey	Available	OK TO USE			G 71163	License Renewed & Current	941
Click Here	Alameda	Kabaker	Sheldon	Available	OK TO USE			G12959	License Renewed & Current	946
Click Here	Los Angeles	Pincus	Stephen	Available	OK TO USE	5	3	G21830	License Renewed & Current	902

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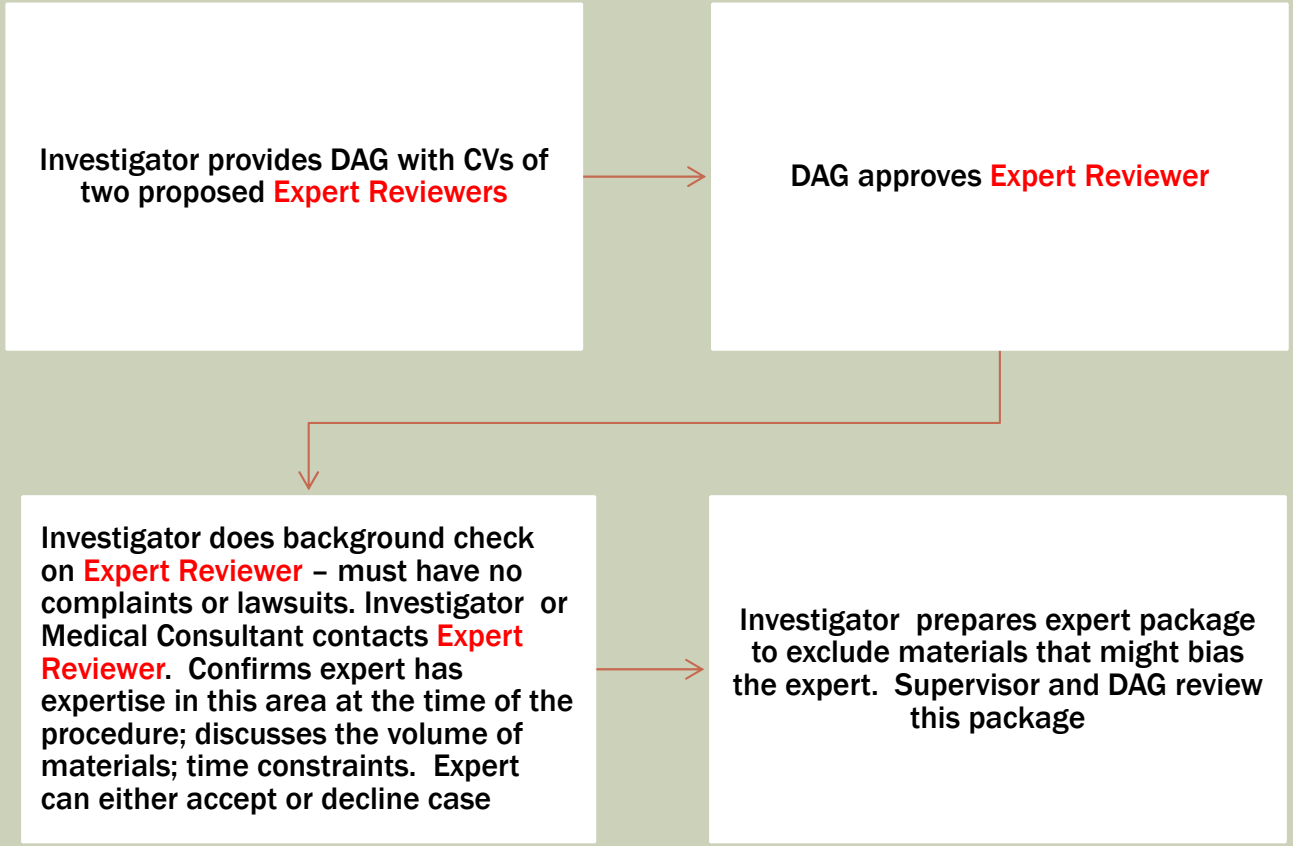
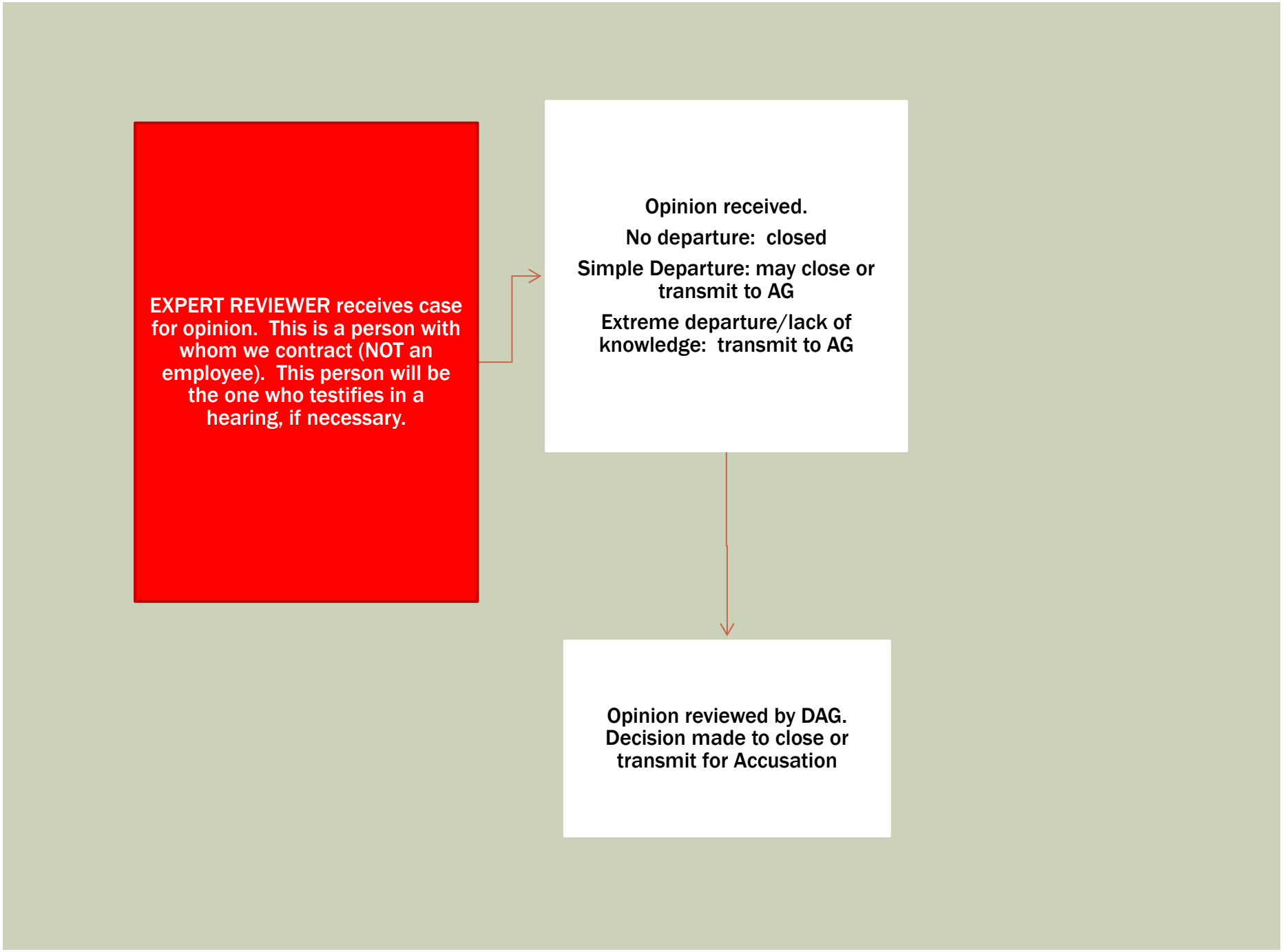
REVIEW/APPROVAL OF EXPERT REVIEWER

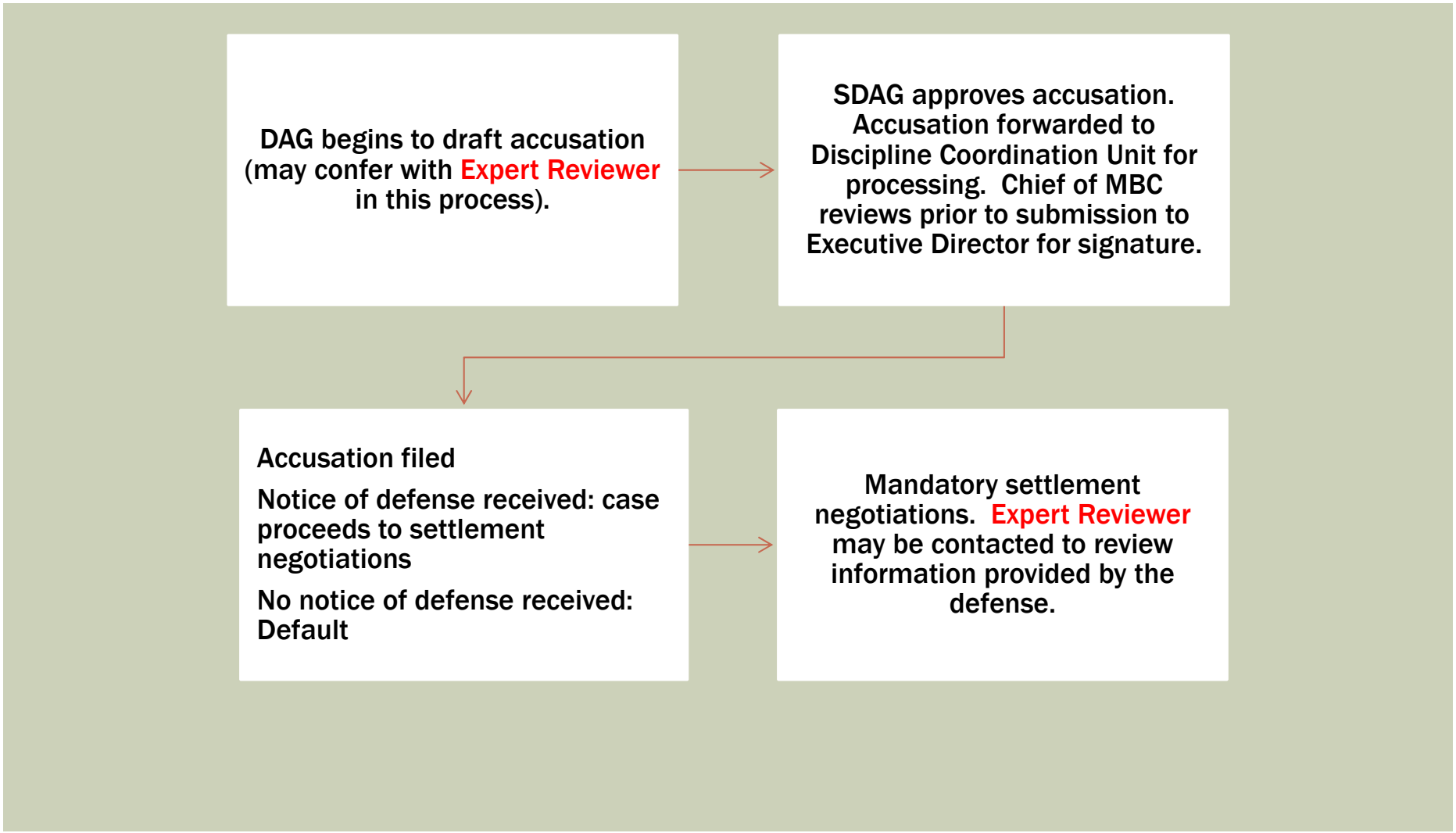



EXPERT REVIEWER receives case for opinion. This is a person with whom we contract (NOT an employee). This person will be the one who testifies in a hearing, if necessary.
Opinion received.
No departure: closed
Simple Departure: may close or transmit to AG
Extreme departure/lack of knowledge: transmit to AG
Opinion reviewed by DAG. Decision made to close or transmit for Accusation

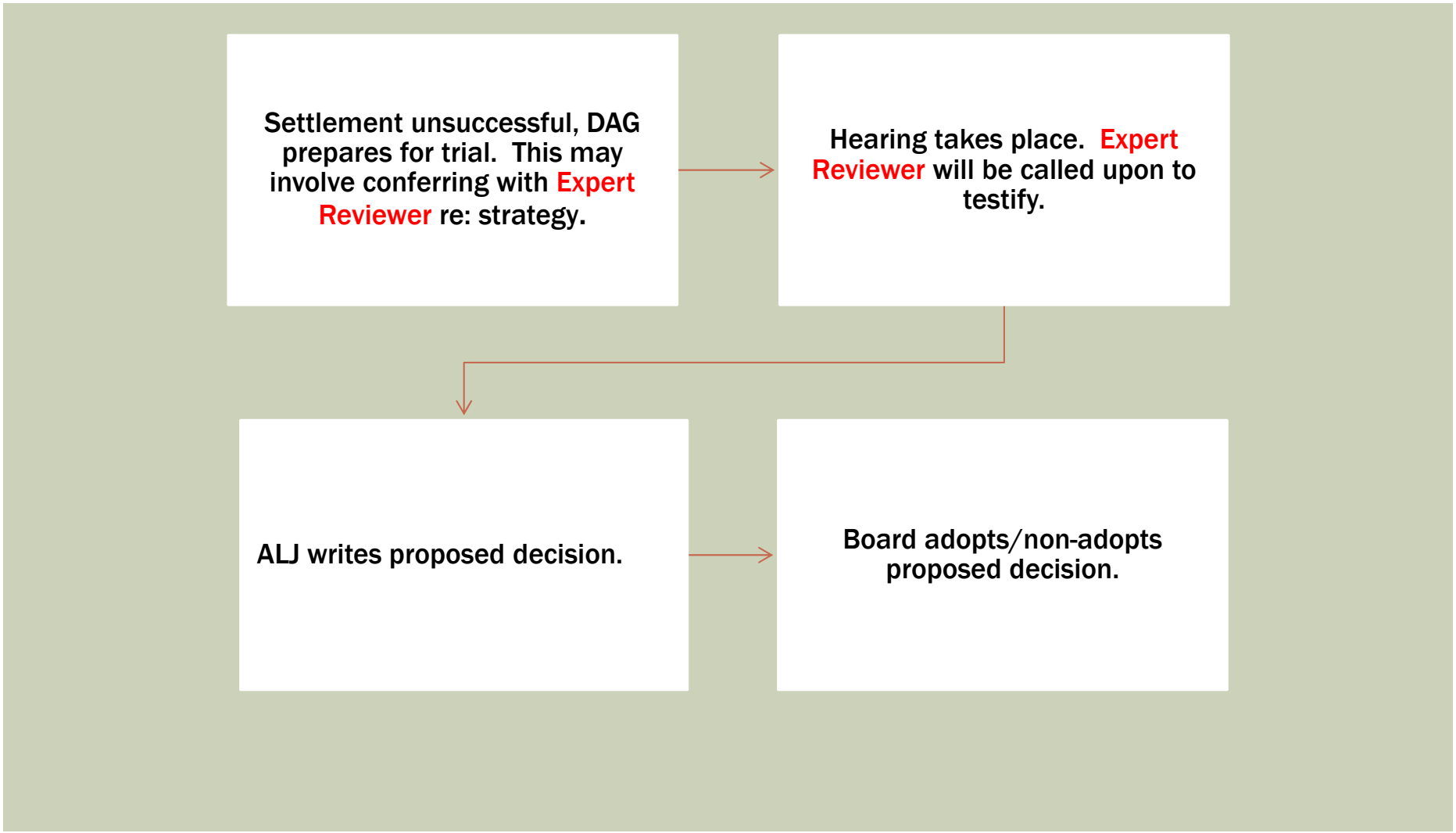
THE OFFICE OF THE ATTORNEY GENERAL

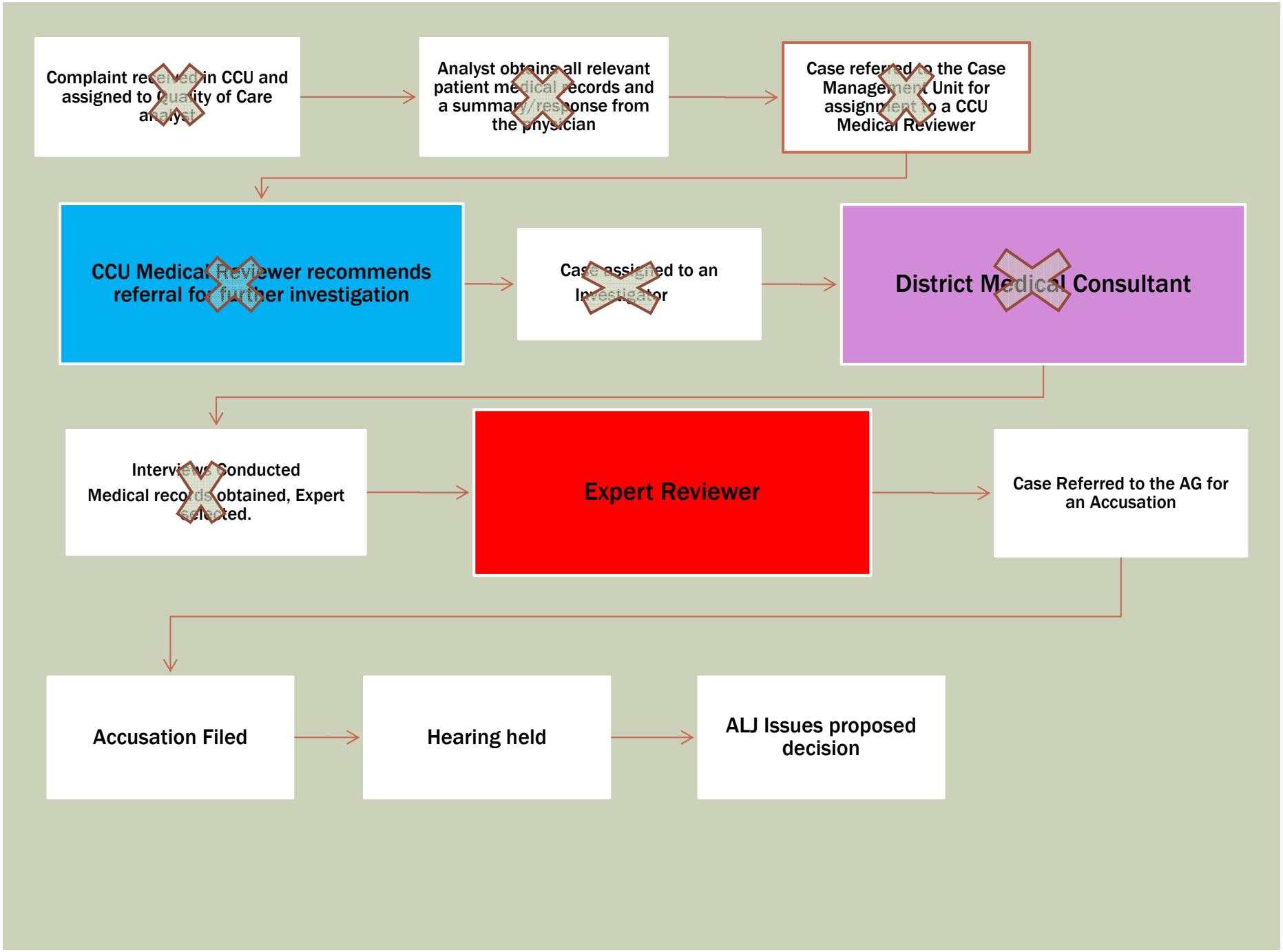
Prosecution

PROSECUTION PROCESS



PROSECUTION PROCESS

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Analyst obtains all relevant patient medical records and a summary/response from the physician
Case referred to the Case Management Unit for assignment to a CCU Medical Reviewer
CCU Medical Reviewer recommends referral for further investigation
Case assigned to an Investigator
District Medical Consultant
Interviews Conducted
Medical records obtained, Expert selected.
Expert Reviewer
Case Referred to the AG for an Accusation
Accusation Filed
Hearing held
ALJ Issues proposed decision

PROPOSED DECISION ISSUED

- Our Expert is identified as the “Complainant’s” Expert
- The Physician’s Expert is identified as the “Respondent’s Expert”

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: April 10, 2013
ATTENTION: Medical Board of California Members
SUBJECT: Joint Forum to Promote Appropriate Prescribing and Dispensing
STAFF CONTACT: Letitia Robinson, Research Program Specialist

RECOMMENDED ACTION:
The Medical Board of California (Board) should review the various ideas presented at the Joint Forum to Promote Appropriate Prescribing and Dispensing.

BACKGROUND AND ANALYSIS:
Prescription drug abuse and the resulting deaths are something the Board recognized as an issue that must be given the utmost priority. The Board wanted to provide education to its licensees and the public in an effort to prevent prescription drug abuse. To that end, the Board, in collaboration with the Pharmacy Board, held a "Joint Forum to Promote Appropriate Prescribing and Dispensing" for all interested parties on February 21-22, 2013.

The Forum focused on 1) the problem, including inappropriate prescribing, inappropriate security of drugs, etc; 2) the responsible parties, including prescribers, dispensers, patients, and regulators/law enforcement; and 3) the solutions, including education, enforcement, and necessary tools (CURES).

Both the Pharmacy and Medical Boards provided staff to ensure the Forum activities were sufficiently planned before, during and after the event. The Boards provided Continuing Medical Education (CME) to physicians and pharmacists who could earn up to four credit hours on the first day of the Forum and up to six credit hours on the second day. Certificates were mailed to all participants.

A link has been placed on the Board's Web site under "Highlights", "Licensees", and "Consumers". The link provides all the speakers presentations as well as video clips of each speaker. Getting this information placed on the Board's Web site is a first step in endeavoring to educate physicians and the public on efforts to prevent prescription drug abuse.

Below is a breakdown on the number of Forum attendees by type:

	Day 1	Day 2
• Osteopathic Physician	3	2
• Pharmacist	115	112
• Physician	206	216
• Physician Assistant	1	2
• Registered Nurse	6	4
• Other Interested Parties	50	30
Total Attendees	*381*	*366*

The Forum was well received by most attendees. The Program Evaluation forms were completed by approximately 83% of the attendees on the first day and 88% of attendees on the second day. The Program Evaluation data indicates that about 87% of responders agreed or strongly agreed that

Speaker presentations were effective and enhanced participants' knowledge base. The following are additional responses from the evaluations (full statistics are attached):

- I gained knowledge from this activity: *95% strongly agreed or agreed*

- I will apply what I learned in my practice: *88% strongly agreed or agreed; 11% were neutral; 1% disagreed*

- What I learned will change my practice: *71% strongly agreed or agreed; 26% were neutral; 3% strongly disagreed or disagreed*

In addition to providing feedback via the Program Evaluations, when solicited, many attendees voiced their comments and suggestions during the final segment of the Forum: "Expectations vs. Reality: What is the future? Developing operational and legal solutions". The following recommendations were compiled from attendees, speakers, and staff feedback with regard to additional needs.

Educational Recommendations

Prescribers

- Provide Tip Sheets on prescribing issues
- Develop/include Board Newsletter articles on prescribing issues
- Educate prescribers to not use a "default" prescription amount
- Promote subscription to CURES
- Provide samples of patient pain management contracts (links on Web site)
- Identify actions for prescribers to take if a prescription pad has been stolen
- Educate prescribers on communicating with dispensers

Dispensers

- Provide Tip Sheets on dispensing issues
- Develop/include Board Newsletter articles on dispensing issues
- Educate dispensers on how to work more closely with prescribers
- Promote subscription to CURES
- Identify actions for dispensers to take if presented with a fake prescription

Other Interested Parties

- Provide consumer Tip Sheets
- Partner with advocacy groups to educate the public
- Link to other Web sites with tips and information, such as, take back programs

Other Recommendations

- Develop an enforcement task force to develop and address best practices related to prescribing controlled substances to relieve pain

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

Program Evaluation Data – Day 1 – Thursday, February 21, 2013

Please rate your level of agreement for the program meeting the following objectives:

Objective	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
To educate participants in the problems created by overprescribing narcotics, addiction, and diversion of prescription drugs.	6	**1**	**5**	**114**	**196**
To inform participants of the nature of drug diversion – how legitimate patients' medications are diverted to illegitimate use.	**5**	**2**	**10**	**127**	**180**
To provide tools to physicians and pharmacists on how to spot problematic patients and prescriptions.	**7**	**4**	**37**	**136**	**126**
To inform participants of resources available to physicians who may have patients who are addicts.	**12**	**15**	**56**	**129**	**107**
To inform participants of the tools available from state and federal regulatory agencies	**7**	**9**	**40**	**145**	**113**

Please rate your level of agreement with the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
This activity was commercially biased.	**219**	**63**	**13**	**8**	**16**
I gained knowledge from this activity.	**2**	**1**	**13**	**140**	**169**
I will apply what I learned in my practice.	**1**	**2**	**38**	**146**	**135**
What I learned will change my practice.	**3**	**6**	**102**	**124**	**74**

Please indicate whether the speaker(s) was/were effective and enhanced your knowledge base.

Speakers	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Michael P. Botticelli	**2**	**3**	**35**	**153**	**124**
Joseph Rannazzisi	**7**	**6**	**15**	**69**	**221**
Laura Meyers and Ruth Morentz	**5**	**5**	**40**	**131**	**92**

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

Program Evaluation Data – Day 2 – Friday, February 22, 2013

Please rate your level of agreement for the program meeting the following objectives:

Objective	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
To provide tools to physicians and pharmacists on how to spot problematic patients and prescriptions.	3	4	13	156	156
To inform participants of resources available to physicians who may have patients who are addicts.	9	20	38	149	114
To educate participants in the use of the California CURES program.	3	14	0	135	180
To educate participants of the penalties related to improper prescribing and dispensing of controlled substances.	3	10	31	158	120
To inform participants of the tools available from state and federal regulatory agencies.	4	10	51	148	109
To inform and encourage cooperation and communication between physicians and pharmacists.	4	1	11	131	185
To inform participants in how they can become involved in the public policy discussions.	5	21	66	127	82

Please rate your level of agreement with the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
This activity was commercially biased.	242	62	12	7	11
I gained knowledge from this activity.	2	2	12	148	169
I will apply what I learned in my practice.	2	2	34	153	139
What I learned will change my practice.	4	6	62	155	100

Please indicate whether the speaker(s) was/were effective and enhanced your knowledge base.

Speakers	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Cesar A. Aristeiguieta, M.D.	**5**	**5**	**20**	**114**	**177**
Judi Nurse, Pharm.D.	**5**	**2**	**35**	**145**	**134**
Darlene Fujimoto, Pharm.D.	**5**	**3**	**21**	**154**	**137**
David Greenberg, M.D.	**9**	**1**	**24**	**123**	**167**
Michel Sucher, M.D.	**3**	**0**	**25**	**54**	**32**
Kevin Barnard	**7**	**5**	**39**	**146**	**107**
Panel of Medical and Pharmacy Experts	**4**	**3**	**40**	**143**	**135**
Darlene Fujimoto, Pharm.D. / Gregory Polston, M.D.	**6**	**3**	**32**	**144**	**128**
Mike Small	**5**	**1**	**34**	**133**	**136**
Panel of Experts from Federal, State, and Local Law Enforcement/Prosecutors	**5**	**3**	**35**	**133**	**132**
Panel of Regulators and Policy Makers	**3**	**5**	**25**	**112**	**99**

LEGISLATIVE PACKET

MEDICAL BOARD MEETING

April 25, 2013
Los Angeles, CA

MEDICAL BOARD OF CALIFORNIA - 2013 TRACKER LIST
April 16, 2013

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 27	Medina	UC Riverside Medical School: Funding	Asm. Approps.	Reco: Support	3/21/13
AB 154	Atkins	Healing Arts: Reproductive Health Care	Asm. Health	**Exec. Reco: Neutral**	3/19/13
AB 186	Mainschein	Professions & Vocations: Military Spouses: Temporary Licenses	Asm. B&P	Reco: Oppose Unless Amended	4/1/13
AB 496	Gordon	Task Force: LGBT Cultural Competency	Asm. B&P	Reco: Neutral	4/10/13
AB 512	Rendon	Sponsored Health Care Events: Sunset Extension	Asm. Approps.	Reco: Support	Intro.
AB 565	Salas	California Physician Corps Program	Asm. Health	Reco: Support	4/10/13
AB 589	Fox	Underrepresented Medical Specialties	Asm. Health	2-year Bill	Intro.
AB 635	Ammiano	Drug Overdose Treatment: Liability	Senate	**Exec. Reco: Support in Concept**	4/11/13
AB 809	Logue	Healing Arts: Telehealth	Asm. Health	Reco: Neutral	4/3/13
AB 831	Bloom	Drug Overdoses	Asm. Approps.	**Exec. Reco: Support**	4/3/13
AB 860	Perea	Medical School Scholarships	Asm. Approps.	Reco: Support	4/8/13
AB 916	Eggman	Healing Arts: False or Misleading Advertising	Asm. B&P	**Exec. Reco: Support**	Intro.
AB 1000	Wieckowski	Physical Therapists: Direct Access to Services	Asm. B&P	Reco: Oppose **Exec - Defer**	3/21/13
AB 1003	Mainschein	Professional Corporations: Healing Arts Practitioners	Asm. B&P	Reco: Support	4/1/13
AB 1176	Bocanegra & Bonta	Medical Residency Training Program Grants	Asm. Health	Reco: Support	3/21/13
AB 1182	Brown	Medically Underserved Areas	Assembly	SPOT	Intro.
AB 1269	Gray	Medicine: Special Faculty Permit	Asm. B&P	SPOT	Intro.
AB 1278	Hueso	Integrative Cancer Treatment	Now SB 117	**Exec. Reco: Neutral**	SB 117
AB 1288	Perez, M.	Medical Board of California: Licensing Application	Asm. Health	Reco: Neutral	4/11/13

Green – For Discussion, Yellow – Consent Items, Orange – Position Taken, Blue – Spot or 2-year Bill

MEDICAL BOARD OF CALIFORNIA - 2013 TRACKER LIST
April 16, 2013

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 1308	Bonilla	Midwifery	Asm. B&P	**Exec. Reco: Support if Amended**	3/21/13
ACR 40	Perez	Donate Life California Day	Enrollment	Reco: Support	4/8/13
SB 20	Hernandez	Health Care: Workforce Training	Sen. Approps.	Reco: Support	2/14/13
SB 21	Roth	UC Riverside Medical School: Funding	Sen. Education	Reco: Support	3/18/13
SB 62	Price	Coroners: Reporting Requirements: Prescription Drug Use	Sen. B&P, 4/15	Support if Amended	4/9/13
SB 117	Hueso	Integrative Cancer Treatment	Sen. Health	**Exec. Reco: Neutral**	4/8/13
SB 304	Price	Healing Arts: Sunset Bill	Sen. B&P	Reco: Support	Intro.
SB 305	Price	Healing Arts: Boards	Sen. B&P	Reco: Support	4/15/13
SB 352	Pavley	Medical Assistants: Supervision	Sen. 3rd Reading	**Exec. Reco: Neutral if Amended**	4/10/13
SB 410	Yee	Controlled Substances & Dangerous Drugs	Senate	SPOT	Intro.
SB 491	Hernandez	Nurse Practitioners	Sen. B&P	Reco: Oppose	4/1/13
SB 492	Hernandez	Optometric Corporations	Sen. B&P	Reco: Oppose	4/1/13
SB 493	Hernandez	Pharmacy Practice	Sen. B&P	Reco: Oppose	4/1/13
SB 670	Steinberg	Limitation on Licensee Authority: Controlled Substances	Sen. B&P	Reco: Support in Concept	4/8/13
SB 701	Emmerson	Hospital-Affiliated Outpatient Settings	Sen. B&P	Reco: Neutral	Intro.
SB 796	Nielsen	Medicine: Physicians and Surgeons	Senate	SPOT	Intro.
SB 809	DeSaulnier	Controlled Substances: Reporting: CURES	Sen. B&P, 4/15	**Exec. Reco: Support in Concept**	Intro.
SCR 8	DeSaulnier	Prescription Drug Abuse Awareness Month	Asm. 3rd Reading	Support	Intro.

Green – For Discussion, Yellow – Consent Items, Orange – Position Taken, Blue – Spot or 2-year Bill

AB 27

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 27 and SB 21
Author: Medina and Roth
Bill Date: March 21 and 18, 2013, amended
Subject: UC Riverside Medical School: Funding
Sponsor: Authors

STATUS OF BILL:

AB 27 is in the Assembly Appropriations Committee and SB 21 is in the Senate Education Committee.

DESCRIPTION OF CURRENT LEGISLATION:

These bills mirror each other and would both annually appropriate $15,000,000 from the General Fund to the Regents of the University of California for allocation to the School of Medicine at the University of California, Riverside. Both bills contain urgency clauses, which mean that the bills would take effect immediately once signed into law.

ANALYSIS:

The foundation of the School of Medicine at UC Riverside goes back to 1974, when the UC Riverside / University of California, Los Angeles (UCLA) Thomas Haider Program in Biomedical Sciences was established. This program has allowed approximately 700 students to complete their first two years of medical school at UC Riverside, and their last two years at the David Geffen School of Medicine at UCLA, which confers their medical degrees.

In July 2008, the UC Board of Regents officially approved the proposed establishment of an independent four-year School of Medicine at UC Riverside, intended to serve the medically underserved in the Inland Empire. However, in the summer of 2011, UC Riverside failed to gain accreditation for an independent four-year medical school from the Liaison Committee on Medical Education (LCME), the national accrediting body for educational programs leading to the Medical Doctor degree in United States. LCME withheld preliminary accreditation due to a lack of stable state funding support for the school. In April 2012, UC Riverside secured substantial new funding from a variety of non-state funding sources, and submitted a second accreditation application to LCME. In June 2012, a second accreditation site visit took place and in October 2012, UC Riverside received notification from LCME that its planned medical school received "preliminary accreditation." Preliminary accreditation from LCME enables prospective students to begin applying to the UC Riverside School of Medicine in order to potentially enroll in August 2013.

These bills would appropriate $15,000,000 from the General Fund in order to establish a more viable funding source for the UC Riverside School of Medicine. According to the author, the highest indicator of where a physician practices is where he or she attends medical school and the Inland

Empire trails behind much of the state in several key health indicators, including coronary heart disease and diabetes. The author believes that the establishment of a medical school in the Inland Empire will help to ensure more physicians are trained and remain in the Inland Empire. The author contends that one of the areas that will aid in the UCR School of Medicine receiving final accreditation from LCME and meeting the medical needs of the Inland Empire is for the Medical School to receive a stable funding source, which is why this bill seeks to appropriate General Fund monies.

According the Public Policy Institute of California, the Inland Empire is the fastest-growing region of the state and it is estimated that more than 300,000 residents of the Inland Empire will have health insurance coverage extended to them as a result of the Affordable Care Act. The U.S. Department of Health and Human Services' Council on Graduate Medical Education recommends that a given region have 60 to 80 primary care physicians per 100,000 residents and 85 to 105 specialists. The Inland Empire has about 40 primary care doctors and 70 specialists per 100,000 residents, which is a severe shortage.

These bills will help to increase access to care and help the Inland Empire area of California to prepare and be ready for implementation of the Affordable Care Act. Board staff suggests that the Board support this bill.

FISCAL: None to the Board

SUPPORT: California Department of Insurance; California Medical Association; City of Riverside; Enterprise Media; Riverside County Superintendent of Schools, Kenneth M. Young; Southwest California Legislative Council; University of California at Riverside; UC Riverside Alumni Association; UC Riverside Board of Trustees; and two individuals.

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY MARCH 21, 2013

AMENDED IN ASSEMBLY MARCH 13, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 27

Introduced by Assembly Member Medina
(Coauthor: Assembly Member Linder)

December 3, 2012

An act relating to the University of California, ~~and~~ making an appropriation therefor, *and declaring the urgency thereof, to take effect immediately.*

LEGISLATIVE COUNSEL'S DIGEST

AB 27, as amended, Medina. University of California: UC Riverside Medical School: funding.

Existing provisions of the California Constitution establish the University of California as a public trust under the administration of the Regents of the University of California. The University of California system includes 10 campuses, which are located in Berkeley, Davis, Irvine, Los Angeles, Merced, Riverside, San Diego, San Francisco, Santa Barbara, and Santa Cruz.

This bill would annually appropriate $15,000,000 from the General Fund to the Regents of the University of California for allocation to the School of Medicine at the University of California, Riverside.

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

Vote: ⅔. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.

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

1 SECTION 1. The sum of fifteen million dollars ($15,000,000)
2 is hereby appropriated annually from the General Fund to the
3 Regents of the University of California for allocation to the School
4 of Medicine at the University of California, Riverside.
5 *SEC. 2. This act is an urgency statute necessary for the*
6 *immediate preservation of the public peace, health, or safety within*
7 *the meaning of Article IV of the Constitution and shall go into*
8 *immediate effect. The facts constituting the necessity are:*
9 *In order to serve students without disrupting their education at*
10 *the School of Medicine at the University of California, Riverside,*
11 *and to ensure the continuation of funding to this school, it is*
12 *necessary for this act to take effect immediately.*

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AB 154

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 the Assembly Health 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 performs 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 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 DCSMC 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); ACT for Women and Girls; American Association of University Women; American College of Nurse-Midwives; American Nurses Association; Bay Area Communities for Health Education; California Academy of Family Physicians; California Academy of Physician Assistants; California Association for Nurse Practitioners; California Church IMPACT; California Family Health Council; California Nurse-Midwives Association; California Women's Law Center; Cardea Institute; Center on Reproductive Rights and Justice at UC Berkeley School of Law; Choice USA; Choice USA at California State University Long Beach; Choice USA at

California State University Sacramento; Choice USA at Mills College; Choice USA at San Jose State University; Choice USA at Scripps College Beach; Forward Together; Fresno Barrios Unidos; Khmer Girls in Action; Law Students for Reproductive Justice; League of Women Voters of California; National Asian Pacific American Women's Forum; National Center for Lesbian Rights; National Health Law Program; National Latina Institute for Reproductive Health; National Network of Abortion Funds; Nevada County Citizens for Choice; Physicians for Reproductive Health; Planned Parenthood Mar Monte; Planned Parenthood of Orange and San Bernadino Counties; Planned Parenthood Pasadena & San Gabriel Valley; Planned Parenthood of Santa Barbara, Ventura, and San Luis Obispo Counties; Planned Parenthood of the Pacific Southwest; Reproductive Justice Coalition of Los Angeles; Six Rivers Planned Parenthood; Students for Reproductive Justice at Stanford University; Women's Community Clinic; Women's Health Specialists of California; and numerous private individuals

OPPOSITION: California Catholic Conference; California Right to Life Committee; Capitol Resource Institute; and numerous private individuals and churches

POSITION: Executive Committee 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.

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.

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*

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

~~(c) For purposes of this section, "nonsurgical abortion" includes termination of the use of pharmacological agents.~~

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

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

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

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

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

3502.4. (a) In order to receive authority from his or her supervising physician and surgeon to perform an abortion by aspiration techniques, a physician assistant shall complete training either through training programs approved by the Physician Assistant Board pursuant to Section 3513 or by training to perform medical services which augment his or her current areas of competency pursuant to Section 1399.543 of Title 16 of the California Code of Regulations. Beginning January 1, 2014, and until January 1, 2016, the training and clinical competency protocols established by Health Workforce Pilot Project (HWPP) No. 171 through the Office of Statewide Health Planning and Development shall be used as training and clinical competency guidelines to meet this requirement.

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

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

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

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

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

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

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

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

~~SECTION 1. 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, provided that the functions are within the scope of their licenses.~~

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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

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)

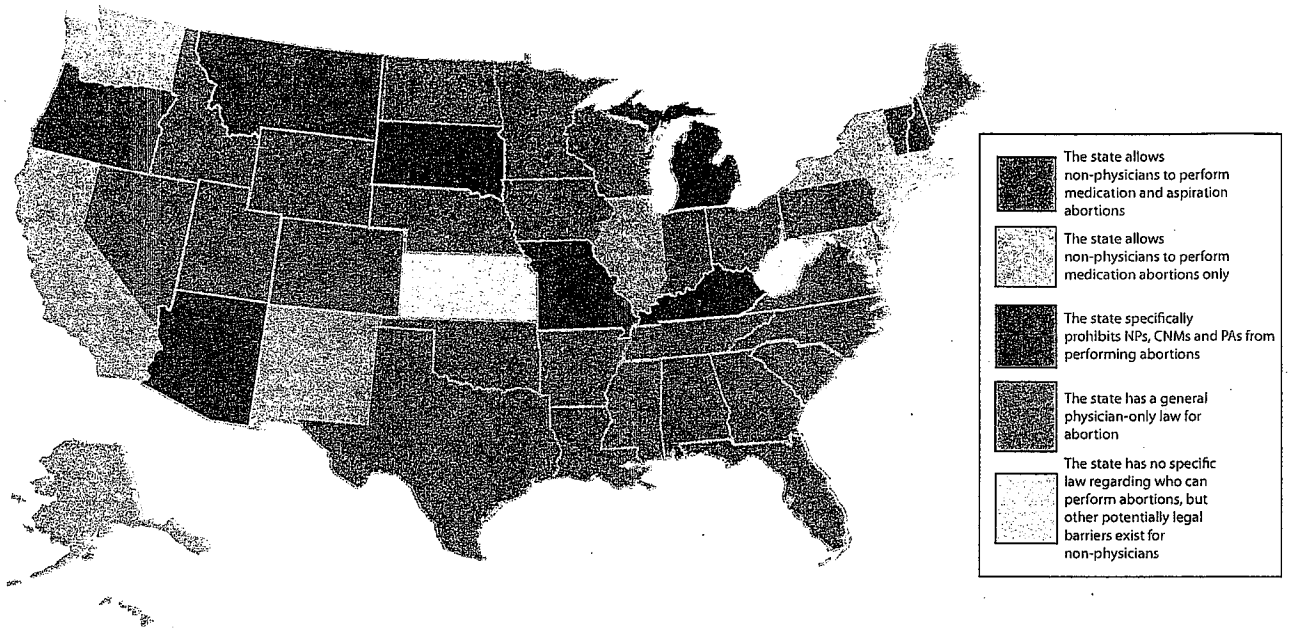
Increased access to early abortion is a pressing public health need. By 2005, the number of abortion care facilities in the United States had decreased 38% from its peak in 1982.[1] Although the number has since remained stable, the proportion of US counties with no facility remains high at 87%; more 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 complications[4] 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] 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.



Note. CNM = certified nurse midwife; NP = nurse practitioner; PAs = physician assistants.

FIGURE 1—Landscape of health professional regulation of abortion provision in the United States.

METHODS

In 2005, study investigators applied to the California Office of Statewide Health Planning and Development (OSHPD) for a waiver of legal statutes that limit the completion of surgical abortion to physicians.[26–28] Following a public meeting, hearing, and extensive input from stakeholders, the State of California granted approval for Health Workforce Pilot Project No. 171 in March 2007, followed by approval of 4 subsequent extensions. The study received institutional review board approvals from the University of California, San Francisco; Ethical and Independent Review Services; and Kaiser Permanente of Northern California (KPNC).

In this prospective, observational cohort study, NPs, CNMs, and PAs from 5 partner organizations (4 Planned Parenthood affiliates and KPNC) were trained to competence in the provision of aspiration abortion (a minimum of 40 procedures over 6 clinical days, with competence assessed by an authorized physician trainer). To be qualified for training, NPs, CNMs, and PAs had to have a California professional license, basic life support certification, and 12 months or more of clinical experience, including 3 months or more experience in medication abortion provision. Physicians employed by the facility served as the comparison group. A total of 28 NPs, 5 CNMs, and 7 PAs (n = 40) and 96 physicians (with training in either family medicine or obstetrics and gynecology) completed procedures during the study period. Physicians had a mean of 14 years of experience providing abortions compared with a mean of 1.5 years among NPs, CNMs, and PAs. This analysis did not include procedures performed by NPs, CNMs, and PAs during their training phase.

Patients were enrolled at 22 clinical facilities between August 2007 and August 2011. Patients were eligible for the study if they were aged 16 years or older (18 years at Planned Parenthood affiliates), were seeking a first-trimester aspiration abortion (facilities self-defined this as ≤ 12 or ≤ 14 weeks' gestation by ultrasound), and could speak English or Spanish. Patients were excluded if they requested general anesthesia or did not meet the health-related criteria (unexplained historical, physical, or laboratory findings or known or suspected cervical or uterine abnormalities).

Study Procedures

Eligible patients reviewed a consent form with a facility staff member. If a patient agreed to participate, she was asked whether she was willing to have her abortion done by an NP, CNM, or PA; if so, the aspiration was performed by the NP, CNM, or PA on duty. Patients in this group were routed to a physician if clinical flow necessitated reorganizing patients. Patients were also routed to a physician if they were unwilling to have their abortions performed by an NP, CNM, or PA or arrived for care when only a physician was present.

Each patient received $5 and a follow-up survey about medical problems after the abortion to capture any delayed postprocedure complications. If patients did not return the survey, clinic staff made at least 3 attempts to administer the survey by phone. If the patient experienced postabortion problems, she was asked a defined set of questions to obtain medical details. Additionally, staff conducted patient chart abstractions 2 to 4 weeks after abortion to ensure delayed complications were

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[g]			
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.
[a]*P* 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.
[b]Data missing for 70 women in the NP-CNM-PA group and 56 in the physician group.
[c]California's Medicaid program.
[d]Data missing for 11 women in each provider group.
[e]Data missing for 25 women in the NP-CNM-PA group and 20 in the physician group.
[f]Data missing for 17 women in the NP-CNM-PA group and 18 in the physician group.
[g]All 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

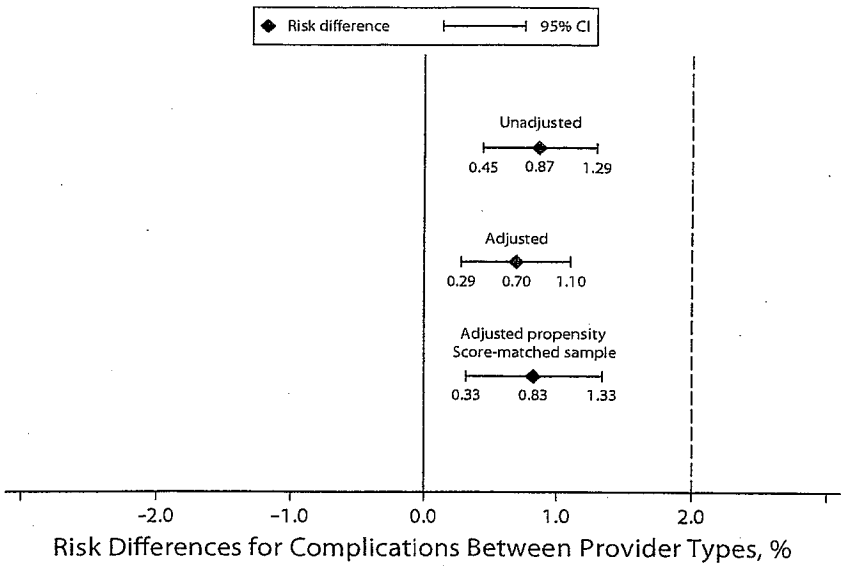
In 2008, 1.21 million abortions took place in the United States, with more 200 000 (18%) in the State of California.[2] Nationally, 92% of abortions take place in the first trimester,[7] but Black, uninsured, and low-income women have less access to this care.[6] In California, only 87% of women using 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

	Physicians (n = 5812)		NPs-CNMs-PAs (n = 5675)		Total (n = 11 487)		Risk Difference Between Provider Groups (n = 11 487)
Complication Type	Rate/100 (95% CI)	No.	Rate/100 (95% CI)	No.	Rate/100 (95% CI)	No.	Difference in Rate/100 (95% CI)
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 secondnd-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 international[13] and national[47] 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] ■

About the Authors

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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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AB 186

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 186
Author: Maienschein
Bill Date: April 1, 2013, amended
Subject: Military Spouses: Temporary Licenses
Sponsor: Author

STATUS OF BILL:

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

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow spouses of military personnel that have moved to California based upon active duty orders of the military spouse, and who have a physician and surgeon license in another state, to receive an 18 month provisional license, if they meet the licensing requirements, complete an application and provide specified information.

ANALYSIS:

Existing law requires boards in the Department of Consumer Affairs (DCA) to expedite the licensure process for applicants if they supply evidence satisfactory to the Board that the applicant is married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in California under official active duty military orders, and if they hold a current license in another state in the profession or vocation for which he or she seeks a license from the Board.

This bill would require all boards under DCA, including the Medical Board of California (Board), to issue a 18-month provisional license to applicants that qualify for an expedited license if the applicant has not committed an act in any jurisdiction that would have constituted grounds for denial, suspension, or revocation of the license and if the applicant has not been disciplined by a licensing entity in another jurisdiction and is not the subject of an unresolved complaint, review procedure, or disciplinary proceeding conducted by a licensing entity in another jurisdiction. This bill would require the applicant to submit an application that includes an affidavit that the information submitted in the application is accurate and that verification documentation form the other jurisdiction has been requested. The provisional license would expire 18 months after issuance, or upon issuance of the expedited license. This bill would allow the Board to adopt necessary regulations.

The fact sheet on this bill states that according to a recent study by the California Research Bureau, California has about 72,500 military spouses residing in this state, and over one third of these individuals are involved in a profession that requires some sort of licensing requirement. According to the author's office, this bill will allow military spouses to immediately look for employment to help support their families, while taking all the necessary steps to apply and receive a license from the state.

This bill would require the applicant to meet all licensing requirements in existing law and would require fingerprints to be cleared, would require license verification through the American Medical Association and/or the National Practitioner's Data bank, and verification from the state the applicant is licensed in before the provisional license could be issued. However, Board staff is suggesting that the Board oppose this bill unless it is amended to include language that would specify if the information on the applicant's application is found to be inaccurate, contrary to the affidavit, that the Board could require the individual that has been issued a provisional license to immediately cease practice, in order to ensure consumer protection.

FISCAL: Minor and absorbable

SUPPORT: National Military Family Association
Department of Defense, State Liaison's Office

OPPOSITION: None on file

POSITION: Recommendation: Oppose unless amended to include a cease practice provision

AMENDED IN ASSEMBLY APRIL 1, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 186

Introduced by Assembly Member Maienschein
(Principal coauthor: Assembly Member Hagman)
(Coauthors: Assembly Members Dahle, Donnelly, Beth Gaines, Harkey, Olsen, and Patterson)
(Coauthors: Senators Fuller and Huff)

January 28, 2013

An act to amend Section 115.5 of the Business and Professions Code, relating to professions and vocations, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 186, as amended, Maienschein. Professions and vocations: military spouses: temporary licenses.

Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs. Existing law provides for the issuance of reciprocal licenses in certain fields where the applicant, among other requirements, has a license to practice within that field in another jurisdiction, as specified. ~~Under existing law, licensing fees imposed by certain boards within the department are deposited in funds that are continuously appropriated.~~ Existing law requires a board within the department to expedite the licensure process for an applicant who holds a current license in another jurisdiction in the same profession or vocation and who supplies satisfactory evidence of being married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces

of the United States who is assigned to a duty station in California under official active duty military orders.

This bill would authorize a board within the department to issue a provisional license to an applicant who qualifies for an expedited license pursuant to the above-described provision. *The bill would prohibit a provisional license from being provided to any applicant who has committed an act in any jurisdiction that would have constituted grounds for denial, suspension, or revocation of the license at the time the act was committed, or has been disciplined by a licensing entity in another jurisdiction, or is the subject of an unresolved complaint, review procedure, or disciplinary proceeding conducted by a licensing entity in another jurisdiction. The bill would require the board to approve a provisional license based on an application that includes an affidavit that the information submitted in the application is accurate and that verification documentation from the other jurisdiction has been requested.* The bill would require the provisional license to expire after 18 months *or at the issuance of the expedited license.*

By creating provisional licenses for which a fee may be collected and deposited into a continuously appropriated fund, this bill would make an appropriation.

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

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

1 SECTION 1. Section 115.5 of the Business and Professions
2 Code is amended to read:
3 115.5. (a) A board within the department shall expedite the
4 licensure process for an applicant who meets both of the following
5 requirements:
6 (1) Supplies evidence satisfactory to the board that the applicant
7 is married to, or in a domestic partnership or other legal union
8 with, an active duty member of the Armed Forces of the United
9 States who is assigned to a duty station in this state under official
10 active duty military orders.
11 (2) Holds a current license in another state, district, or territory
12 of the United States in the profession or vocation for which he or
13 she seeks a license from the board.
14 (b) *(1)* For each applicant who is eligible for an expedited
15 license pursuant to subdivision (a) *and meets the requirements in*

paragraph (2), the board ~~may~~ *shall* provide a provisional license while the board processes the application for licensure. *The board shall approve a provisional license based on an application that includes an affidavit that the information submitted in the application is accurate and that verification documentation from the other jurisdiction has been requested.* The provisional license shall expire 18 months after issuance *or upon issuance of the expedited license.*

(2) (A) The applicant shall not have committed an act in any jurisdiction that would have constituted grounds for denial, suspension, or revocation of the license under this code at the time the act was committed.

(B) The applicant shall not have been disciplined by a licensing entity in another jurisdiction and shall not be the subject of an unresolved complaint, review procedure, or disciplinary proceeding conducted by a licensing entity in another jurisdiction.

(c) A board may adopt regulations necessary to administer this section.

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AB 496

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 496
Author: Gordon
Bill Date: April 10, 2013, amended
Subject: Medicine: Sexual Orientation, Gender Identity, and Gender Expression
Sponsor: Equality California

STATUS OF BILL:

This bill is in Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would reauthorize the Task Force on Culturally and Linguistically Competent Physicians and Dentists in order to expand the Task Force's membership and charge to include the lesbian, gay, bisexual and transgender (LGBT) community. This bill would require the reconstituted Task Force to report its findings to the Legislature by January 1, 2016. This bill would also expand the definition of cultural competency.

ANALYSIS:

This bill would reauthorize the Task Force on Culturally and Linguistically Competent Physicians and Dentists to consist of the following members: The Deputy Director of the Office of Health Equity or his or her designee and the Director of the Department of Consumer Affairs (DCA) or his or her designee to serve as co-chairs; the Executive Director of the Medical Board of California (Board) or his or her designee; the Executive Director of the Dental Board of California or his or her designee; one member appointed by the Senate; and one member appointed by the Assembly. This bill would allow additional members to be appointed by the Director of DCA, in consultation with the Office of Health Equality, as follows: representatives of organizations that advocate on behalf of physicians and dentists; physicians and dentists who provide health services to members of language and ethnic minority groups and LGBT groups; representatives of entities that offer continuing education for physicians and dentists; representatives of California's medical and dental schools; and individuals with experience in developing, implementing, monitoring, and evaluating cultural and linguistic programs.

This bill would specify that the duties of the Task Force would be the same as before: to develop recommendations for a continuing education program that includes language proficiency standards of foreign language to meet linguistic competence; to identify key cultural elements necessary to meet cultural competency by physicians, dentists, and their offices; and to assess the need for voluntary certification standards and examinations for cultural competency. This bill would require the Task Force to hold hearings and convene meetings to obtain input from persons belonging to language and ethnic minority groups, and this bill would add LGBT groups, to determine their needs and preferences for having culturally competent medical providers. This bill would require the hearings to be held in

communities that have large populations of language and ethnic minority groups and LGBT groups. This bill would require the Task Force to report its findings to the Legislature and appropriate licensing boards by January 1, 2016. This bill would require the Board and the Dental Board to pay the administrative costs of implementing the Task Force, the hearings, and the report.

This bill would also amend the Cultural and Linguistic Competency of Physicians Act of 2003 regarding the cultural and linguistic physician competency program that is operated by local medical societies of the California Medical Association and monitored by the Board. The program is a voluntary program consisting of educational classes. This bill would expand the program to require it to additionally address LGBT groups of interest to local medical societies. In addition, this bill would require the training programs to be formulated in collaboration with LGBT medical societies

This bill does not add to or change existing law related to the working group that has already been convened by the Board and that continues to exist, which is the Cultural and Linguistic Physician Competency Program (CLC) Workgroup. Lastly, this bill would define "cultural and linguistic competency" to include understanding and applying the roles that sexual orientation, gender identity, and gender expression play in diagnosis, treatment and clinical care.

According to the author's office, LGBT patients have reported a reluctance to reveal their sexual orientation or gender identity to their providers, despite the importance of such information for their health care. The author believes that cultural competency plays a crucial role in understanding, diagnosing, and delivering appropriate care to LGBT patients. The ability of physicians to effectively communicate with, and to create a welcoming and safe environment for their LGBT patients, has an impact on LGBT patient health outcomes and on provider-patient relationships.

Although DCA, the Board, and the Dental Board already convened and participated in the Task Force on Culturally and Linguistically Competent Physicians and Dentists, LGBT issues were not addressed at the Task Force, the hearings, or in the final report to the Legislature. This bill would reauthorize this Task Force and include LGBT issues for the Task Force to hold hearings on and include in its report to the Legislature. Since this bill does not expand the working group convened by the Board, the Board would only need to include agenda items at future meetings that address understanding and applying the roles that sexual orientation, gender identity, and gender expression play in diagnosis, treatment and clinical care. The Board's Executive Director would be required to participate in the reauthorized Task Force and the Board would be partially responsible for the costs associated with the Task Force, hearings, and the report to the Legislature. Board staff is suggesting a neutral position on this bill.

FISCAL: $43,000 (this is the Board's portion of the cost associated with the prior Task Force)

SUPPORT: Equality California (sponsor)
California Communities United Institute

OPPOSITION: None on file

POSITION: Recommendation: Neutral

AMENDED IN ASSEMBLY APRIL 10, 2013

AMENDED IN ASSEMBLY APRIL 2, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 496

Introduced by Assembly Member Gordon

February 20, 2013

An act to amend Sections 852, 2198, and 2198.1 of the Business and Professions Code, relating to medicine.

LEGISLATIVE COUNSEL'S DIGEST

AB 496, as amended, Gordon. Medicine: sexual orientation, gender identity, and gender expression.

Existing law creates the Task Force on Culturally and Linguistically Competent Physicians and Dentists. Existing law requires the Director of Health Care Services and the Director of Consumer Affairs to serve as cochairs of the task force. *Existing law requires that the task force consist of, among other people, the Executive Director of the Medical Board of California and the Executive Director of the Dental Board of California.* Existing law *additionally* requires the Director of Consumer Affairs, in consultation with the Director of Health Care Services, to appoint as task force members, among other people, California licensed physicians and dentists ~~that~~ *who* provide health services to members of language and ethnic minority groups and representatives of organizations that advocate on behalf of, or provide health services to, members of language and ethnic minority groups. Existing law required the task force to report its findings to the Legislature and appropriate licensing boards by January 1, 2003.

This bill would replace the Director of Health Care Services with the Deputy Director of the Office of Health Equity, *or his or her designee,* as cochair of the task force. The bill would also instead require the appointment of members to be made in consultation with the Office of Health Equity. *The bill would authorize a designee of the Director of Consumer Affairs to serve as cochair of the task force and would authorize designees of the Executive Director of the Medical Board of California and the Executive Director of the Dental Board of California to serve as task force members.* The bill would require the licensed task force members and advocate task force members to ~~provide~~ *be providers of* health services to, or ~~advocate~~ *advocates* on behalf of, members of language and ethnic minority groups as well as lesbian, gay, bisexual, and transgender groups. The bill would require the task force to report its findings to the Legislature and appropriate licensing boards by January 1, 2016.

Existing law, the Cultural and Linguistic Competency of Physicians Act of 2003, establishes the cultural and linguistic physician competency program which is operated by local medical societies of the California Medical Association and is monitored by the Medical Board of California. That voluntary program consists of educational classes for all interested physicians and is designed to teach foreign language and cultural beliefs and practices that may impact patient health care practices and allow physicians to incorporate this knowledge in the diagnosis and treatment of patients who are not from the predominate culture in California. Existing law also defines "cultural and linguistic competency" for the purposes of those provisions as meaning cultural and linguistic abilities that can be incorporated into therapeutic and medical evaluation and treatment, including understanding and applying the roles that culture, ethnicity, and race play in diagnosis, treatment, and clinical care, and awareness of how the attitudes, values, and beliefs of health care providers and patients influence and impact professional and patient relations.

This bill would additionally require the program to address lesbian, gay, bisexual, and transgender groups of interest to local medical societies. The bill would require the training programs to be formulated in collaboration with California-based lesbian, gay, bisexual, and transgender medical societies. The bill would also redefine the term "cultural and linguistic competency" as understanding and applying the roles that culture, ethnicity, race, sexual orientation, gender identity, and gender expression play in diagnosis, treatment, and clinical care,

and awareness of how the attitudes, values, and beliefs of health care providers, patients, and society influence and impact professional and patient relations. The bill would also make related technical, nonsubstantive changes.

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

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

1 SECTION 1. Section 852 of the Business and Professions Code
2 is amended to read:
3 852. (a) The Task Force on Culturally and Linguistically
4 Competent Physicians and Dentists is hereby created and shall
5 consist of the following members:
6 (1) The Deputy Director of the Office of Health Equity, *or his*
7 *or her designee,* and the Director of Consumer Affairs, *or his or*
8 *her designee,* who shall serve as cochairs of the task force.
9 (2) The Executive Director of the Medical Board of California,
10 *or his or her designee.*
11 (3) The Executive Director of the Dental Board of California,
12 *or his or her designee.*
13 (4) One member appointed by the Senate Committee on Rules.
14 (5) One member appointed by the Speaker of the Assembly.
15 (b) Additional task force members shall be appointed by the
16 Director of Consumer Affairs, in consultation with the Office of
17 Health Equity, as follows:
18 (1) Representatives of organizations that advocate on behalf of
19 California licensed physicians and dentists.
20 (2) California licensed physicians and dentists ~~that~~ *who* provide
21 health services to members of language and ethnic minority groups,
22 as well as lesbian, gay, bisexual, and transgender groups.
23 (3) Representatives of organizations that advocate on behalf of,
24 or provide health services to, members of language and ethnic
25 minority groups, as well as lesbian, gay, bisexual, and transgender
26 groups.
27 (4) Representatives of entities that offer continuing education
28 for physicians and dentists.
29 (5) Representatives of California's medical and dental schools.
30 (6) Individuals with experience in developing, implementing,
31 monitoring, and evaluating cultural and linguistic programs.

(c) The duties of the task force shall include the following:

(1) Developing recommendations for a continuing education program that includes language proficiency standards of foreign language to be acquired to meet linguistic competency.

(2) Identifying the key cultural elements necessary to meet cultural competency by physicians, dentists, and their offices.

(3) Assessing the need for voluntary certification standards and examinations for cultural and linguistic competency.

(d) The task force shall hold hearings and convene meetings to obtain input from persons belonging to language and ethnic minority groups, as well as lesbian, gay, bisexual, and transgender groups, to determine their needs and preferences for having culturally competent medical providers. These hearings and meetings shall be convened in communities that have large populations of language and ethnic minority groups, as well as lesbian, gay, bisexual, and transgender groups.

(e) The task force shall report its findings to the Legislature and appropriate licensing boards on or before January 1, 2016.

(f) The Medical Board of California and the Dental Board of California shall pay the state administrative costs of implementing this section.

(g) Nothing in this section shall be construed to require mandatory continuing education of physicians and dentists.

SEC. 2. Section 2198 of the Business and Professions Code is amended to read:

2198. (a) This article shall be known and may be cited as the Cultural and Linguistic Competency of Physicians Act of 2003. The cultural and linguistic physician competency program is hereby established and shall be operated by local medical societies of the California Medical Association and shall be monitored by the Medical Board of California.

(b) This program shall be a voluntary program for all interested physicians. As a primary objective, the program shall consist of educational classes which shall be designed to teach physicians the following:

(1) A foreign language at the level of proficiency that initially improves their ability to communicate with non-English speaking patients.

(2) A foreign language at the level of proficiency that eventually enables direct communication with the non-English speaking patients.

(3) Cultural beliefs and practices that may impact patient health care practices and allow physicians to incorporate this knowledge in the diagnosis and treatment of patients who are not from the predominate culture in California.

(c) The program shall operate through local medical societies and shall be developed to address the ethnic language minority groups, as well as lesbian, gay, bisexual, and transgender groups, of interest to local medical societies.

(d) In dealing with Spanish language and cultural practices of Mexican immigrant communities, the cultural and linguistic training program shall be developed with direct input from physician groups in Mexico who serve the same immigrant population in Mexico. A similar approach may be used for any of the languages and cultures that are taught by the program or appropriate ethnic medical societies may be consulted for the development of these programs.

(e) Training programs shall be based and developed on the established knowledge of providers already serving target populations and shall be formulated in collaboration with the California Medical Association, the Medical Board of California, and other California-based ethnic medical societies, as well as lesbian, gay, bisexual, and transgender medical societies.

(f) Programs shall include standards that identify the degree of competency for participants who successfully complete independent parts of the course of instruction.

(g) Programs shall seek accreditation by the Accreditation Council for Continuing Medical Education.

(h) The Medical Board of California shall convene a workgroup including, but not limited to, representatives of affected patient populations, medical societies engaged in program delivery, and community clinics to perform the following functions:

(1) Evaluation of the progress made in the achievement of the intent of this article.

(2) Determination of the means by which achievement of the intent of this article can be enhanced.

(3) Evaluation of the reasonableness and the consistency of the standards developed by those entities delivering the program.

(4) Determination and recommendation of the credit to be given to participants who successfully complete the identified programs. Factors to be considered in this determination shall include, at a minimum, compliance with requirements for continuing medical education and eligibility for increased rates of reimbursement under Medi-Cal, the Healthy Families Program, and health maintenance organization contracts.

(i) Funding shall be provided by fees charged to physicians who elect to take these educational classes and any other funds that local medical societies may secure for this purpose.

(j) A survey for language minority patients shall be developed and distributed by local medical societies, to measure the degree of satisfaction with physicians who have taken the educational classes on cultural and linguistic competency provided under this section. Local medical societies shall also develop an evaluation survey for physicians to assess the quality of educational or training programs on cultural and linguistic competency. This information shall be shared with the workgroup established by the Medical Board of California.

SEC. 3. Section 2198.1 of the Business and Professions Code is amended to read:

2198.1. For purposes of this article, "cultural and linguistic competency" means cultural and linguistic abilities that can be incorporated into therapeutic and medical evaluation and treatment, including, but not limited to, the following:

(a) Direct communication in the patient-client primary language.

(b) Understanding and applying the roles that culture, ethnicity, race, sexual orientation, gender identity, and gender expression play in diagnosis, treatment, and clinical care.

(c) Awareness of how the attitudes, values, and beliefs of health care providers, patients, and society influence and impact professional and patient relations.

O

AB 512

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 512
Author: Rendon
Bill Date: February 20, 2013, Introduced
Subject: Sponsored Health Care Events: Sunset Extension
Sponsor: Los Angeles County

STATUS OF BILL:

This bill is in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would extend the sunset date in existing law, from 2014 to 2018, for provisions that authorize health care practitioners who are licensed or certified in other states to provide health care services on a voluntary basis to uninsured or underinsured individuals in California at sponsored free health care events.

ANALYSIS

AB 2699 (Bass, Chapter 270, Statutes of 2010) allows health care practitioners, including physicians, who are not licensed to practice in California, but that hold a valid license or certificate in good standing in good standing, to volunteer to provide health care services at sponsored free health care events, under specified circumstances. The bill required that all appropriate boards under the Department of Consumer Affairs (DCA) promulgate regulations before the bill could be implemented. The Medical Board was the first board under DCA to develop regulations, which became effective on August 20, 2012. Physicians licensed in other states are required to submit a request for authorization to practice without a California license at a sponsored free health care event to the Board and must also submit fingerprints before they can participate. The authorization period may not be for more than 10 days.

Existing law would sunset the ability for out-of-state health care practitioners to participate in sponsored free health care events in 2014. Although the Medical Board has promulgated regulations, many boards under DCA have not. The author and sponsor would like to extend the sunset date in existing law to allow health care practitioners to participate in sponsored free health care events and give the program more time to demonstrate its success. According to Los Angeles County, an extension of the sunset date in existing law will allow California to continue to provide access to needed health care and dental services to uninsured and underinsured consumers in this state.

Although the Board has only issued one physician permit under the authorization program that was created by AB 2699, the Board has already done the work to promulgate regulations; as such, it seems reasonable to extend the sunset date to allow more individuals to volunteer health care services at sponsored free health care events in California. This bill would enable all boards to collect data and track the number of out-of-state health care practitioners that request authorization to participate in sponsored free health care events. This bill would help to ensure these events have enough providers to serve more uninsured and underinsured consumers in California; Board staff suggests that the Board support this bill.

FISCAL: None

SUPPORT: Los Angeles County (Sponsor)
Association of Healthcare Districts

OPPOSITION: California Nurses Association
American Nurses Association of California

POSITION: Recommendation: Support

ASSEMBLY BILL No. 512

Introduced by Assembly Member Rendon

February 20, 2013

An act to amend Section 901 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 512, as introduced, Rendon. Healing arts: licensure exemption.

Existing law provides for the licensure and regulation of various healing arts practitioners by boards within the Department of Consumer Affairs. Existing law provides an exemption from these requirements for a health care practitioner licensed in another state who offers or provides health care for which he or she is licensed during a state of emergency, as defined, and upon request of the Director of the Emergency Medical Services Authority, as specified.

Existing law provides, until January 1, 2014, an exemption from the licensure and regulation requirements for a health care practitioner, as defined, licensed or certified in good standing in another state or states, who offers or provides health care services for which he or she is licensed or certified through a sponsored event, as defined, (1) to uninsured or underinsured persons, (2) on a short-term voluntary basis, (3) in association with a sponsoring entity that registers with the applicable healing arts board, as defined, and provides specified information to the county health department of the county in which the health care services will be provided, and (4) without charge to the recipient or a 3rd party on behalf of the recipient, as specified. Existing law also requires an exempt health care practitioner to obtain prior authorization to provide these services from the applicable licensing

board, as defined, and to satisfy other specified requirements, including payment of a fee as determined by the applicable licensing board.

This bill would delete the January 1, 2014, date of repeal, and instead allow the exemption to operate until January 1, 2018.

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

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

1 SECTION 1. Section 901 of the Business and Professions Code
2 is amended to read:
3 901. (a) For purposes of this section, the following provisions
4 apply:
5 (1) "Board" means the applicable healing arts board, under this
6 division or an initiative act referred to in this division, responsible
7 for the licensure or regulation in this state of the respective health
8 care practitioners.
9 (2) "Health care practitioner" means any person who engages
10 in acts that are subject to licensure or regulation under this division
11 or under any initiative act referred to in this division.
12 (3) "Sponsored event" means an event, not to exceed 10 calendar
13 days, administered by either a sponsoring entity or a local
14 government, or both, through which health care is provided to the
15 public without compensation to the health care practitioner.
16 (4) "Sponsoring entity" means a nonprofit organization
17 organized pursuant to Section 501(c)(3) of the Internal Revenue
18 Code or a community-based organization.
19 (5) "Uninsured or underinsured person" means a person who
20 does not have health care coverage, including private coverage or
21 coverage through a program funded in whole or in part by a
22 governmental entity, or a person who has health care coverage,
23 but the coverage is not adequate to obtain those health care services
24 offered by the health care practitioner under this section.
25 (b) A health care practitioner licensed or certified in good
26 standing in another state, district, or territory of the United States
27 who offers or provides health care services for which he or she is
28 licensed or certified is exempt from the requirement for licensure
29 if all of the following requirements are met:
30 (1) Prior to providing those services, he or she does all of the
31 following:

(A) Obtains authorization from the board to participate in the sponsored event after submitting to the board a copy of his or her valid license or certificate from each state in which he or she holds licensure or certification and a photographic identification issued by one of the states in which he or she holds licensure or certification. The board shall notify the sponsoring entity, within 20 calendar days of receiving a request for authorization, whether that request is approved or denied, provided that, if the board receives a request for authorization less than 20 days prior to the date of the sponsored event, the board shall make reasonable efforts to notify the sponsoring entity whether that request is approved or denied prior to the date of that sponsored event.

(B) Satisfies the following requirements:

(i) The health care practitioner has not committed any act or been convicted of a crime constituting grounds for denial of licensure or registration under Section 480 and is in good standing in each state in which he or she holds licensure or certification.

(ii) The health care practitioner has the appropriate education and experience to participate in a sponsored event, as determined by the board.

(iii) The health care practitioner shall agree to comply with all applicable practice requirements set forth in this division and the regulations adopted pursuant to this division.

(C) Submits to the board, on a form prescribed by the board, a request for authorization to practice without a license, and pays a fee, in an amount determined by the board by regulation, which shall be available, upon appropriation, to cover the cost of developing the authorization process and processing the request.

(2) The services are provided under all of the following circumstances:

(A) To uninsured or underinsured persons.

(B) On a short-term voluntary basis, not to exceed a 10-calendar-day period per sponsored event.

(C) In association with a sponsoring entity that complies with subdivision (d).

(D) Without charge to the recipient or to a third party on behalf of the recipient.

(c) The board may deny a health care practitioner authorization to practice without a license if the health care practitioner fails to

comply with this section or for any act that would be grounds for denial of an application for licensure.

(d) A sponsoring entity seeking to provide, or arrange for the provision of, health care services under this section shall do both of the following:

(1) Register with each applicable board under this division for which an out-of-state health care practitioner is participating in the sponsored event by completing a registration form that shall include all of the following:

(A) The name of the sponsoring entity.

(B) The name of the principal individual or individuals who are the officers or organizational officials responsible for the operation of the sponsoring entity.

(C) The address, including street, city, ZIP Code, and county, of the sponsoring entity's principal office and each individual listed pursuant to subparagraph (B).

(D) The telephone number for the principal office of the sponsoring entity and each individual listed pursuant to subparagraph (B).

(E) Any additional information required by the board.

(2) Provide the information listed in paragraph (1) to the county health department of the county in which the health care services will be provided, along with any additional information that may be required by that department.

(e) The sponsoring entity shall notify the board and the county health department described in paragraph (2) of subdivision (d) in writing of any change to the information required under subdivision (d) within 30 calendar days of the change.

(f) Within 15 calendar days of the provision of health care services pursuant to this section, the sponsoring entity shall file a report with the board and the county health department of the county in which the health care services were provided. This report shall contain the date, place, type, and general description of the care provided, along with a listing of the health care practitioners who participated in providing that care.

(g) The sponsoring entity shall maintain a list of health care practitioners associated with the provision of health care services under this section. The sponsoring entity shall maintain a copy of each health care practitioner's current license or certification and shall require each health care practitioner to attest in writing that

his or her license or certificate is not suspended or revoked pursuant to disciplinary proceedings in any jurisdiction. The sponsoring entity shall maintain these records for a period of at least five years following the provision of health care services under this section and shall, upon request, furnish those records to the board or any county health department.

(h) A contract of liability insurance issued, amended, or renewed in this state on or after January 1, 2011, shall not exclude coverage of a health care practitioner or a sponsoring entity that provides, or arranges for the provision of, health care services under this section, provided that the practitioner or entity complies with this section.

(i) Subdivision (b) shall not be construed to authorize a health care practitioner to render care outside the scope of practice authorized by his or her license or certificate or this division.

(j) (1) The board may terminate authorization for a health care practitioner to provide health care services pursuant to this section for failure to comply with this section, any applicable practice requirement set forth in this division, any regulations adopted pursuant to this division, or for any act that would be grounds for discipline if done by a licensee of that board.

(2) The board shall provide both the sponsoring entity and the health care practitioner with a written notice of termination including the basis for that termination. The health care practitioner may, within 30 days after the date of the receipt of notice of termination, file a written appeal to the board. The appeal shall include any documentation the health care practitioner wishes to present to the board.

(3) A health care practitioner whose authorization to provide health care services pursuant to this section has been terminated shall not provide health care services pursuant to this section unless and until a subsequent request for authorization has been approved by the board. A health care practitioner who provides health care services in violation of this paragraph shall be deemed to be practicing health care in violation of the applicable provisions of this division, and be subject to any applicable administrative, civil, or criminal fines, penalties, and other sanctions provided in this division.

(k) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall

not affect other provisions or applications that can be given effect without the invalid provision or application.

(*l*) This section shall remain in effect only until January 1, ~~2014,~~ *2018,* and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, ~~2014,~~ *2018,* deletes or extends that date.

O

ABC

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 565
Author: Salas
Bill Date: April 10, 2013, amended
Subject: California Physician Corps Program
Sponsor: California Medical Association

STATUS OF BILL:

This bill is currently in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would tighten the guidelines for selection of applicants to the Steven M. Thompson Physician Corps Loan Repayment Program (STLRP) and would expand on the definition of practice settings for this program.

ANALYSIS:

The STLRP was created in 2002 via legislation which was co-sponsored by the Medical Board of California (Board). The STLRP encourages recently licensed physicians to practice in underserved locations in California by authorizing a plan for repayment of their student loans (up to $105,000) in exchange for a minimum three years of service. In 2006, the administration of STLRP was transitioned from the Board to the Health Professions Education Foundation (HPEF). Since 1990, HPEF has administered statewide scholarship and loan repayment programs for a wide range of health professions students and recent graduates and is funded through grants and contributions from public and private agencies, hospitals, health plans, foundations, corporations, as well as through a surcharge on the renewal fees of various health professionals, including a $25 fee paid by physicians and surgeons.

AB 565 would amend the STLRP guidelines to require applicants to have three years of experience providing health care services to medically underserved populations in a federally designated health professional shortage area or medically underserved area. Existing law only requires applicants to have three years of experience working in medically underserved areas or with medically underserved populations. This bill would also delete the existing guideline that would seek to place the most qualified applicants in the areas with the greatest need and replace it with a guideline that would give preference to applicants who agree to practice in a federally designated health professional shortage area or medically underserved area, and who agree to serve a medically underserved population.

For purposes of the STLRP, this bill would also add to the definition of a "practice setting" a private practice that provides primary care located in a medically underserved area and has a minimum of 30 percent uninsured, Medi-Cal, or other publicly funded program that serves patients who earn less than 250 percent of the federal poverty level.

According to the author, California faces a misdistribution of physicians and there are shortages of primary care physicians in 74 percent of counties in California. In the last five years, only one physician has been selected to practice in Kings and Kern counties under the STLRP. The author and stakeholders have recognized the STLRP's high demand and the need to tighten the criteria to ensure that scarce resources are going to the most medically underserved communities.

Adding federally designated health professional shortage areas to the guidelines will help to ensure that STLRP applicants are serving in the areas with the most need; Board staff suggests that the Board support this bill.

FISCAL: None

SUPPORT: California Medical Association (Sponsor)

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY APRIL 10, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 565

Introduced by Assembly Member Salas

February 20, 2013

An act to amend ~~Section 128553~~ *Sections 128552 and 128553* of the Health and Safety Code, relating to physicians and surgeons.

LEGISLATIVE COUNSEL'S DIGEST

AB 565, as amended, Salas. California Physician Corps Program.

Existing law establishes the Steven M. Thompson Physician Corps Loan Repayment Program in the California Physician Corps Program within the Health Professions Education Foundation, which provides financial incentives, as specified, to a physician and surgeon for practicing in a medically underserved community. Existing law authorizes the Office of Statewide Health Planning and Development to adopt guidelines by regulation and requires the foundation to use guidelines for selection and placement of program applicants. These guidelines provide priority consideration to applicants who meet specified criteria, including that the applicant has 3 years of experience working in medically underserved areas or with medically underserved populations. The guidelines also must seek to place the most qualified applicants in the areas with the greatest need.

This bill would *delete the requirement that the guidelines seek to place the most qualified applicants in the areas of greatest need. The bill would* require the guidelines for the selection and placement of program applicants to include criteria that would give priority consideration to program applicants who have 3 years of experience providing health care services to medically underserved populations in

a federally designated health professional shortage area or medically underserved area, and *to applicants* who agree to practice in those areas and serve a medically underserved population.

Existing law defines "practice setting," for these purposes, to include a community clinic, as defined, a clinic owned and operated by a public hospital and health system, or a clinic owned and operated by a hospital that maintains the primary contract with a county government to fulfill the county's role to serve its indigent population and that is located in a medically underserved area and has at least 50% of its patients from that population.

This bill would include a private practice that provides primary care located in a medically underserved area and has a minimum of 30% uninsured, Medi-Cal, or other publicly funded program that serves patients who earn less than 250% of the federal poverty level, within this definition of "practice setting."

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

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

1 *SECTION 1. Section 128552 of the Health and Safety Code is*
2 *amended to read:*
3 128552. For purposes of this article, the following definitions
4 shall apply:
5 (a) "Account" means the Medically Underserved Account for
6 Physicians established within the Health Professions Education
7 Fund pursuant to this article.
8 (b) "Foundation" means the Health Professions Education
9 Foundation.
10 (c) "Fund" means the Health Professions Education Fund.
11 (d) "Medi-Cal threshold languages" means primary languages
12 spoken by limited-English-proficient (LEP) population groups
13 meeting a numeric threshold of 3,000, eligible LEP Medi-Cal
14 beneficiaries residing in a county, 1,000 Medi-Cal eligible LEP
15 beneficiaries residing in a single ZIP Code, or 1,500 LEP Medi-Cal
16 beneficiaries residing in two contiguous ZIP Codes.
17 (e) "Medically underserved area" means an area defined as a
18 health professional shortage area in Part 5 of Subchapter A of
19 Chapter 1 of Title 42 of the Code of Federal Regulations or an
20 area of the state where unmet priority needs for physicians exist

as determined by the California Healthcare Workforce Policy Commission pursuant to Section 128225.

(f) "Medically underserved population" means the Medi-Cal program, Healthy Families Program, and uninsured populations.

(g) "Office" means the Office of Statewide Health Planning and Development (OSHPD).

(h) "Physician Volunteer Program" means the Physician Volunteer Registry Program established by the Medical Board of California.

(i) "Practice setting" means either of the following:

(1) A community clinic as defined in subdivision (a) of Section 1204 and subdivision (c) of Section 1206, a clinic owned or operated by a public hospital and health system, ~~or~~ a clinic owned and operated by a hospital that maintains the primary contract with a county government to fulfill the county's role pursuant to Section 17000 of the Welfare and Institutions Code, which is located in a medically underserved area and at least 50 percent of whose patients are from a medically underserved population, *or a private practice that provides primary care located in a medically underserved area and has a minimum of 30 percent uninsured, Medi-Cal, or other publicly funded program that serves patients who earn less than 250 percent of the federal poverty level.*

(2) A medical practice located in a medically underserved area and at least 50 percent of whose patients are from a medically underserved population.

(j) "Primary specialty" means family practice, internal medicine, pediatrics, or obstetrics/gynecology.

(k) "Program" means the Steven M. Thompson Physician Corps Loan Repayment Program.

(*l*) "Selection committee" means a minimum three-member committee of the board, that includes a member that was appointed by the Medical Board of California.

~~SECTION 1.~~

SEC. 2. Section 128553 of the Health and Safety Code is amended to read:

128553. (a) Program applicants shall possess a current valid license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act.

(b) The foundation, in consultation with those identified in subdivision (b) of Section 123551, shall use guidelines developed by the Medical Board of California for selection and placement of applicants until the office adopts other guidelines by regulation. The foundation shall interpret the guidelines to apply to both osteopathic and allopathic physicians and surgeons.

(c) The guidelines shall meet all of the following criteria:

(1) Provide priority consideration to applicants that are best suited to meet the cultural and linguistic needs and demands of patients from medically underserved populations and who meet one or more of the following criteria:

(A) Speak a Medi-Cal threshold language.

(B) Come from an economically disadvantaged background.

(C) Have received significant training in cultural and linguistically appropriate service delivery.

(D) Have three years of experience providing health care services to medically underserved populations in a federally designated health professional shortage area or medically underserved area.

(E) Have recently obtained a license to practice medicine.

(2) Include a process for determining the needs for physician services identified by the practice setting and for ensuring that the practice setting meets the definition specified in subdivision (h) of Section 128552.

(3) Give preference to applicants who have completed a three-year residency in a primary specialty.

(4) Give preference to applicants who agree to practice in a federally designated health professional shortage area or medically underserved area, and who agree to serve a medically underserved population.

(5) Include a factor ensuring geographic distribution of placements.

(6) Provide priority consideration to applicants who agree to practice in a geriatric care setting and are trained in geriatrics, and who can meet the cultural and linguistic needs and demands of a diverse population of older Californians. On and after January 1, 2009, up to 15 percent of the funds collected pursuant to Section 2436.5 of the Business and Professions Code shall be dedicated to loan assistance for physicians and surgeons who agree to practice

in geriatric care settings or settings that primarily serve adults over the age of 65 years or adults with disabilities.

(d) (1) The foundation may appoint a selection committee that provides policy direction and guidance over the program and that complies with the requirements of subdivision (*l*) of Section 128552.

(2) The selection committee may fill up to 20 percent of the available positions with program applicants from specialties outside of the primary care specialties.

(e) Program participants shall meet all of the following requirements:

(1) Shall be working in or have a signed agreement with an eligible practice setting.

(2) Shall have full-time status at the practice setting. Full-time status shall be defined by the board and the selection committee may establish exemptions from this requirement on a case-by-case basis.

(3) Shall commit to a minimum of three years of service in a medically underserved area. Leaves of absence shall be permitted for serious illness, pregnancy, or other natural causes. The selection committee shall develop the process for determining the maximum permissible length of an absence and the process for reinstatement. Loan repayment shall be deferred until the physician is back to full-time status.

(f) The office shall adopt a process that applies if a physician is unable to complete his or her three-year obligation.

(g) The foundation, in consultation with those identified in subdivision (b) of Section 128551, shall develop a process for outreach to potentially eligible applicants.

(h) The foundation may recommend to the office any other standards of eligibility, placement, and termination appropriate to achieve the aim of providing competent health care services in approved practice settings.

O

AB 635

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 635
Author: Ammiano
Bill Date: April 11, 2013, Introduced
Subject: Drug Overdose Treatment: Liability
Sponsor: Harm Reduction Coalition
California Society of Addiction Medicine

STATUS OF BILL:

This bill is in the Senate.

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 on 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 provide to issue standing orders for the administration of the opioid antagonist. This bill would require a person who is prescribed an opioid antagonist or possesses it pursuant to a standing order to receive specified training. 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.

This bill would require a person who is prescribed an opioid antagonist or possesses it pursuant to a standing order to receive training provided by an opioid overdose prevention and treatment training program. An opioid overdose prevention and treatment training program is defined in the bill as a program operated by a local health jurisdiction or that is registered by a local health jurisdiction to train individuals to prevent, recognize, and respond to an opiate overdose, and that provides, at a minimum, training in the following: the causes of an opiate overdose; mouth to mouth resuscitation; how to contact appropriate emergency medical services; and how to administer an opioid antagonist.

Language in existing law for the pilot project only provides civil and criminal liability, it does not exclude health care providers from "professional review". According to the author's office, the intent of the professional review language is to make it clear that the action of prescribing an opioid antagonist by standing order cannot be grounds for disciplinary action. Many states that have similar law include this type of language. Kentucky's statute says that a practitioner operating under the law shall not "be subject to disciplinary or other adverse action under any professional licensing statute". Illinois statute contains the same language, while Washington's statute says that actions under the law "shall not constitute unprofessional conduct". Massachusetts law declares that a naloxone script "shall be regarded as being issued for a legitimate medical purpose in the usual course of professional practice".

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.

The Executive Committee voted to recommend that the Board support this bill in concept until staff consulted with the author's office regarding the meaning of professional review. This was done and the author's office confirmed it means disciplinary review, and similar language is included in statute in other states that have similar laws. This bill will help to further the Board's mission of consumer protection, staff is suggesting that the Board support this bill.

FISCAL: None

SUPPORT: Harm Reduction Coalition (sponsor)
California Society of Addiction Medicine (sponsor)
California Attorneys for Criminal Justice
California Opioid Maintenance Providers
California Public Defenders Association
Civil Justice Association of California

OPPOSITION: None on file

POSITION: Executive Committee Recommendation: Support in Concept
Staff Recommendation (after consulting with the author's office): Support

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives. Protecting People.™

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.

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

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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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AMENDED IN ASSEMBLY APRIL 11, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

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 amended, 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.

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, ~~"opioid~~ *the following*
4 *definitions shall apply:*

(1) "Opioid antagonist" means naloxone hydrochloride that is approved by the federal Food and Drug Administration for the treatment of an opioid overdose.

(2) "Opioid overdose prevention and treatment training program" means any program operated by a local health jurisdiction or that is registered by a local health jurisdiction to train individuals to prevent, recognize, and respond to an opiate overdose, and that provides, at a minimum, training in all of the following:

(A) The causes of an opiate overdose.

(B) Mouth to mouth resuscitation.

(C) How to contact appropriate emergency medical services.

(D) How to administer an opioid antagonist.

(b) A licensed health care provider who is authorized by law to prescribe an opioid antagonist may, if acting with reasonable care, prescribe and subsequently dispense or distribute 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 a person at risk of an opioid-related overdose.

(c) (1) A licensed health care provider who is authorized by law to prescribe an opioid antagonist may 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 a person at risk of an opioid-related overdose.

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

(d) A person who is prescribed an opioid antagonist or possesses it pursuant to a standing order shall receive the training provided by an opioid overdose prevention and treatment training program.

~~(d)~~

(e) A licensed health care provider who acts with reasonable care 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 pursuant to subdivision (b) or (c).

~~(e)~~

1 *(f)* Notwithstanding any other law, a person who possesses or
2 distributes an opioid antagonist pursuant to a prescription or
3 standing order shall not be subject to professional review, be found
4 liable in a civil action, or be subject to criminal prosecution for
5 this possession or distribution. Notwithstanding any other law, a
6 person who acts with reasonable care and administers an opioid
7 antagonist to a person who is experiencing or is suspected of
8 experiencing an overdose shall not be subject to professional
9 review, be liable in a civil action, or be subject to criminal
10 prosecution for this administration.

O

AB 809

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 809
Author: Logue
Bill Date: April 3, 2013, amended
Subject: Healing Arts: Telehealth
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Assembly Health Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would revise the existing requirement on health care providers that they must verbally inform and document consent of the patient prior to delivery of health care services via telehealth and would replace it with a requirement that the provider must obtain a waiver for treatment involving telehealth services, as specified.

ANALYSIS:

The Telehealth Advancement Act of 2011 was signed into law as a result of AB 415 (Logue, Chapter 547). This bill would delete the requirement included in that Act that is now in existing law that requires physicians, prior to the delivery of health care via telehealth, to verbally inform the patient at the originating site that telehealth may be used and obtain verbal consent from the patient for this use. This bill would also delete the requirement for the verbal consent to be documented in the patient's medical records. This bill would instead require the health care provider, prior to the delivery of health care via telehealth, to provide the patient at the originating site with a waiver for the course of treatment involving telehealth services and to obtain informed consent for the agreed upon course of treatment. This bill would require the signed waiver to be contained in the patient's medical record. This bill would also provide that it does not preclude a patient from receiving in-person health care delivery services during a course of treatment after agreeing to receive services via telehealth.

According to the author, under existing law, in order to ensure that both physicians and patients understood that telehealth may be used to treat the patient, a physician is required to obtain verbal consent for each and every visit with the patient. Physicians have reported that this constant requirement is burdensome on their ability to treat patients effectively. This was a requirement added to statute from AB 415 (Logue, Chapter 547, Statutes of 2011). The author of this bill, who also authored AB 415, believes that the requirement included in his bill in 2011 eliminates efficiencies achieved in rendering telehealth services and was an unintended consequence that is inconsistent with the intent and principles of his bill.

The California Association of Physician Groups supports this bill because telehealth is a critical component of expanding access to care and this bill is an important clean up provision.

Board staff suggests that the Board support this bill in order to allow the Telemedicine Advancement Act of 2011 to be better implemented, which will help to improve access to care via telehealth.

FISCAL: None

SUPPORT: Association of California Healthcare Districts
California Association of Physician Groups

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY APRIL 3, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 809

Introduced by Assembly Member Logue

February 21, 2013

An act to amend Sections 1626.2, 2290.5, 4980.01, 4982, 4989.54, 4992.3, 4996, and 4999.90 of the Business and Professions Code, relating to telehealth, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 809, as amended, Logue. Healing arts: telehealth.

Existing law requires a health care provider, as defined, prior to the delivery of health care services via telehealth, as defined, to verbally inform the patient that telehealth may be used and obtain verbal consent from the patient for this use. Existing law also provides that failure to comply with this requirement constitutes unprofessional conduct.

This bill would ~~delete those provisions~~ *instead require the health care provider at the originating site to provide the patient with a waiver for the course of treatment involving telehealth services to obtain informed consent for the agreed upon course of treatment. The bill would require the signed waiver to be contained in the patient's medical record.* The bill would make additional conforming changes.

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

Vote: ⅔. 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 1626.2 of the Business and Professions
2 Code is amended to read:
3 1626.2. A dentist licensed under this chapter is a licentiate for
4 purposes of paragraph (2) of subdivision (a) of Section 805, and
5 thus is a health care practitioner subject to the provisions of Section
6 2290.5.
7 SEC. 2. Section 2290.5 of the Business and Professions Code
8 is amended to read:
9 2290.5. (a) For purposes of this division, the following
10 definitions shall apply:
11 (1) "Asynchronous store and forward" means the transmission
12 of a patient's medical information from an originating site to the
13 health care provider at a distant site without the presence of the
14 patient.
15 (2) "Distant site" means a site where a health care provider who
16 provides health care services is located while providing these
17 services via a telecommunications system.
18 (3) "Health care provider" means a person who is licensed under
19 this division.
20 (4) "Originating site" means a site where a patient is located at
21 the time health care services are provided via a telecommunications
22 system or where the asynchronous store and forward service
23 originates.
24 (5) "Synchronous interaction" means a real-time interaction
25 between a patient and a health care provider located at a distant
26 site.
27 (6) "Telehealth" means the mode of delivering health care
28 services and public health via information and communication
29 technologies to facilitate the diagnosis, consultation, treatment,
30 education, care management, and self-management of a patient's
31 health care while the patient is at the originating site and the health
32 care provider is at a distant site. Telehealth facilitates patient
33 self-management and caregiver support for patients and includes
34 synchronous interactions and asynchronous store and forward
35 transfers.
36 *(b) Prior to the delivery of health care via telehealth, the health*
37 *care provider at the originating site shall provide the patient with*
38 *a waiver for the course of treatment involving telehealth services*

to obtain informed consent for the agreed upon course of treatment. The signed waiver shall be contained in the patient's medical record.

(c) Nothing in this section shall preclude a patient from receiving in-person health care delivery services during a course of treatment after agreeing to receive services via telehealth.

(d) The failure of a health care provider to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.

~~(b)~~

(e) This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

~~(c)~~

(f) All laws regarding the confidentiality of health care information and a patient's rights to his or her medical information shall apply to telehealth interactions.

~~(d)~~

(g) This section shall not apply to a patient under the jurisdiction of the Department of Corrections and Rehabilitation or any other correctional facility.

~~(e)~~

(h) (1) Notwithstanding any other provision of law and for purposes of this section, the governing body of the hospital whose patients are receiving the telehealth services may grant privileges to, and verify and approve credentials for, providers of telehealth services based on its medical staff recommendations that rely on information provided by the distant-site hospital or telehealth entity, as described in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

(2) By enacting this subdivision, it is the intent of the Legislature to authorize a hospital to grant privileges to, and verify and approve credentials for, providers of telehealth services as described in paragraph (1).

(3) For the purposes of this subdivision, "telehealth" shall include "telemedicine" as the term is referenced in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

SEC. 3. Section 4980.01 of the Business and Professions Code is amended to read:

4980.01. (a) Nothing in this chapter shall be construed to constrict, limit, or withdraw the Medical Practice Act, the Social Work Licensing Law, the Nursing Practice Act, the Licensed Professional Clinical Counselor Act, or the Psychology Licensing Act.

(b) This chapter shall not apply to any priest, rabbi, or minister of the gospel of any religious denomination when performing counseling services as part of his or her pastoral or professional duties, or to any person who is admitted to practice law in the state, or who is licensed to practice medicine, when providing counseling services as part of his or her professional practice.

(c) (1) This chapter shall not apply to an employee working in any of the following settings if his or her work is performed solely under the supervision of the employer:

(A) A governmental entity.

(B) A school, college, or university.

(C) An institution that is both nonprofit and charitable.

(2) This chapter shall not apply to a volunteer working in any of the settings described in paragraph (1) if his or her work is performed solely under the supervision of the entity, school, or institution.

(d) A marriage and family therapist licensed under this chapter is a licentiate for purposes of paragraph (2) of subdivision (a) of Section 805, and thus is a health care practitioner subject to the provisions of Section 2290.5.

(e) Notwithstanding subdivisions (b) and (c), all persons registered as interns or licensed under this chapter shall not be exempt from this chapter or the jurisdiction of the board.

SEC. 4. Section 4982 of the Business and Professions Code is amended to read:

4982. The board may deny a license or registration or may suspend or revoke the license or registration of a licensee or registrant if he or she has been guilty of unprofessional conduct. Unprofessional conduct includes, but is not limited to, the following:

(a) The conviction of a crime substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred. The board may inquire into the circumstances surrounding the commission of the crime

in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter shall be deemed to be a conviction within the meaning of this section. The board may order any license or registration suspended or revoked, or may decline to issue a license or registration when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or, when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw a plea of guilty and enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

(b) Securing a license or registration by fraud, deceit, or misrepresentation on any application for licensure or registration submitted to the board, whether engaged in by an applicant for a license or registration, or by a licensee in support of any application for licensure or registration.

(c) Administering to himself or herself any controlled substance or using of any of the dangerous drugs specified in Section 4022, or of any alcoholic beverage to the extent, or in a manner, as to be dangerous or injurious to the person applying for a registration or license or holding a registration or license under this chapter, or to any other person, or to the public, or, to the extent that the use impairs the ability of the person applying for or holding a registration or license to conduct with safety to the public the practice authorized by the registration or license. The board shall deny an application for a registration or license or revoke the license or registration of any person, other than one who is licensed as a physician and surgeon, who uses or offers to use drugs in the course of performing marriage and family therapy services.

(d) Gross negligence or incompetence in the performance of marriage and family therapy.

(e) Violating, attempting to violate, or conspiring to violate any of the provisions of this chapter or any regulation adopted by the board.

(f) Misrepresentation as to the type or status of a license or registration held by the person, or otherwise misrepresenting or permitting misrepresentation of his or her education, professional qualifications, or professional affiliations to any person or entity.

(g) Impersonation of another by any licensee, registrant, or applicant for a license or registration, or, in the case of a licensee, allowing any other person to use his or her license or registration.

(h) Aiding or abetting, or employing, directly or indirectly, any unlicensed or unregistered person to engage in conduct for which a license or registration is required under this chapter.

(i) Intentionally or recklessly causing physical or emotional harm to any client.

(j) The commission of any dishonest, corrupt, or fraudulent act substantially related to the qualifications, functions, or duties of a licensee or registrant.

(k) Engaging in sexual relations with a client, or a former client within two years following termination of therapy, soliciting sexual relations with a client, or committing an act of sexual abuse, or sexual misconduct with a client, or committing an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of a marriage and family therapist.

(*l*) Performing, or holding oneself out as being able to perform, or offering to perform, or permitting any trainee or registered intern under supervision to perform, any professional services beyond the scope of the license authorized by this chapter.

(m) Failure to maintain confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client in confidence during the course of treatment and all information about the client that is obtained from tests or other means.

(n) Prior to the commencement of treatment, failing to disclose to the client or prospective client the fee to be charged for the professional services, or the basis upon which that fee will be computed.

(o) Paying, accepting, or soliciting any consideration, compensation, or remuneration, whether monetary or otherwise, for the referral of professional clients. All consideration, compensation, or remuneration shall be in relation to professional counseling services actually provided by the licensee. Nothing in

this subdivision shall prevent collaboration among two or more licensees in a case or cases. However, no fee shall be charged for that collaboration, except when disclosure of the fee has been made in compliance with subdivision (n).

(p) Advertising in a manner that is false, fraudulent, misleading, or deceptive, as defined in Section 651.

(q) Reproduction or description in public, or in any publication subject to general public distribution, of any psychological test or other assessment device, the value of which depends in whole or in part on the naivete of the subject, in ways that might invalidate the test or device.

(r) Any conduct in the supervision of any registered intern, associate clinical social worker, or trainee by any licensee that violates this chapter or any rules or regulations adopted by the board.

(s) Performing or holding oneself out as being able to perform professional services beyond the scope of one's competence, as established by one's education, training, or experience. This subdivision shall not be construed to expand the scope of the license authorized by this chapter.

(t) Permitting a trainee or registered intern under one's supervision or control to perform, or permitting the trainee or registered intern to hold himself or herself out as competent to perform, professional services beyond the trainee's or registered intern's level of education, training, or experience.

(u) The violation of any statute or regulation governing the gaining and supervision of experience required by this chapter.

(v) Failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered.

(w) Failure to comply with the child abuse reporting requirements of Section 11166 of the Penal Code.

(x) Failure to comply with the elder and dependent adult abuse reporting requirements of Section 15630 of the Welfare and Institutions Code.

(y) Willful violation of Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

(z) (1) Engaging in an act described in Section 261, 286, 288a, or 289 of the Penal Code with a minor or an act described in Section 288 or 288.5 of the Penal Code regardless of whether the

act occurred prior to or after the time the registration or license was issued by the board. An act described in this subdivision occurring prior to the effective date of this subdivision shall constitute unprofessional conduct and shall subject the licensee to refusal, suspension, or revocation of a license under this section.

(2) The Legislature hereby finds and declares that protection of the public, and in particular minors, from sexual misconduct by a licensee is a compelling governmental interest, and that the ability to suspend or revoke a license for sexual conduct with a minor occurring prior to the effective date of this section is equally important to protecting the public as is the ability to refuse a license for sexual conduct with a minor occurring prior to the effective date of this section.

(aa) Engaging in any conduct that subverts or attempts to subvert any licensing examination or the administration of an examination as described in Section 123.

SEC. 5. Section 4989.54 of the Business and Professions Code is amended to read:

4989.54. The board may deny a license or may suspend or revoke the license of a licensee if he or she has been guilty of unprofessional conduct. Unprofessional conduct includes, but is not limited to, the following:

(a) Conviction of a crime substantially related to the qualifications, functions, and duties of an educational psychologist.

(1) The record of conviction shall be conclusive evidence only of the fact that the conviction occurred.

(2) The board may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, or duties of a licensee under this chapter.

(3) A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions, or duties of a licensee under this chapter shall be deemed to be a conviction within the meaning of this section.

(4) The board may order a license suspended or revoked, or may decline to issue a license when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under

Section 1203.4 of the Penal Code allowing the person to withdraw a plea of guilty and enter a plea of not guilty or setting aside the verdict of guilty or dismissing the accusation, information, or indictment.

(b) Securing a license by fraud, deceit, or misrepresentation on an application for licensure submitted to the board, whether engaged in by an applicant for a license or by a licensee in support of an application for licensure.

(c) Administering to himself or herself a controlled substance or using any of the dangerous drugs specified in Section 4022 or an alcoholic beverage to the extent, or in a manner, as to be dangerous or injurious to himself or herself or to any other person or to the public or to the extent that the use impairs his or her ability to safely perform the functions authorized by the license. The board shall deny an application for a license or revoke the license of any person, other than one who is licensed as a physician and surgeon, who uses or offers to use drugs in the course of performing educational psychology.

(d) Advertising in a manner that is false, fraudulent, misleading, or deceptive, as defined in Section 651.

(e) Violating, attempting to violate, or conspiring to violate any of the provisions of this chapter or any regulation adopted by the board.

(f) Commission of any dishonest, corrupt, or fraudulent act substantially related to the qualifications, functions, or duties of a licensee.

(g) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action imposed by another state or territory or possession of the United States or by any other governmental agency, on a license, certificate, or registration to practice educational psychology or any other healing art. A certified copy of the disciplinary action, decision, or judgment shall be conclusive evidence of that action.

(h) Revocation, suspension, or restriction by the board of a license, certificate, or registration to practice as an educational psychologist, a clinical social worker, professional clinical counselor, or marriage and family therapist.

(i) Failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered.

(j) Gross negligence or incompetence in the practice of educational psychology.

(k) Misrepresentation as to the type or status of a license held by the licensee or otherwise misrepresenting or permitting misrepresentation of his or her education, professional qualifications, or professional affiliations to any person or entity.

(*l*) Intentionally or recklessly causing physical or emotional harm to any client.

(m) Engaging in sexual relations with a client or a former client within two years following termination of professional services, soliciting sexual relations with a client, or committing an act of sexual abuse or sexual misconduct with a client or committing an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of a licensed educational psychologist.

(n) Prior to the commencement of treatment, failing to disclose to the client or prospective client the fee to be charged for the professional services or the basis upon which that fee will be computed.

(o) Paying, accepting, or soliciting any consideration, compensation, or remuneration, whether monetary or otherwise, for the referral of professional clients.

(p) Failing to maintain confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client in confidence during the course of treatment and all information about the client that is obtained from tests or other means.

(q) Performing, holding himself or herself out as being able to perform, or offering to perform any professional services beyond the scope of the license authorized by this chapter or beyond his or her field or fields of competence as established by his or her education, training, or experience.

(r) Reproducing or describing in public, or in any publication subject to general public distribution, any psychological test or other assessment device the value of which depends in whole or in part on the naivete of the subject in ways that might invalidate the test or device. An educational psychologist shall limit access to the test or device to persons with professional interests who can be expected to safeguard its use.

(s) Aiding or abetting an unlicensed person to engage in conduct requiring a license under this chapter.

(t) When employed by another person or agency, encouraging, either orally or in writing, the employer's or agency's clientele to utilize his or her private practice for further counseling without the approval of the employing agency or administration.

(u) Failing to comply with the child abuse reporting requirements of Section 11166 of the Penal Code.

(v) Failing to comply with the elder and adult dependent abuse reporting requirements of Section 15630 of the Welfare and Institutions Code.

(w) Willful violation of Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

(x) (1) Engaging in an act described in Section 261, 286, 288a, or 289 of the Penal Code with a minor or an act described in Section 288 or 288.5 of the Penal Code regardless of whether the act occurred prior to or after the time the registration or license was issued by the board. An act described in this subdivision occurring prior to the effective date of this subdivision shall constitute unprofessional conduct and shall subject the licensee to refusal, suspension, or revocation of a license under this section.

(2) The Legislature hereby finds and declares that protection of the public, and in particular minors, from sexual misconduct by a licensee is a compelling governmental interest, and that the ability to suspend or revoke a license for sexual conduct with a minor occurring prior to the effective date of this section is equally important to protecting the public as is the ability to refuse a license for sexual conduct with a minor occurring prior to the effective date of this section.

(y) Engaging in any conduct that subverts or attempts to subvert any licensing examination or the administration of the examination as described in Section 123.

(z) Impersonation of another by any licensee or applicant for a license, or, in the case of a licensee, allowing any other person to use his or her license.

(aa) Permitting a person under his or her supervision or control to perform, or permitting that person to hold himself or herself out as competent to perform, professional services beyond the level of education, training, or experience of that person.

SEC. 6. Section 4992.3 of the Business and Professions Code is amended to read:

4992.3. The board may deny a license or a registration, or may suspend or revoke the license or registration of a licensee or registrant if he or she has been guilty of unprofessional conduct. Unprofessional conduct includes, but is not limited to, the following:

(a) The conviction of a crime substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred. The board may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter is a conviction within the meaning of this section. The board may order any license or registration suspended or revoked, or may decline to issue a license or registration when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or, when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw a plea of guilty and enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

(b) Securing a license or registration by fraud, deceit, or misrepresentation on any application for licensure or registration submitted to the board, whether engaged in by an applicant for a license or registration, or by a licensee in support of any application for licensure or registration.

(c) Administering to himself or herself any controlled substance or using any of the dangerous drugs specified in Section 4022 or any alcoholic beverage to the extent, or in a manner, as to be dangerous or injurious to the person applying for a registration or license or holding a registration or license under this chapter, or to any other person, or to the public, or, to the extent that the use impairs the ability of the person applying for or holding a

registration or license to conduct with safety to the public the practice authorized by the registration or license. The board shall deny an application for a registration or license or revoke the license or registration of any person who uses or offers to use drugs in the course of performing clinical social work. This provision does not apply to any person also licensed as a physician and surgeon under Chapter 5 (commencing with Section 2000) or the Osteopathic Act who lawfully prescribes drugs to a patient under his or her care.

(d) Incompetence in the performance of clinical social work.

(e) An act or omission that falls sufficiently below the standard of conduct of the profession as to constitute an act of gross negligence.

(f) Violating, attempting to violate, or conspiring to violate this chapter or any regulation adopted by the board.

(g) Misrepresentation as to the type or status of a license or registration held by the person, or otherwise misrepresenting or permitting misrepresentation of his or her education, professional qualifications, or professional affiliations to any person or entity. For purposes of this subdivision, this misrepresentation includes, but is not limited to, misrepresentation of the person's qualifications as an adoption service provider pursuant to Section 8502 of the Family Code.

(h) Impersonation of another by any licensee, registrant, or applicant for a license or registration, or, in the case of a licensee, allowing any other person to use his or her license or registration.

(i) Aiding or abetting any unlicensed or unregistered person to engage in conduct for which a license or registration is required under this chapter.

(j) Intentionally or recklessly causing physical or emotional harm to any client.

(k) The commission of any dishonest, corrupt, or fraudulent act substantially related to the qualifications, functions, or duties of a licensee or registrant.

(*l*) Engaging in sexual relations with a client or with a former client within two years from the termination date of therapy with the client, soliciting sexual relations with a client, or committing an act of sexual abuse, or sexual misconduct with a client, or committing an act punishable as a sexually related crime, if that

act or solicitation is substantially related to the qualifications, functions, or duties of a clinical social worker.

(m) Performing, or holding one's self out as being able to perform, or offering to perform or permitting, any registered associate clinical social worker or intern under supervision to perform any professional services beyond the scope of one's competence, as established by one's education, training, or experience. This subdivision shall not be construed to expand the scope of the license authorized by this chapter.

(n) Failure to maintain confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client in confidence during the course of treatment and all information about the client that is obtained from tests or other means.

(o) Prior to the commencement of treatment, failing to disclose to the client or prospective client the fee to be charged for the professional services, or the basis upon which that fee will be computed.

(p) Paying, accepting, or soliciting any consideration, compensation, or remuneration, whether monetary or otherwise, for the referral of professional clients. All consideration, compensation, or remuneration shall be in relation to professional counseling services actually provided by the licensee. Nothing in this subdivision shall prevent collaboration among two or more licensees in a case or cases. However, no fee shall be charged for that collaboration, except when disclosure of the fee has been made in compliance with subdivision (o).

(q) Advertising in a manner that is false, fraudulent, misleading, or deceptive, as defined in Section 651.

(r) Reproduction or description in public, or in any publication subject to general public distribution, of any psychological test or other assessment device, the value of which depends in whole or in part on the naivete of the subject, in ways that might invalidate the test or device. A licensee shall limit access to that test or device to persons with professional interest who are expected to safeguard its use.

(s) Any conduct in the supervision of any registered associate clinical social worker, intern, or trainee by any licensee that violates this chapter or any rules or regulations adopted by the board.

(t) Failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered.

(u) Failure to comply with the child abuse reporting requirements of Section 11166 of the Penal Code.

(v) Failure to comply with the elder and dependent adult abuse reporting requirements of Section 15630 of the Welfare and Institutions Code.

(w) Willful violation of Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

(x) (1) Engaging in an act described in Section 261, 286, 288a, or 289 of the Penal Code with a minor or an act described in Section 288 or 288.5 of the Penal Code regardless of whether the act occurred prior to or after the time the registration or license was issued by the board. An act described in this subdivision occurring prior to the effective date of this subdivision shall constitute unprofessional conduct and shall subject the licensee to refusal, suspension, or revocation of a license under this section.

(2) The Legislature hereby finds and declares that protection of the public, and in particular minors, from sexual misconduct by a licensee is a compelling governmental interest, and that the ability to suspend or revoke a license for sexual conduct with a minor occurring prior to the effective date of this section is equally important to protecting the public as is the ability to refuse a license for sexual conduct with a minor occurring prior to the effective date of this section.

(y) Engaging in any conduct that subverts or attempts to subvert any licensing examination or the administration of the examination as described in Section 123.

SEC. 7. Section 4996 of the Business and Professions Code is amended to read:

4996. (a) Only individuals who have received a license under this article may style themselves as "Licensed Clinical Social Workers." Every individual who styles himself or herself or who holds himself or herself out to be a licensed clinical social worker, or who uses any words or symbols indicating or tending to indicate that he or she is a licensed clinical social worker, without holding his or her license in good standing under this article, is guilty of a misdemeanor.

(b) It is unlawful for any person to engage in the practice of clinical social work unless at the time of so doing that person holds a valid, unexpired, and unrevoked license under this article.

(c) A clinical social worker licensed under this chapter is a licentiate for purposes of paragraph (2) of subdivision (a) of Section 805, and thus is a health care practitioner subject to the provisions of Section 2290.5.

SEC. 8. Section 4999.90 of the Business and Professions Code is amended to read:

4999.90. The board may refuse to issue any registration or license, or may suspend or revoke the registration or license of any intern or licensed professional clinical counselor, if the applicant, licensee, or registrant has been guilty of unprofessional conduct. Unprofessional conduct includes, but is not limited to, the following:

(a) The conviction of a crime substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred. The board may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter shall be deemed to be a conviction within the meaning of this section. The board may order any license or registration suspended or revoked, or may decline to issue a license or registration when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or, when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw a plea of guilty and enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

(b) Securing a license or registration by fraud, deceit, or misrepresentation on any application for licensure or registration submitted to the board, whether engaged in by an applicant for a

license or registration, or by a licensee in support of any application for licensure or registration.

(c) Administering to himself or herself any controlled substance or using any of the dangerous drugs specified in Section 4022, or any alcoholic beverage to the extent, or in a manner, as to be dangerous or injurious to the person applying for a registration or license or holding a registration or license under this chapter, or to any other person, or to the public, or, to the extent that the use impairs the ability of the person applying for or holding a registration or license to conduct with safety to the public the practice authorized by the registration or license. The board shall deny an application for a registration or license or revoke the license or registration of any person, other than one who is licensed as a physician and surgeon, who uses or offers to use drugs in the course of performing licensed professional clinical counseling services.

(d) Gross negligence or incompetence in the performance of licensed professional clinical counseling services.

(e) Violating, attempting to violate, or conspiring to violate any of the provisions of this chapter or any regulation adopted by the board.

(f) Misrepresentation as to the type or status of a license or registration held by the person, or otherwise misrepresenting or permitting misrepresentation of his or her education, professional qualifications, or professional affiliations to any person or entity.

(g) Impersonation of another by any licensee, registrant, or applicant for a license or registration, or, in the case of a licensee or registrant, allowing any other person to use his or her license or registration.

(h) Aiding or abetting, or employing, directly or indirectly, any unlicensed or unregistered person to engage in conduct for which a license or registration is required under this chapter.

(i) Intentionally or recklessly causing physical or emotional harm to any client.

(j) The commission of any dishonest, corrupt, or fraudulent act substantially related to the qualifications, functions, or duties of a licensee or registrant.

(k) Engaging in sexual relations with a client, or a former client within two years following termination of therapy, soliciting sexual relations with a client, or committing an act of sexual abuse, or

sexual misconduct with a client, or committing an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of a licensed professional clinical counselor.

(*l*) Performing, or holding oneself out as being able to perform, or offering to perform, or permitting any trainee, applicant, or registrant under supervision to perform, any professional services beyond the scope of the license authorized by this chapter.

(m) Failure to maintain confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client in confidence during the course of treatment and all information about the client which is obtained from tests or other means.

(n) Prior to the commencement of treatment, failing to disclose to the client or prospective client the fee to be charged for the professional services, or the basis upon which that fee will be computed.

(o) Paying, accepting, or soliciting any consideration, compensation, or remuneration, whether monetary or otherwise, for the referral of professional clients. All consideration, compensation, or remuneration shall be in relation to professional clinical counseling services actually provided by the licensee. Nothing in this subdivision shall prevent collaboration among two or more licensees in a case or cases. However, no fee shall be charged for that collaboration, except when disclosure of the fee has been made in compliance with subdivision (n).

(p) Advertising in a manner that is false, fraudulent, misleading, or deceptive, as defined in Section 651.

(q) Reproduction or description in public, or in any publication subject to general public distribution, of any psychological test or other assessment device, the value of which depends in whole or in part on the naivete of the subject, in ways that might invalidate the test or device.

(r) Any conduct in the supervision of a registered intern, associate clinical social worker, or clinical counselor trainee by any licensee that violates this chapter or any rules or regulations adopted by the board.

(s) Performing or holding oneself out as being able to perform professional services beyond the scope of one's competence, as established by one's education, training, or experience. This

subdivision shall not be construed to expand the scope of the license authorized by this chapter.

(t) Permitting a clinical counselor trainee or intern under one's supervision or control to perform, or permitting the clinical counselor trainee or intern to hold himself or herself out as competent to perform, professional services beyond the clinical counselor trainee's or intern's level of education, training, or experience.

(u) The violation of any statute or regulation of the standards of the profession, and the nature of the services being rendered, governing the gaining and supervision of experience required by this chapter.

(v) Failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered.

(w) Failure to comply with the child abuse reporting requirements of Section 11166 of the Penal Code.

(x) Failing to comply with the elder and dependent adult abuse reporting requirements of Section 15630 of the Welfare and Institutions Code.

(y) Repeated acts of negligence.

(z) (1) Engaging in an act described in Section 261, 286, 288a, or 289 of the Penal Code with a minor or an act described in Section 288 or 288.5 of the Penal Code regardless of whether the act occurred prior to or after the time the registration or license was issued by the board. An act described in this subdivision occurring prior to the effective date of this subdivision shall constitute unprofessional conduct and shall subject the licensee to refusal, suspension, or revocation of a license under this section.

(2) The Legislature hereby finds and declares that protection of the public, and in particular minors, from sexual misconduct by a licensee is a compelling governmental interest, and that the ability to suspend or revoke a license for sexual conduct with a minor occurring prior to the effective date of this section is equally important to protecting the public as is the ability to refuse a license for sexual conduct with a minor occurring prior to the effective date of this section.

(aa) Engaging in any conduct that subverts or attempts to subvert any licensing examination or the administration of an examination as described in Section 123.

(ab) Revocation, suspension, or restriction by the board of a license, certificate, or registration to practice as a professional clinical counselor, clinical social worker, educational psychologist, or marriage and family therapist.

(ac) Willful violation of Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

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

In order to protect the health and safety of the public due to a lack of access to health care providers in rural and urban medically underserved areas of California, the increasing strain on existing providers expected to occur with the implementation of the federal Patient Protection and Affordable Care Act, and the assistance that further implementation of telehealth can provide to help relieve these burdens, it is necessary for this act to take effect immediately.

O

AB 831

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 831
Author: Bloom
Bill Date: April 3, 2013, Amended
Subject: Drug Overdoses
Sponsor: Drug Policy Alliance

STATUS OF BILL:

This bill is in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill makes findings and declarations related to the prevalence of fatal drug overdoses and proven interventions. 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 Emergency Medical Services Authority, 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, programs serving veterans or military personnel, and other organizations that work with or have access to people who misuse prescription or illegal drugs, 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 people misusing prescription or illegal drugs, 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, and 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. The Executive Committee also voted to recommend that the Board support this bill.

FISCAL: None

SUPPORT: Drug Policy Alliance (Sponsor); A New Parents for Addiction Treatment & Healing; All of Us or None, Los Angeles/Long Beach - A New Way of Life Reentry Project; Broken No More; California Hepatitis Alliance; California Opioid Maintenance Providers; Center for Living and Learning; Center on Juvenile and Criminal Justice; Children's Hospital Los Angeles; Clean Needles Now; Glide Health Services; Harm Reduction Coalition; HealthRIGHT360; Homeless Health Care Los Angeles; La Ventana Treatment Programs; Los Angeles

Community Action Network; Los Angeles Community Health Outreach Project; Los Angeles County Board of Supervisors; Mission Neighborhood Health Center; Mothers Against Prescription Drug Abuse; Mothers With a Purpose; National Coalition Against Prescription Drug Abuse; Safer Alternatives Thru Networking and Education; San Francisco Hepatitis C Task Force; and Several individuals

OPPOSITION: None on file

POSITION: Executive Committee Recommendation: Support

AMENDED IN ASSEMBLY APRIL 3, 2013

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 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. 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~~

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

The bill would also make related legislative findings and declarations.

Vote: ⅔. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.

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

1 *SECTION 1. The Legislature finds and declares the following:*
2 *(a) According to the United States Centers for Disease Control*
3 *and Prevention (CDC), a fatal drug overdose occurs in the United*
4 *States every 14 minutes and drug overdose deaths are up for the*
5 *11th consecutive year. Drug overdose rates have tripled since*
6 *1990 and have never been higher.*
7 *(b) In recent years, over 3,500 Californians have died annually*
8 *from drug overdose, or approximately 10 people each day, on*
9 *average. In 2009, more Californians died of drug overdoses than*
10 *in car accidents, and 1,000 more Californians died from drug*
11 *overdoses than from gun homicides.*
12 *(c) There are cost-effective, proven interventions to reduce the*
13 *number of drug overdoses caused by prescription analgesics and*
14 *illegal drugs. An evaluation published by the CDC in 2012*
15 *identified 50 overdose prevention and education programs*
16 *operating in 19 states, including California. These programs*
17 *provide overdose prevention and recognition and response training*
18 *to laypersons, including first responders, law enforcement officers,*
19 *pain patients, family members, and at-risk drug users, and, when*
20 *appropriate, prescriptions for the overdose reversal medication*
21 *naloxone. These programs have reported over 50,000 doses of*
22 *opiate overdose antidote prescribed and over 10,000 life-saving*
23 *reversals of an overdose.*
24 *(d) According to an economic analysis published in the January*
25 *2013 edition of the Annals of Internal Medicine, community-level*
26 *reductions of overdose death ranged from 37 percent to 90 percent*
27 *in various cities that have implemented overdose prevention*
28 *education projects that include naloxone prescriptions. The authors*
29 *concluded, "[n]aloxone distribution to heroin users is likely to*
30 *reduce heroin death and is cost-effective, even under markedly*
31 *conservative assumptions."*

(e) Between 2003 and 2011, the Drug Overdose Prevention and Education project, in partnership with the San Francisco County Department of Health, has recorded over 600 "saves" by laypersons providing first aid and administering naloxone to persons experiencing opiate overdose. The antidote was provided by prescription, with training by staff.

(f) Since the implementation of the drug overdose prevention project in San Francisco, emergency room visits for drug overdose have dropped by approximately 50 percent, resulting in significant savings to the healthcare system.

(g) Medical personnel at Fort Bragg Army Base in North Carolina implemented a comprehensive program to serve Unites States Army personnel. The base had suffered an unacceptably high rate of fatal drug overdoses, at an average of eight deaths per month, fueled by the misuse of pain medication and treatments for war-related injuries, including traumatic brain injury and post-traumatic stress disorder. Several programmatic steps were taken, including careful monitoring of prescription practices. However, the supervising physicians credited naloxone prescriptions as being the lynchpin that prevented any further overdoses, fatal or nonfatal, among United States Army personnel being treated at Fort Bragg Army Base.

(h) Project Lazarus, a community-level intervention that worked with physicians, patients, and family members of prescription analgesic pain medication patients, achieved a 38 percent reduction in overdose deaths in rural Wilkes County, North Carolina.

(i) The State of Massachusetts implemented a project to provide prevention education and response training, including the use of naloxone by prescription, to law enforcement personnel and laypersons who are likely to witness a potentially fatal drug overdose. Between December 2007 and September 2011, over 10,000 persons were trained and over 1,100 opioid overdose reversals were recorded.

(j) A study of the Massachusetts program published by the British Medical Journal in January of 2013 described overdose education and naloxone distribution by laypersons as "an effective public health intervention to address increasing mortality in the opioid overdose epidemic by training potential bystanders to prevent, recognize, and respond to opioid overdoses."

(k) The American Medical Association resolved on June 19, 2012, that it "(1) recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients; (2) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; (3) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (4) will continue to monitor the progress of such initiatives and respond as appropriate."

(l) The American Public Health Association resolved on October 30, 2012, to "[e]ncourage local and state health departments to increase public and health professional awareness of the signs and symptoms of overdose; improve awareness of and facilitate access to naloxone; and support entry into treatment and recovery for those individuals seeking such services."

(m) The United Nations Commission on Narcotic Drugs resolved on March 16, 2012, that it "[e]ncourages all Member States to include effective elements for the prevention and treatment of drug overdose, in particular opioid overdose, in national drug policies, where appropriate, and to share best practices and information on the prevention and treatment of drug overdose, in particular opioid overdose, including the use of opioid receptor antagonists such as naloxone."

(n) In enacting this act, it is the intent of the Legislature that overdose prevention programs be conducted in the most cost-effective manner possible, while coordinating state efforts across agencies and supporting culturally appropriate local programs in areas of high need in a manner consistent with local needs and values.

~~SECTION 1.~~

SEC. 2. Section 11758.07 is added to the Health and Safety Code, to read:

11758.07. (a) The California Health and Human Services Agency shall convene a temporary working group within the agency to develop a plan to reduce the rate of fatal drug overdoses in the state. Experts and staff from the ~~Office of~~ Emergency *Medical* Services *Authority*, State Department of Alcohol and Drug Programs, State Department of Public Health, Office of

AIDS, and any other staff that the Secretary of California Health and Human Services designates may participate in the temporary working group. Additionally, staff from the Medical Board of California and California State Board of Pharmacy may also participate for the purpose of identifying promising practices to reduce accidental drug overdose among patients and other at-risk groups.

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

(c) The temporary working group shall 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.

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

~~SEC. 2.~~

SEC. 3. Section 11758.08 is added to the Health and Safety Code, to read:

11758.08. (a) The California Health and Human Services Agency shall make grants to local agencies from funds appropriated pursuant to this section for any of the following purposes:

(1) Drug overdose prevention, recognition, and response education projects in jails, prisons, drug treatment centers, syringe exchange programs, clinics, *programs serving veterans or military personnel,* and other organizations that work with or have access to ~~drug users,~~ *people who misuse prescription or illegal drugs,* their families, and communities.

(2) 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.

(3) Naloxone hydrochloride prescription or distribution projects.

(4) Development and implementation of policies and projects to encourage people, including ~~drug users,~~ *people misusing prescription or illegal drugs,* to call the 911 emergency response system when they witness potentially fatal drug overdoses.

(5) Programs to educate Californians over 65 years of age about the risks associated with using opiate-based medications, ways to

prevent overdose, ~~or~~ *and* how to respond if they witness an overdose.

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

(7) 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.

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

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

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

(d) There is hereby appropriated from the General Fund, in the 2014–15 fiscal year, five hundred thousand dollars ($500,000) for the purpose of funding the grants provided in subdivision (a). Additional funds necessary for the implementation of this section in the 2014–15 fiscal year and in later fiscal years may be included in the budget appropriation for the California Health and Human Services Agency.

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AB 860

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 860
Author: Perea
Bill Date: April 8, 2013, amended
Subject: Medical School Scholarships
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would provide that $600,000 from the Managed Care Administrative Fines and Penalties Fund (Fund) shall be transferred to the Steven M. Thompson Medical School Scholarship Program (STMSSP) Account within the Health Professions Education Foundation (HPEF) for purposes of funding the STMSSP.

ANALYSIS:

The Steven M. Thompson Loan Repayment Program (STLRP) was created in 2002 via legislation which was co-sponsored by the Medical Board of California (the Board). The STLRP encourages recently licensed physicians to practice in underserved locations in California by authorizing a plan for repayment of their student loans (up to $105,000) in exchange for a minimum three years of service. In 2006, the administration of STLRP was transitioned from the Board to HPEF. Since 1990, HPEF has administered statewide scholarship and loan repayment programs for a wide range of health professions students and recent graduates and is funded through grants and contributions from public and private agencies, hospitals, health plans, foundations, corporations, as well as through a surcharge on the renewal fees of various health professionals, including a $25 fee paid by physicians and surgeons.

AB 589 (Perea, Chapter 339, Statutes of 2012) created the STMSSP within the HPEF. STMSSP participants are required to commit in writing to three years of full-time professional practice in direct patient care in an eligible setting. The maximum amount per total scholarship is $105,000 per recipient, to be distributed over the course of medical school. The committee charged with selecting scholarship recipients must use guidelines that provide priority consideration to applicants who are best suited to meet the cultural and linguistic needs and demands of patients from medically underserved populations and who meet specified criteria. The selection committee must give preference to applicants who have committed to practicing in a primary specialty and who will serve in a practice setting in a super-medically underserved area. The selection committee must also include a factor ensuring geographic distribution of placements.

The STMSSP would have originally been funded by funds transferred from the Managed Care Administrative Fines and Penalties Fund that are in excess of the first $1,000,000, including accrued interest, as the first $1,000,000 funds the STLRP. However, the bill was amended to take these provisions out and the STMSSP is currently funded by federal or private funds only and cannot be implemented until HPEF determines that there are sufficient funds available in order to implement STMSSP. The Board had a support position on AB 589.

This bill would now require $600,000 from the Managed Care Fund to be transferred to the Steven M. Thompson Medical School Scholarship Program (STMSSP) Account within the Health Professions Education Foundation (HPEF) for purposes of funding the STMSSP. This bill would not affect the amount transferred to the STLRP, as the statute still specifies that the first $1 million dollars is set aside to fund the STLRP in HPEF.

The purpose of this bill is to fund the STMSSP to make medical school more financially accessible for students who are willing to pursue careers in primary care. According to the author's office, this bill will help to address the geographical disparity of physician supply in California, as well as the increasing cost of medical education. The author's office believes that by funding the STMSSP, this bill will provide underserved communities with greater access to medical care. This bill is consistent with the mission of the Medical Board of promoting access to care. Board staff suggests that the Board support this bill.

FISCAL: None to the Board

SUPPORT: American College of Emergency Physicians, California Chapter
California Academy of Family Physicians

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY APRIL 8, 2013

AMENDED IN ASSEMBLY MARCH 19, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 860

Introduced by Assembly Members Perea and Bocanegra
(Coauthor: Assembly Member Bonta)
(Coauthor: Senator Rubio)

February 21, 2013

An act to amend Section 1341.45 of the Health and Safety Code, relating to health professions.

LEGISLATIVE COUNSEL'S DIGEST

AB 860, as amended, Perea. Medical school scholarships.

Existing law provides for the regulation of health care service plans by the Department of Managed Health Care and imposes certain requirements on health care service plans. Existing law imposes various fines and administrative penalties for certain violations of these provisions that are deposited in the Managed Care Administrative Fines and Penalties Fund. Existing law requires the first $1,000,000 in the fund to be transferred each year to the Medically Underserved Account for Physicians for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program. Existing law requires all remaining funds to be transferred each year to the Major Risk Medical Insurance Fund for purposes of the Major Risk Medical Insurance Program.

Existing law establishes within the Health Professions Education Foundation the Steven M. Thompson Medical School Scholarship Program (STMSSP), managed by the foundation and the Office of Statewide Health Planning and Development to promote the education

of medical doctors and doctors of osteopathy, as specified. ~~Existing law provides up to $105,000 per recipient in scholarships to selected participants who agree in writing prior to completing an accredited medical or osteopathic school based in the United States to serve in an eligible setting.~~ Existing law establishes the Steven M. Thompson Medical School Scholarship Account within the Health Professions Education Fund, which consists of private moneys donated to the STMSSP.

This bill would~~, beginning January 1, 2014~~, require that, *after* the first $1,000,000,~~ be~~ *is* transferred each year from the Managed Care Administrative Fines and Penalties Fund to the Medically Underserved Account for Physicians,~~ for purposes of the STMSSP, as specified, upon appropriation by the legislature. This bill would, beginning January 1, 2014, require that no less than $1,000,000~~ *$600,000* be transferred each year from the~~ Managed Care Administrative Fines and Penalties Fund, provided that the fund has $2,000,000 or more in it,~~ *fund* to the Steven M. Thompson Medical School Scholarship Account, for purposes of the STMSSP~~, upon appropriation by the Legislature. The bill would provide that if the Managed Care Administrative Fines and Penalties Fund has a balance of less than $2,000,000, the first $1,000,000 be transferred to the Medically Underserved Account for Physicians and the remainder, if any, to the Steven M. Thompson Medical School Scholarship Account~~. The bill would require that any amount remaining over the amounts transferred to~~ the Medically Underserved Account for Physicians and the Steven M. Thompson Medical School Scholarship Account~~ *those two accounts* be transferred each year to the Major Risk Medical Insurance Fund for purposes of the Major Risk Medical Insurance Program.

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

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

1 SECTION 1. Section 1341.45 of the Health and Safety Code
2 is amended to read:
3 1341.45. (a) There is hereby created in the State Treasury the
4 Managed Care Administrative Fines and Penalties Fund.
5 (b) The fines and administrative penalties collected pursuant to
6 this chapter, on and after September 30, 2008, shall be deposited
7 into the Managed Care Administrative Fines and Penalties Fund.

(c) The fines and administrative penalties deposited into the Managed Care Administrative Fines and Penalties Fund shall be transferred by the department, beginning September 1, 2009, and annually thereafter, as follows:

(1) The first one million dollars ($1,000,000) shall be transferred to the Medically Underserved Account for Physicians within the Health Professions Education Fund and shall, upon appropriation by the Legislature, be used for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program, as specified in Article 5 (commencing with Section 128550) ~~or~~ *of* Chapter 5 of Part 3 of Division 107 and, notwithstanding Section 128555, shall not be used to provide funding for the Physician Volunteer Program.

(2) ~~Beginning January 1, 2014, if the Managed Care Administrative Fines and Penalties Fund has two million dollars ($2,000,000) or more, no less than one million dollars ($1,000,000)~~ *Six hundred thousand dollars ($600,000)* shall be transferred to the Steven M. Thompson Medical School Scholarship Account within the Health Professions Education Fund, ~~created pursuant to Section 128580, and shall, upon appropriation by the Legislature, be used by the Office of Statewide Health Planning and Development~~ for *purposes of* the Steven M. Thompson Medical School Scholarship Program ~~for the purposes~~, *as* specified in Article 6 (commencing with Section 128560) of Chapter 5 of Part 3 of Division 107.

(3) Any amount over the amounts that are subject to transfer as specified in paragraphs (1) and (2), including accrued interest, in the fund shall be transferred to the Major Risk Medical Insurance Fund created pursuant to Section 12739 of the Insurance Code and shall, upon appropriation by the Legislature, be used for the Major Risk Medical Insurance Program for the purposes specified in Section 12739.1 of the Insurance Code.

~~(4) If the Managed Care Administrative Fines and Penalties Fund has a balance of less than two million dollars ($2,000,000), the first one million dollars ($1,000,000), shall be transferred pursuant to paragraph (1), and the remainder, if any, shall be transferred to the Steven M. Thompson Medical School Scholarship Account and shall, upon appropriation by the Legislature, be used for the purposes described in paragraph (2).~~

1 (d) Notwithstanding subdivision (b) of Section 1356 and Section
2 1356.1, the fines and administrative penalties authorized pursuant
3 to this chapter shall not be used to reduce the assessments imposed
4 on health care service plans pursuant to Section 1356.

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AB 916

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. The Executive Committee voted to recommend that the Board support this bill.

FISCAL: None

SUPPORT: California Society of Plastic Surgeons (Sponsor)

OPPOSITION: None on file

POSITION: Executive Committee 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.

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.

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

(1) Contains a misrepresentation of fact.

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

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

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

(C) Use of any photograph or other image of an actual patient that depicts or purports to depict the results of any procedure, or presents "before" and "after" views of a patient, without specifying in a prominent location in easily readable type size what procedures were performed on that patient is a violation of subdivision (a). Any "before" and "after" views (i) shall be comparable in presentation so that the results are not distorted by favorable poses, lighting, or other features of presentation, and (ii) shall contain a statement that the same "before" and "after" results may not occur for all patients.

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

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

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

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

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

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

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

(e) Any person so licensed may not use any professional card, professional announcement card, office sign, letterhead, telephone directory listing, medical list, medical directory listing, or a similar professional notice or device if it includes a statement or claim that is false, fraudulent, misleading, or deceptive within the meaning of subdivision (b).

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

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

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

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

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

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

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

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

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

(C) A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California may include a statement that he or she limits his or her practice to specific fields, but shall not include a statement that he or she is certified or eligible for certification by a private or public board or parent association, including, but not limited to, a multidisciplinary board or association, unless that board or association is (i) an American Board of Medical Specialties member board, (ii) a board or association with equivalent requirements approved by that physician and surgeon's licensing board, or (iii) a board or association with an Accreditation Council for Graduate Medical Education approved postgraduate training program that provides complete training in that specialty or subspecialty. A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by an organization other than a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" in reference to that certification, unless the physician and surgeon is also licensed under Chapter 4 (commencing with Section 1600) and the use of the term "board certified" in reference to that certification is in accordance with subparagraph (A). A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by a board or association referred to in clause (i), (ii), or (iii) shall not use *any of* the ~~term~~ *terms "board," "certified," "certification," or* "board certified" unless the full

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

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

~~For purposes of the term "board certified," as used in this subparagraph, the terms "board" and "association" mean an organization that is an American Board of Medical Specialties member board, an organization with equivalent requirements approved by a physician and surgeon's licensing board, or an organization with an Accreditation Council for Graduate Medical Education approved postgraduate training program that provides complete training in a specialty or subspecialty.~~

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

(D) A doctor of podiatric medicine licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California may include a statement that he or she is certified or eligible or qualified for certification by a private or public board or parent association, including, but not limited to, a multidisciplinary board or association, if that board or association meets one of the following requirements: (i) is approved by the Council on Podiatric Medical Education, (ii) is a board or association with equivalent requirements approved by the California Board of Podiatric Medicine, or (iii) is a board or

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

For purposes of this subparagraph, a "multidisciplinary board or association" means an educational certifying body that has a psychometrically valid testing process, as determined by the California Board of Podiatric Medicine, for certifying doctors of podiatric medicine that is based on the applicant's education, training, and experience. For purposes of the term "board certified," as used in this subparagraph, the terms "board" and "association" mean an organization that is a Council on Podiatric Medical Education approved board, an organization with equivalent requirements approved by the California Board of Podiatric Medicine, or an organization with a Council on Podiatric Medical Education approved postgraduate training program that provides training in podiatric medicine and podiatric surgery.

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

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

(7) A statement of names of schools and postgraduate clinical training programs from which the practitioner has graduated, together with the degrees received.

(8) A statement of publications authored by the practitioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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AB 1000

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1000
Author: Wieckowski
Bill Date: March 21, 2013, 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 with 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 oppose 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. The Executive Committee deferred to the Full Board on the position for 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

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

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

(b) For the purposes of this section, "physical therapy diagnosis" means a systematic 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 disease.

~~(b)~~

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

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

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

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

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

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

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

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

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

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

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

(a) Advertising in violation of Section 17500.

(b) Fraud in the procurement of any license under this chapter.

(c) Procuring or aiding or offering to procure or aid in criminal abortion.

(d) Conviction of a crime that substantially relates to the qualifications, functions, or duties of a physical therapist or physical therapist assistant. The record of conviction or a certified copy thereof shall be conclusive evidence of that conviction.

(e) Habitual intemperance.

(f) Addiction to the excessive use of any habit-forming drug.

(g) Gross negligence in his or her practice as a physical therapist or physical therapist assistant.

(h) Conviction of a violation of any of the provisions of this chapter or of the Medical Practice Act, or violating, or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter or of the Medical Practice Act.

(i) The aiding or abetting of any person to violate this chapter or any regulations duly adopted under this chapter.

(j) The aiding or abetting of any person to engage in the unlawful practice of physical therapy.

(k) The commission of any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, or duties of a physical therapist or physical therapist assistant.

(l) Except for good cause, the knowing failure to protect patients by failing to follow infection control guidelines of the board, thereby risking transmission of blood-borne infectious diseases from licensee to patient, from patient to patient, and from patient to licensee. In administering this subdivision, the board shall consider referencing the standards, regulations, and guidelines of the State Department of Public Health developed pursuant to Section 1250.11 of the Health and Safety Code and the standards, regulations, and guidelines pursuant to the California Occupational Safety and Health Act of 1973 (Part 1 (commencing with Section 6300) of Division 5 of the Labor Code) for preventing the transmission of HIV, hepatitis B, and other blood-borne pathogens in health care settings. As necessary, the board shall consult with the Medical Board of California, the California Board of Podiatric Medicine, the Dental Board of California, the Board of Registered Nursing, and the Board of Vocational Nursing and Psychiatric Technicians of the State of California, to encourage appropriate consistency in the implementation of this subdivision.

The board shall seek to ensure that licensees are informed of the responsibility of licensees and others to follow infection control guidelines, and of the most recent scientifically recognized safeguards for minimizing the risk of transmission of blood-borne infectious diseases.

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

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

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

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

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

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

~~A physical therapist licensed pursuant to this chapter may utilize the services of one aide engaged in patient-related tasks to assist the physical therapist in his or her practice of physical therapy. "Patient-related task" means a physical therapy service rendered directly to the patient by an aide, excluding non-patient-related tasks. "Non-patient-related task" means a task related to observation of the patient, transport of the patient, physical support only during gait or transfer training, housekeeping duties, clerical duties, and similar functions. The aide shall at all times be under the orders, direction, and immediate supervision of the physical therapist. Nothing in this section shall authorize an aide to independently perform physical therapy or any physical therapy procedure. The board shall adopt regulations that set forth the standards and requirements for the orders, direction, and immediate supervision of an aide by a physical therapist. The physical therapist shall provide continuous and immediate supervision of the aide. The physical therapist shall be in the same facility as, and in proximity to, the location where the aide is performing patient-related tasks, and shall be readily available at all times to provide advice or instruction to the aide. When patient-related tasks are provided to a patient by an aide, the supervising physical therapist shall, at some point during the treatment day, provide direct service to the patient as treatment for the patient's condition, or to further evaluate and monitor the patient's progress, and shall correspondingly document the patient's record.~~

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

AB 1003

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1003
Author: Maienschein
Bill Date: April 1, 2013, amended
Subject: Professional Corporations: Healing Arts Practitioners
Sponsor: California Medical Association (CMA)

STATUS OF BILL:

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

DESCRIPTION OF CURRENT LEGISLATION:

This bill would specify that the list of healing arts practitioners who may be shareholders, officers, directors, or professional employees of a medical corporation does not limit employment of professional corporations to the licensed professionals listed in that section and would specify that any person duly licensed under the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act, may be employed to render professional services by a professional corporation listed in existing law. This bill would also add physical therapists, and other licensed professionals, to the listing in the Corporations Code.

ANALYSIS:

Since 1990, the Physical Therapy Board has allowed physical therapist's to be employed by medical corporations. On September 29, 2010, the California Legislative Counsel issued a legal opinion that concluded a physical therapist may not be employed by a professional medical corporation and stated that only professional physical therapy corporations or naturopathic corporations may employ physical therapists. This issue came to the Legislature's attention when existing law was amended to add naturopathic doctor corporations and physical therapists were listed as professionals allowed to be employed by these corporations. Because the medical corporation section of law did not specifically list physical therapists, the issue was brought to the forefront and to the California Legislative Counsel for an opinion. On November 3, 2010, the Physical Therapy Board voted to rescind the 1990 resolution that authorized the forming of a general corporation employing physical therapists.

Currently, due to the legal opinion, professional corporations are only allowed to employ the licensed practitioners listed in Corporations Code Section 13401.5. According to the author's office, this could result in harming quality of care by eliminating the line of

communication between physicians and the licensed professionals assisting in the patient's care and it may interrupt continuity of care and convenience of care, as well as fragmenting the delivery of care and impeding a patient's right to choose integrated, comprehensive care.

This bill would specify that the list of healing arts practitioners who may be shareholders, officers, directors, or professional employees of a medical corporation does not limit employment of professional corporations to the licensed professionals listed in that section and would specify that any person duly licensed under the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act, may be employed to render professional services by a professional corporation listed in existing law. This bill would also add physical therapists, and other licensed professionals, to the listing in the Corporations Code.

SB 543 (Steinberg, Chapter 448, Statutes of 2011) was signed into law and was effective from January 1, 2012 to January 1, 2013. This bill specified that no physical therapist shall be subject to discipline by the Physical Therapy Board for providing physical therapy services as a professional employee of a professional medical corporation; this provision was sunset on January 1, 2013. The language in SB 543 was added because the Physical Therapy Board was attempting to take action against physical therapists employed by a medical corporation. SB 543 put this issue in a holding pattern, until January 1, 2013; however, this issue was not addressed in legislation last year, so it still remains an issue that must be addressed.

This bill will codify the practice that has been allowed for over 20 years and allow physicians in medical corporations to employ physical therapists. The Board also supported AB 783 (Hayashi, 2011) which would have added licensed physical therapists and occupational therapists to the list of healing arts practitioners who may be shareholders, officers, directors, or professional employees of a medical corporation. Board staff suggests that the Board support this bill.

FISCAL: None to the Board

SUPPORT: CMA (Sponsor), California Orthopaedic Association; California Chiropractic Association; and several individuals

OPPOSITION: California Physical Therapy Association
Numerous individual Physical Therapists

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY APRIL 1, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1003

Introduced by Assembly Member Maienschein

February 22, 2013

An act to amend 13401.5 of the Corporations Code, relating to professional corporations.

LEGISLATIVE COUNSEL'S DIGEST

AB 1003, as amended, Maienschein. Professional corporations: healing arts practitioners.

The Moscone-Knox Professional Corporation Act provides for the organization of a corporation under certain existing law for the purposes of qualifying as a professional corporation under that act and rendering professional services. The act defines a professional corporation as a corporation organized under the General Corporation Law or pursuant to specified law that is engaged in rendering professional services in a single profession, except as otherwise authorized in the act, pursuant to a certificate of registration issued by the governmental agency regulating the profession and that in its practice or business designates itself as a professional or other corporation as may be required by statute. The act authorizes specified listed types of healing arts practitioners to be shareholders, officers, directors, or professional employees of a designated professional corporation, subject to certain limitations relating to ownership of shares.

This bill would ~~delete professional employees from that authorization, and, instead, would provide that those provisions do not limit the employment of persons duly licensed under the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act to render professional~~

~~services, by a designated professional corporation, to the listed licensed professionals specified in the provisions~~ *specify that those provisions do not limit the employment by a professional corporation to only those specified licensed professionals. The bill would authorize any person duly licensed under the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act to be employed to render professional services by a professional corporation.*

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 13401.5 of the Corporations Code is*
2 *amended to read:*
3 13401.5. Notwithstanding subdivision (d) of Section 13401
4 and any other provision of law, the following licensed persons
5 may be shareholders, officers, directors, or professional employees
6 of the professional corporations designated in this section so long
7 as the sum of all shares owned by those licensed persons does not
8 exceed 49 percent of the total number of shares of the professional
9 corporation so designated herein, and so long as the number of
10 those licensed persons owning shares in the professional
11 corporation so designated herein does not exceed the number of
12 persons licensed by the governmental agency regulating the
13 designated professional corporation~~:~~. *This section does not limit*
14 *the employment by a professional corporation designated in this*
15 *section to only those licensed professionals listed under each*
16 *subdivision. Any person duly licensed under the Business and*
17 *Professions Code, the Chiropractic Act, or the Osteopathic Act*
18 *may be employed to render professional services by a professional*
19 *corporation designated in this section.*
20 (a) Medical corporation.
21 (1) Licensed doctors of podiatric medicine.
22 (2) Licensed psychologists.
23 (3) Registered nurses.
24 (4) Licensed optometrists.
25 (5) Licensed marriage and family therapists.
26 (6) Licensed clinical social workers.
27 (7) Licensed physician assistants.
28 (8) Licensed chiropractors.

1 (9) Licensed acupuncturists.
2 (10) Naturopathic doctors.
3 (11) Licensed professional clinical counselors.
4 (b) Podiatric medical corporation.
5 (1) Licensed physicians and surgeons.
6 (2) Licensed psychologists.
7 (3) Registered nurses.
8 (4) Licensed optometrists.
9 (5) Licensed chiropractors.
10 (6) Licensed acupuncturists.
11 (7) Naturopathic doctors.
12 (c) Psychological corporation.
13 (1) Licensed physicians and surgeons.
14 (2) Licensed doctors of podiatric medicine.
15 (3) Registered nurses.
16 (4) Licensed optometrists.
17 (5) Licensed marriage and family therapists.
18 (6) Licensed clinical social workers.
19 (7) Licensed chiropractors.
20 (8) Licensed acupuncturists.
21 (9) Naturopathic doctors.
22 (10) Licensed professional clinical counselors.
23 (d) Speech-language pathology corporation.
24 (1) Licensed audiologists.
25 (e) Audiology corporation.
26 (1) Licensed speech-language pathologists.
27 (f) Nursing corporation.
28 (1) Licensed physicians and surgeons.
29 (2) Licensed doctors of podiatric medicine.
30 (3) Licensed psychologists.
31 (4) Licensed optometrists.
32 (5) Licensed marriage and family therapists.
33 (6) Licensed clinical social workers.
34 (7) Licensed physician assistants.
35 (8) Licensed chiropractors.
36 (9) Licensed acupuncturists.
37 (10) Naturopathic doctors.
38 (11) Licensed professional clinical counselors.
39 (g) Marriage and family therapist corporation.
40 (1) Licensed physicians and surgeons.

1 (2) Licensed psychologists.
2 (3) Licensed clinical social workers.
3 (4) Registered nurses.
4 (5) Licensed chiropractors.
5 (6) Licensed acupuncturists.
6 (7) Naturopathic doctors.
7 (8) Licensed professional clinical counselors.
8 (h) Licensed clinical social worker corporation.
9 (1) Licensed physicians and surgeons.
10 (2) Licensed psychologists.
11 (3) Licensed marriage and family therapists.
12 (4) Registered nurses.
13 (5) Licensed chiropractors.
14 (6) Licensed acupuncturists.
15 (7) Naturopathic doctors.
16 (8) Licensed professional clinical counselors.
17 (i) Physician assistants corporation.
18 (1) Licensed physicians and surgeons.
19 (2) Registered nurses.
20 (3) Licensed acupuncturists.
21 (4) Naturopathic doctors.
22 (j) Optometric corporation.
23 (1) Licensed physicians and surgeons.
24 (2) Licensed doctors of podiatric medicine.
25 (3) Licensed psychologists.
26 (4) Registered nurses.
27 (5) Licensed chiropractors.
28 (6) Licensed acupuncturists.
29 (7) Naturopathic doctors.
30 (k) Chiropractic corporation.
31 (1) Licensed physicians and surgeons.
32 (2) Licensed doctors of podiatric medicine.
33 (3) Licensed psychologists.
34 (4) Registered nurses.
35 (5) Licensed optometrists.
36 (6) Licensed marriage and family therapists.
37 (7) Licensed clinical social workers.
38 (8) Licensed acupuncturists.
39 (9) Naturopathic doctors.
40 (10) Licensed professional clinical counselors.

(*l*) Acupuncture corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Licensed psychologists.
(4) Registered nurses.
(5) Licensed optometrists.
(6) Licensed marriage and family therapists.
(7) Licensed clinical social workers.
(8) Licensed physician assistants.
(9) Licensed chiropractors.
(10) Naturopathic doctors.
(11) Licensed professional clinical counselors.
(m) Naturopathic doctor corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.
(3) Registered nurses.
(4) Licensed physician assistants.
(5) Licensed chiropractors.
(6) Licensed acupuncturists.
(7) Licensed physical therapists.
(8) Licensed doctors of podiatric medicine.
(9) Licensed marriage and family therapists.
(10) Licensed clinical social workers.
(11) Licensed optometrists.
(12) Licensed professional clinical counselors.
(n) Dental corporation.
(1) Licensed physicians and surgeons.
(2) Dental assistants.
(3) Registered dental assistants.
(4) Registered dental assistants in extended functions.
(5) Registered dental hygienists.
(6) Registered dental hygienists in extended functions.
(7) Registered dental hygienists in alternative practice.
(o) Professional clinical counselor corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.
(3) Licensed clinical social workers.
(4) Licensed marriage and family therapists.
(5) Registered nurses.
(6) Licensed chiropractors.

(7) Licensed acupuncturists.
(8) Naturopathic doctors.

~~SECTION 1. Section 13401.5 of the Corporations Code is amended to read:~~

~~13401.5. (a) Notwithstanding subdivision (d) of Section 13401 and any other provision of law, the following licensed persons may be shareholders, officers, or directors of the professional corporations designated in this section so long as the sum of all shares owned by those licensed persons does not exceed 49 percent of the total number of shares of the professional corporation so designated herein, and so long as the number of those licensed persons owning shares in the professional corporation so designated herein does not exceed the number of persons licensed by the governmental agency regulating the designated professional corporation:~~

~~(1) Medical corporation.~~
~~(A) Licensed doctors of podiatric medicine.~~
~~(B) Licensed psychologists.~~
~~(C) Registered nurses.~~
~~(D) Licensed optometrists.~~
~~(E) Licensed marriage and family therapists.~~
~~(F) Licensed clinical social workers.~~
~~(G) Licensed physician assistants.~~
~~(H) Licensed chiropractors.~~
~~(I) Licensed acupuncturists.~~
~~(J) Naturopathic doctors.~~
~~(K) Licensed professional clinical counselors.~~
~~(2) Podiatric medical corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed psychologists.~~
~~(C) Registered nurses.~~
~~(D) Licensed optometrists.~~
~~(E) Licensed chiropractors.~~
~~(F) Licensed acupuncturists.~~
~~(G) Naturopathic doctors.~~
~~(3) Psychological corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed doctors of podiatric medicine.~~
~~(C) Registered nurses.~~
~~(D) Licensed optometrists.~~

~~(E) Licensed marriage and family therapists.~~
~~(F) Licensed clinical social workers.~~
~~(G) Licensed chiropractors.~~
~~(H) Licensed acupuncturists.~~
~~(I) Naturopathic doctors.~~
~~(J) Licensed professional clinical counselors.~~
~~(4) Speech-language pathology corporation.~~
~~(A) Licensed audiologists.~~
~~(5) Audiology corporation.~~
~~(A) Licensed speech-language pathologists.~~
~~(6) Nursing corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed doctors of podiatric medicine.~~
~~(C) Licensed psychologists.~~
~~(D) Licensed optometrists.~~
~~(E) Licensed marriage and family therapists.~~
~~(F) Licensed clinical social workers.~~
~~(G) Licensed physician assistants.~~
~~(H) Licensed chiropractors.~~
~~(I) Licensed acupuncturists.~~
~~(J) Naturopathic doctors.~~
~~(K) Licensed professional clinical counselors.~~
~~(7) Marriage and family therapist corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed psychologists.~~
~~(C) Licensed clinical social workers.~~
~~(D) Registered nurses.~~
~~(E) Licensed chiropractors.~~
~~(F) Licensed acupuncturists.~~
~~(G) Naturopathic doctors.~~
~~(H) Licensed professional clinical counselors.~~
~~(8) Licensed clinical social worker corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed psychologists.~~
~~(C) Licensed marriage and family therapists.~~
~~(D) Registered nurses.~~
~~(E) Licensed chiropractors.~~
~~(F) Licensed acupuncturists.~~
~~(G) Naturopathic doctors.~~
~~(H) Licensed professional clinical counselors.~~

~~(9) Physician assistants corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Registered nurses.~~
~~(C) Licensed acupuncturists.~~
~~(D) Naturopathic doctors.~~
~~(10) Optometric corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed doctors of podiatric medicine.~~
~~(C) Licensed psychologists.~~
~~(D) Registered nurses.~~
~~(E) Licensed chiropractors.~~
~~(F) Licensed acupuncturists.~~
~~(G) Naturopathic doctors.~~
~~(11) Chiropractic corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed doctors of podiatric medicine.~~
~~(C) Licensed psychologists.~~
~~(D) Registered nurses.~~
~~(E) Licensed optometrists.~~
~~(F) Licensed marriage and family therapists.~~
~~(G) Licensed clinical social workers.~~
~~(H) Licensed acupuncturists.~~
~~(I) Naturopathic doctors.~~
~~(J) Licensed professional clinical counselors.~~
~~(12) Acupuncture corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed doctors of podiatric medicine.~~
~~(C) Licensed psychologists.~~
~~(D) Registered nurses.~~
~~(E) Licensed optometrists.~~
~~(F) Licensed marriage and family therapists.~~
~~(G) Licensed clinical social workers.~~
~~(H) Licensed physician assistants.~~
~~(I) Licensed chiropractors.~~
~~(J) Naturopathic doctors.~~
~~(K) Licensed professional clinical counselors.~~
~~(13) Naturopathic doctor corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed psychologists.~~
~~(C) Registered nurses.~~

~~(D) Licensed physician assistants.~~
~~(E) Licensed chiropractors.~~
~~(F) Licensed acupuncturists.~~
~~(G) Licensed physical therapists.~~
~~(H) Licensed doctors of podiatric medicine.~~
~~(I) Licensed marriage and family therapists.~~
~~(J) Licensed clinical social workers.~~
~~(K) Licensed optometrists.~~
~~(L) Licensed professional clinical counselors.~~
~~(14) Dental corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Dental assistants.~~
~~(C) Registered dental assistants.~~
~~(D) Registered dental assistants in extended functions.~~
~~(E) Registered dental hygienists.~~
~~(F) Registered dental hygienists in extended functions.~~
~~(G) Registered dental hygienists in alternative practice.~~
~~(15) Professional clinical counselor corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed psychologists.~~
~~(C) Licensed clinical social workers.~~
~~(D) Licensed marriage and family therapists.~~
~~(E) Registered nurses.~~
~~(F) Licensed chiropractors.~~
~~(G) Licensed acupuncturists.~~
~~(H) Naturopathic doctors.~~
~~(b) This section does not limit the employment of persons duly licensed under the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act to render professional services, by a professional corporation designated in the section, to the licensed professionals listed under each paragraph of subdivision (a).~~

O

AB 1176

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1176
Author: Bocanegra and Bonta
Bill Date: March 21, 2013, amended
Subject: Medical Residency Training Program Grants
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would establish the Graduate Medical Education Fund that would be funded by a $5.00 annual fee that would be assessed for each covered life to health insurers and health care plans that provide health coverage in California, for purposes of awarding grants to fund new and existing graduate medical education (GME) residency slots.

ANALYSIS:

This bill would establish the Graduate Medical Education Fund (Fund) that would be funded by a $5.00 annual fee that would be assessed for each covered life to health insurers and health care plans that provide health coverage in California. This fee would not apply to dental-only, vision-only, or Medicare supplement plans or policies or to coverage provided under any public program, including, but not limited to, Medi-Cal or the Healthy Families Program. Moneys in the fund would have to be appropriated by the Legislature and could only be used for the purpose of funding grants to GME residency programs in California.

This bill would require the Office of Statewide Health Planning and Development (OSHPD), in consultation with the California Healthcare Workforce Policy Commission, to develop criteria for distribution of available moneys in the Fund. In developing the criteria, OHSPD would be required to give priority to programs that meet the following specifications:

- Are located in medically underserved areas.
- Place an emphasis on training primary care providers.
- Place an emphasis on training physician specialties that are most needed in the community in which the program is located.

The Fund could be used to fund existing GME residency slots, as well as new GME residency slots. OSHPD would be required to utilize moneys in the Fund to provide a match for available federal funds for GME, when applicable.

According to the author, California's current shortage of primary care physicians is projected to reach a crisis level by 2015, and will likely increase as more people become insured through the Affordable Care Act. The author believes that the additional funding for GME residency slots created by this bill will stabilize and expand medical residency training in California and help to ensure that every Californian has access to a physician when and where they need one. This bill is consistent with the mission of the Medical Board of promoting access to care. Board staff suggests that the Board support this bill.

FISCAL: None

SUPPORT: California Academy of Family Physicians
California Medical Association

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY MARCH 21, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1176

Introduced by Assembly ~~Member~~ *Members* Bocanegra *and Bonta*

February 22, 2013

~~An act to amend Section 92655.1 of the Education Code, relating to postsecondary education.~~ *An act to add Article 4 (commencing with Section 128310) to Chapter 4 of Part 3 of Division 107 of the Health and Safety Code, relating to health care.*

LEGISLATIVE COUNSEL'S DIGEST

AB 1176, as amended, Bocanegra. ~~University of California: health professions education outreach.~~ *Medical residency training program grants.*

Existing law, the Song-Brown Family Physician Training Act, declares the intent of the Legislature to increase the number of students and residents receiving quality education and training in the specialty of family practice and as primary care physician's assistants and primary care nurse practitioners. Existing law establishes, for this purpose, a state medical contract program with accredited medical schools, programs that train primary care physician's assistants, programs that train primary care nurse practitioners, registered nurses, hospitals, and other health care delivery systems.

Existing law establishes the California Healthcare Workforce Policy Commission and requires the commission to, among other things, identify specific areas of the state that have unmet priority needs, and review and make recommendations to the Director of the Office of Statewide Health Planning and Development concerning the funding of those programs that are submitted to the Health Professions

Development Program for participation in the state medical contract program.

The bill would establish the Graduate Medical Education Fund in the State Treasury to consist of annual assessments, on insurers or health care services plans that provide prescribed health care coverage, of $5 per covered life. The bill would require that moneys in the fund be used, upon appropriation by the Legislature, to fund grants to graduate medical residency training programs. The bill would require the Office of Statewide Health Planning and Development, in consultation with the California Healthcare Workforce Policy Commission, to develop criteria for distribution of available funds.

This bill would include a change in state statute that would result in a taxpayer paying a higher tax within the meaning of Section 3 of Article XIII A of the California Constitution, and thus would require for passage the approval of ⅔ of the membership of each house of the Legislature.

~~Existing law establishes the University of California, administered by the Regents of the University of California, as one of the 3 segments of public postsecondary education in the state and provides the university with exclusive jurisdiction in public postsecondary education over graduate instruction in the professions of medicine, dentistry, and veterinary medicine. Existing law requests the regents to use existing resources to establish dental, medical, and optometric health professions outreach and exposure programs.~~

~~This bill would make nonsubstantive changes to that provision.~~

Vote: ~~majority~~ ⅔. Appropriation: no. Fiscal committee: ~~no~~ *yes*. State-mandated local program: no.

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

1 *SECTION 1. Article 4 (commencing with Section 128310) is*
2 *added to Chapter 4 of Part 3 of Division 107 of the Health and*
3 *Safety Code, to read:*
4
5 *Article 4. Medical Residency Training Program Grants*
6
7 *128310. (a) The Graduate Medical Education Fund is hereby*
8 *established in the State Treasury.*
9 *(b) Moneys in the fund shall, upon appropriation by the*
10 *Legislature, be used solely for the purpose of funding grants to*
11 *graduate medical education residency programs in California.*

(c) Notwithstanding Section 16305.7 of the Government Code, all interest earned on the moneys that have been deposited into the fund shall be retained in the fund and used for purposes consistent with the fund.

(d) The fund shall consist of all of the following:

(1) All assessments received pursuant to Section 128311.

(2) Any interest that accrues on amounts in the fund.

(e) The Office of Statewide Health Planning and Development, in consultation with the California Healthcare Workforce Policy Commission, shall develop criteria for distribution of available moneys in the fund. In developing the criteria, the office shall give priority to programs that meet the following specifications:

(1) Are located in medically underserved areas, as defined in Section 128552.

(2) Have a proven record of placing graduates in those medically underserved areas.

(3) Place an emphasis on training primary care providers.

(4) Place an emphasis on training physician specialties that are most needed in the community in which the program is located.

(f) Moneys appropriated from the fund may also be used to fund existing graduate medical education residency slots as well as new graduate medical education residency slots.

(g) Whenever applicable, the office shall utilize moneys appropriated from the fund to provide a match for available federal funds for graduate medical education.

128311. (a) Every health insurer or health care service plan that provides health care coverage in this state shall pay an annual graduate medical education assessment of five dollars ($5.00) for each covered life to the California Healthcare Workforce Policy Commission for deposit into the Graduate Medical Education Fund for the purposes of this article.

(b) This section shall not apply to dental-only, vision-only, or Medicare supplement plans or policies or to coverage provided under any public program, including, but not limited to, Medi-Cal or the Healthy Families Program.

~~SECTION 1. Section 92655.1 of the Education Code is amended to read:~~

~~92655.1. The Legislature requests the Regents of the University of California, to the extent possible, to use existing resources to establish dental, medical, and optometric health professions~~

1 ~~outreach and exposure programs for elementary and high school~~
2 ~~pupils and undergraduate students, including community college~~
3 ~~students.~~

O

AB 1288

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1288
Author: Perez, V.
Bill Date: April 11, 2013, amended
Subject: Medical Board: Licensing: Application Processing
Sponsor: California Medical Association

STATUS OF BILL:

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

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require the Medical Board of California (Board) to develop a process to give priority review status to the application of an applicant who can demonstrate that he or she intends to practice in a medically underserved area or population. This bill would allow an applicant to demonstrate his or her intent to practice in a medically underserved area by providing proper documentation, including a letter from the employer.

ANALYSIS:

Currently, the Board is completing an initial review of applications within 45 calendar days, well under the statutorily mandated 60 business days. However, many times the application does not have all the required information and primary source documentation at the time of initial review; only about 10% of applications are complete at initial review. The Board does not currently request any information on the application regarding where the applicant is planning on working once licensed.

This bill would require the Board to develop a process to give priority review status to an applicant who can demonstrate that he or she intends to practice in a medically underserved area or serve a medically underserved population as defined in existing law. This bill would allow an applicant to demonstrate his or her intent to practice in a medically underserved area or serve a medically underserved population by providing proper documentation, including but not limited to, a letter from the employer indicating that the applicant has accepted employment and including the start date.

The Board does not currently have a process for priority review of applications and the application does not currently request information on where an applicant plans on practicing. However, the Board would be able to review these applications on a priority basis, but would need to revise the application to ask applicants to provide this additional information. The priority review process could be established, but it still would require the applicant to provide all the original source documentation, and this seems to be the

The purpose of this bill is to ensure that applicants who intend on serving in an underserved area or serve an underserved population are licensed in a timely manner. The Board currently does not have any backlog processing applications, and many times the initial review of the application is done before all the primary source documents are received. However, this bill may help to ensure that applicants planning on serving in underserved areas are licensed in a timely manner. Board staff suggests that the Board take a neutral position on this bill.

FISCAL: Minimal and absorbable costs to develop a process for priority review status and to revise the licensing application.

SUPPORT: California Medical Association (sponsor)

OPPOSITION: None on file

POSITION: Recommendation: Neutral

AMENDED IN ASSEMBLY APRIL 11, 2013

AMENDED IN ASSEMBLY MARCH 21, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1288

Introduced by Assembly Member V. Manuel Pérez

February 22, 2013

An act to ~~amend Sections 14085.7 and 14085.8 of~~ *add Section 2092 to* the ~~Welfare and Institutions~~ *Business and Professions* Code, relating to ~~health, and making an appropriation therefor.~~ *healing arts.*

LEGISLATIVE COUNSEL'S DIGEST

AB 1288, as amended, V. Manuel Pérez. ~~Medi-Cal: supplemental hospital funding.~~ *Medical Board of California: licensing: application processing.*

Existing ~~law, operative until June 30, 2013, establishes the Medi-Cal Medical Education Supplemental Payment Fund and the Large Teaching Emphasis Hospital and Children's Hospital Medi-Cal Medical Education Supplemental Payment Fund. Moneys in those funds are continuously appropriated to the State Department of Health Care Services to make supplemental payments to eligible teaching hospitals to reflect additional costs incurred by those hospitals for services rendered to Medi-Cal beneficiaries.~~ *law, the Medical Practice Act, provides for licensure and regulation of physicians and surgeons by the Medical Board of California. Existing law establishes the California Healthcare Workforce Policy Commission and requires the commission to, among other things, identify specific areas of the state where unmet priority needs for primary care exist.*

~~433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal Medicaid laws.~~

~~(2) All private moneys donated by private individuals or entities to the department for deposit in the fund as permitted under applicable federal Medicaid laws.~~

~~(3) Any amounts appropriated to the fund by the Legislature.~~

~~(4) Any interest that accrues on amounts in the fund.~~

~~(b) Any public agency transferring moneys to the fund may, for that purpose, utilize any revenues, grants, or allocations received from the state for health care programs or purposes, unless otherwise prohibited by law. A public agency may also utilize its general funds or any other public moneys or revenues for purposes of transfers to the fund, unless otherwise prohibited by law.~~

~~(c) The department shall have the discretion to accept or not accept moneys offered to the department for deposit in the fund. If the department accepts moneys pursuant to this section, the department shall obtain federal matching funds to the full extent permitted by law. The department shall accept only those funds that are certified by the transferring or donating entity as qualifying for federal financial participation under the terms of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) or Section 433.51 of Title 42 of the Code of Federal Regulations, as applicable, and may return any funds transferred or donated in error.~~

~~(d) Moneys in the fund shall be used as the source for the nonfederal share of payments to hospitals under this section. Moneys shall be allocated from the fund by the department and matched by federal funds in accordance with customary Medi-Cal accounting procedures for purposes of payments under subdivision (e). Distributions from the fund shall be supplemental to any other amounts that hospitals receive under the contracting program.~~

~~(e) (1) For purposes of recognizing medical education costs incurred for services rendered to Medi-Cal beneficiaries, payments from this fund shall be negotiated between the California Medical Assistance Commission and hospitals contracting under this article that meet the definition of university teaching hospitals or major (nonuniversity) teaching hospitals as set forth on page 51 and as listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping." Payments from the fund shall~~

~~(4) Any interest that accrues on amounts in the fund.~~

~~(d) Any public agency transferring moneys to the fund may, for that purpose, utilize any revenues, grants, or allocations received from the state for health care programs or purposes, unless otherwise prohibited by law. A public agency may also utilize its general funds or any other public moneys or revenues for purposes of transfers to the fund, unless otherwise prohibited by law.~~

~~(e) The department may accept or not accept moneys offered to the department for deposit in the fund. If the department accepts moneys pursuant to this section, the department shall obtain federal matching funds to the full extent permitted by law. The department shall accept only those funds that are certified by the transferring or donating entity as qualifying for federal financial participation under the terms of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) or Section 433.51 of Title 42 of the Code of Federal Regulations, as applicable, and may return any funds transferred or donated in error.~~

~~(f) Moneys in the fund shall be used as the source for the nonfederal share of payments to hospitals under this section. Moneys shall be allocated from the fund by the department and matched by federal funds in accordance with customary Medi-Cal accounting procedures for purposes of payments under subdivision (g). Distributions from the fund shall be supplemental to any other amounts that hospitals receive under the contracting program.~~

~~(g) (1) For purposes of recognizing medical education costs incurred for services rendered to Medi-Cal beneficiaries, contracts for payments from the fund may, at the discretion of the California Medical Assistance Commission, be negotiated between the commission and hospitals contracting under this article that are defined as either of the following:~~

~~(A) A large teaching emphasis hospital, as set forth on page 51 and listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping," and meets the definition of eligible hospital as defined in paragraph (3) of subdivision (a) of Section 14105.98.~~

~~(B) A children's hospital pursuant to Section 10727 and meets the definition of eligible hospital as defined in paragraph (3) of subdivision (a) of Section 14105.98.~~

AB 1308

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 supervision 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 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 LM's patient and the fetus or 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.

Board staff has asked the sponsor if "supplies" were meant to include drugs. Board staff was told by the sponsor that they do intend to amend the bill to allow LMs to obtain drugs that they are authorized to provide within their scope.

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. The Executive Committee also voted to recommend that the Board support this bill if it is amended.

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.~~

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.

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

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

2507. (a) The license to practice midwifery authorizes the holder, under the supervision of a licensed physician and surgeon, 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.

(b) As used in this article, the practice of midwifery constitutes the furthering or undertaking by any licensed midwife, under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics, to assist a woman in childbirth so long as progress meets criteria accepted as normal. All complications shall be referred to a physician and surgeon immediately. The practice of midwifery does not include the assisting of childbirth by any artificial, forcible, or mechanical means, nor the performance of any version.

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

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

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

(f) A midwife is authorized 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.

~~(f)~~

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

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

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

(1) All of the provisions of Section 2507.

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

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

~~(3)~~

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

~~(4)~~

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

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

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

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O

ACR 40

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: ACR 40
Author: Perez
Bill Date: April 8, 2013, amended
Subject: Donate Life California Day
Sponsor: Donate Life California

STATUS OF BILL:

This resolution has passed out of the Legislature and has been sent to enrollment.

DESCRIPTION OF CURRENT LEGISLATION:

This resolution would make findings and declarations regarding the importance of organ donation. This resolution would proclaim April 9, 2013, as Department of Motor Vehicles (DMV)/Donate Life California Day and April 2013 as DMV/Donate Life California Month in California. This resolution would encourage all Californians to register with the Donate Life California Registry when applying for renewing a driver's license or identification card.

ANALYSIS:

This resolution makes the following findings and declarations:

- More than 117,000 individuals nationwide and more than 21,000 Californians are currently on the national organ transplant wait list. While about one-third of these patients receive a transplant each year, another one-third die while waiting due to a shortage of donated organs.
- An individual's donation of heart, lungs, liver, kidneys, pancreas, and small intestine can save up to eight lives.
- The donation of tissue can save and enhance the lives of up to 50 others, and a single blood donation can help three people in need.
- Californians by the millions are joining together to save and enhance lives by becoming registered donors and nearly nine million Californians have signed up with the state-authorized Donate Life California Organ and Tissue Donor Registry to ensure that their wishes to be an organ, eye, and tissue donor are honored.
- A California resident can register with the Donate Life California Registry when applying for or renewing his or her driver's license or identification card at the DMV.

This resolution would proclaim April 9, 2013, as DMV/Donate Life California Day and April 2013 as DMV/Donate Life California Month in California. This resolution would encourage all Californian to register with the Donate Life California Registry when applying for renewing a driver's license or identification card.

The Board recently voted to be the honorary state sponsor of Donate Life California's specialized license plate, which will help to increase awareness and raise money for organ and tissue donation, education and outreach. This resolution will also help to raise awareness by proclaiming April 9, 2013 as DMV/Donate Life California Day and April 2013 as DMV/Donate Life California Month. Board staff suggests that the Board support this bill.

FISCAL: None

SUPPORT: Donate Life California (Sponsor)
DMV

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY APRIL 8, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

Assembly Concurrent Resolution No. 40

Introduced by Assembly Member John A. Pérez

(Coauthors: Assembly Members Achadjian, Alejo, Allen, Ammiano, Atkins, Bigelow, Bloom, Blumenfield, Bocanegra, Bonilla, Bonta, Bradford, Brown, Buchanan, Ian Calderon, Campos, Chau, Chávez, Chesbro, Cooley, Dahle, Daly, Dickinson, Donnelly, Eggman, Fong, Fox, Frazier, Beth Gaines, Garcia, Gatto, Gomez, Gordon, Gorell, Gray, Grove, Hagman, Hall, Harkey, Roger Hernández, Holden, Jones, Jones-Sawyer, Levine, Linder, Logue, Maienschein, Medina, Melendez, Mitchell, Morrell, Mullin, Muratsuchi, Nazarian, Nestande, Olsen, Pan, Patterson, Perea, V. Manuel Pérez, Quirk, Quirk-Silva, Rendon, Salas, Skinner, Stone, Ting, Torres, Wagner, Waldron, Weber, Wieckowski, Wilk, Williams, and Yamada)

March 21, 2013

Assembly Concurrent Resolution No. 40—Relative to organ donation.

LEGISLATIVE COUNSEL'S DIGEST

ACR 40, as amended, John A. Pérez. Donate Life California Day: driver's license.

This measure would designate April 9, 2013, as DMV/Donate Life California Day in the State of California, and April 2013 as DMV/Donate Life California Month in the State of California, and would encourage all Californians to sign up with the Donate Life California Organ and Tissue Donor Registry.

Fiscal committee: no.

WHEREAS, Organ, tissue, eye, and blood donations are compassionate and life-giving acts looked upon and recognized with the highest regard; and

WHEREAS, More than 117,000 individuals nationwide and more than 21,000 Californians are currently on the national organ transplant wait list. While about one-third of these patients receive a transplant each year, another one-third die while waiting due to a shortage of donated organs; and

WHEREAS, A single individual's donation of heart, lungs, liver, kidneys, pancreas, and small intestine can save up to eight lives. The donation of tissue can save and enhance the lives of up to 50 others, and a single blood donation can help three people in need; and

WHEREAS, Millions of lives each year are saved and enhanced by donors of organs, tissue, eyes, and blood; and

WHEREAS, Californians by the millions are joining together to save and enhance lives by becoming registered donors. Nearly nine million Californians have signed up with the state-authorized Donate Life California Organ and Tissue Donor Registry to ensure that their wishes to be an organ, eye, and tissue donor are honored; and

WHEREAS, A California resident can register with the Donate Life California Registry when applying for or renewing his or her driver's license or identification card at the Department of Motor Vehicles; now, therefore, be it

Resolved by the Assembly of the State of California, the Senate thereof concurring, That in recognition of April as National Donate Life Month, the Legislature proclaims April 9, 2013, as DMV/Donate Life California Day in the State of California, and April 2013 as DMV/Donate Life California Month in the State of California. In doing so, the Legislature encourages all Californians to check "YES" when applying for or renewing a driver's license or identification card or by signing up at www.donateLIFEcalifornia.org or www.doneVIDAcalifornia.org; and be it further

Resolved, That the Chief Clerk of the Assembly transmit copies of this resolution to the author for appropriate distribution.

O

SB-20

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 20
Author: Hernandez
Bill Date: February 14, 2013, amended
Subject: Health Care: Workforce Training
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require that when the California Major Risk Medical Insurance Program (MRMIP) become inoperative, all the funds in the Managed Care Administrative Fines and Penalties Fund (Managed Care Fund) must be transferred each year to the Medically Underserved Account in the Health Professions Education Foundation (HPEF) Fund for use by the Steven M. Thompson Loan Repayment Program (STLRP).

ANALYSIS:

The STLRP was created in 2002 via legislation which was co-sponsored by the Medical Board of California (Board). The STLRP encourages recently licensed physicians to practice in underserved locations in California by authorizing a plan for repayment of their student loans (up to $105,000) in exchange for a minimum three years of service. In 2006, the administration of STLRP was transitioned from the Board to HPEF. Since 1990, HPEF has administered statewide scholarship and loan repayment programs for a wide range of health professions students and recent graduates and is funded through grants and contributions from public and private agencies, hospitals, health plans, foundations, corporations, as well as through a surcharge on the renewal fees of various health professionals, including a $25 fee paid by physicians and surgeons.

Under existing law, revenue from fines and penalties levied on health plans is deposited in the Managed Care Fund. The first $1 million is used for the STLRP, and fines and penalties above $1 million are used to augment funding for MRMIP, which provides subsidized health insurance for individuals unable to obtain coverage due to a pre-existing condition. In 2014, MRMIP will no longer be necessary due to the reforms enacted under the Affordable Care Act (ACA).

This bill would require, once MRMIP is inoperative, all funds from the Managed Care Fund to go to HPEF, for purposes of funding STLRP. This will provide the STLRP a more robust funding source by shifting monies no longer needed for MRMIP. According to the author's office, implementation of the ACA will result in a further strain on the demand for primary care physicians. This bill will help to ensure that more physicians have incentive to practice in underserved areas of California. As such, this bill promotes the Board's mission of access to care and board staff suggests that the Board support this bill.

FISCAL: None

SUPPORT: California Communities United Institute
California Hospital Association
Los Angeles Board of Supervisors

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN SENATE FEBRUARY 14, 2013

SENATE BILL No. 20

Introduced by Senator Hernandez

December 3, 2012

An act ~~relating to health care coverage.~~ *to amend Section 1341.45 of the Health and Safety Code, relating to health.*

LEGISLATIVE COUNSEL'S DIGEST

SB 20, as amended, Hernandez. ~~Health care coverage: basic health program.~~ *Health care: workforce training.*

Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and imposes certain requirements on health care service plans. Existing law imposes, for certain violations of these provisions, various fines and administrative penalties, which are deposited in the Managed Care Administrative Fines and Penalties Fund. Existing law requires the first $1,000,000 in the fund to be transferred each year to the Medically Underserved Account for Physicians in the Health Professions Education Fund for purposes of the Steven M. Thompson Physician Corps Loan Repayment Program. Existing law requires all remaining funds to be transferred each year to the Major Risk Medical Insurance Fund for purposes of the Major Risk Medical Insurance Program.

This bill, beginning on the date that the Major Risk Medical Insurance Program becomes inoperative, would instead require all the funds in the Managed Care Administrative Fines and Penalties Fund to be transferred each year to the Medically Underserved Account for Physicians in the Health Professions Education Fund for purposes of the Steven M. Thompson Physician Corps Loan Repayment Program.

The bill would require the Director of Finance to notify the Joint Legislative Budget Committee in that regard.

~~Existing law, the federal Patient Protection and Affordable Care Act (PPACA), requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that makes available qualified health plans to qualified individuals and small employers. PPACA also authorizes the establishment of a basic health program under which a state may, if specified criteria are met, enter into contracts to offer one or more standard health plans providing a minimum level of essential health benefits to eligible individuals instead of offering those individuals coverage through an exchange.~~

~~This bill would state the intent of the Legislature to enact legislation that would establish a basic health program in California as described in PPACA.~~

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

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

1 *SECTION 1. Section 1341.45 of the Health and Safety Code*
2 *is amended to read:*
3 1341.45. (a) There is hereby created in the State Treasury the
4 Managed Care Administrative Fines and Penalties Fund.
5 (b) The fines and administrative penalties collected pursuant to
6 this chapter, on and after the operative date of this section, shall
7 be deposited into the Managed Care Administrative Fines and
8 Penalties Fund.
9 (c) *(1)* The fines and administrative penalties deposited into
10 the Managed Care Administrative Fines and Penalties Fund shall
11 be transferred by the department, beginning September 1, 2009,
12 and annually thereafter, as follows:
13 ~~(1)~~
14 *(A)* The first one million dollars ($1,000,000) shall be transferred
15 to the Medically Underserved Account for Physicians within the
16 Health Professions Education Fund and shall, upon appropriation
17 by the Legislature, be used for the purposes of the Steven M.
18 Thompson Physician Corps Loan Repayment Program, as specified
19 in Article 5 (commencing with Section 128550) ~~or~~ *of* Chapter 5
20 of Part 3 of Division 107 and, notwithstanding Section 128555,

shall not be used to provide funding for the Physician Volunteer Program.

~~(2)~~

(B) Any amount over the first one million dollars ($1,000,000), including accrued interest, in the fund shall be transferred to the Major Risk Medical Insurance Fund created pursuant to Section 12739 of the Insurance Code and shall, upon appropriation by the Legislature, be used for the Major Risk Medical Insurance Program for the purposes specified in Section 12739.1 of the Insurance Code.

(C) Transfers under this paragraph shall cease on the date the Managed Risk Medical Insurance Program becomes inoperative. The Director of Finance shall notify the Joint Legislative Budget Committee at the time the program becomes inoperative.

(2) Commencing on the date transfers under paragraph (1) cease, and annually thereafter, the fines and administrative penalties deposited into the Managed Care Administrative Fines and Penalties Fund shall be transferred by the department to the Medically Underserved Account for Physicians within the Health Professions Education Fund and shall, upon appropriation by the Legislature, be used for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program, as specified in Article 5 (commencing with Section 128550) of Chapter 5 of Part 3 of Division 107 and, notwithstanding Section 128555, shall not be used to provide funding for the Physician Volunteer Program.

(d) Notwithstanding subdivision (b) of Section 1356 and Section 1356.1, the fines and administrative penalties authorized pursuant to this chapter shall not be used to reduce the assessments imposed on health care service plans pursuant to Section 1356.

~~SECTION 1. It is the intent of the Legislature to enact legislation that would establish the basic health program described in Section 1331 of the federal Patient Protection and Affordable Care Act (42 U.S.C. Sec. 18051).~~

O

SB 21

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 27 and SB 21
Author: Medina and Roth
Bill Date: March 21 and 18, 2013, amended
Subject: UC Riverside Medical School: Funding
Sponsor: Authors

STATUS OF BILL:

AB 27 is in the Assembly Appropriations Committee and SB 21 is in the Senate Education Committee.

DESCRIPTION OF CURRENT LEGISLATION:

These bills mirror each other and would both annually appropriate $15,000,000 from the General Fund to the Regents of the University of California for allocation to the School of Medicine at the University of California, Riverside. Both bills contain urgency clauses, which mean that the bills would take effect immediately once signed into law.

ANALYSIS:

The foundation of the School of Medicine at UC Riverside goes back to 1974, when the UC Riverside / University of California, Los Angeles (UCLA) Thomas Haider Program in Biomedical Sciences was established. This program has allowed approximately 700 students to complete their first two years of medical school at UC Riverside, and their last two years at the David Geffen School of Medicine at UCLA, which confers their medical degrees.

In July 2008, the UC Board of Regents officially approved the proposed establishment of an independent four-year School of Medicine at UC Riverside, intended to serve the medically underserved in the Inland Empire. However, in the summer of 2011, UC Riverside failed to gain accreditation for an independent four-year medical school from the Liaison Committee on Medical Education (LCME), the national accrediting body for educational programs leading to the Medical Doctor degree in United States. LCME withheld preliminary accreditation due to a lack of stable state funding support for the school. In April 2012, UC Riverside secured substantial new funding from a variety of non-state funding sources, and submitted a second accreditation application to LCME. In June 2012, a second accreditation site visit took place and in October 2012, UC Riverside received notification from LCME that its planned medical school received "preliminary accreditation." Preliminary accreditation from LCME enables prospective students to begin applying to the UC Riverside School of Medicine in order to potentially enroll in August 2013.

These bills would appropriate $15,000,000 from the General Fund in order to establish a more viable funding source for the UC Riverside School of Medicine. According to the author, the highest indicator of where a physician practices is where he or she attends medical school and the Inland

Empire trails behind much of the state in several key health indicators, including coronary heart disease and diabetes. The author believes that the establishment of a medical school in the Inland Empire will help to ensure more physicians are trained and remain in the Inland Empire. The author contends that one of the areas that will aid in the UCR School of Medicine receiving final accreditation from LCME and meeting the medical needs of the Inland Empire is for the Medical School to receive a stable funding source, which is why this bill seeks to appropriate General Fund monies.

According the Public Policy Institute of California, the Inland Empire is the fastest-growing region of the state and it is estimated that more than 300,000 residents of the Inland Empire will have health insurance coverage extended to them as a result of the Affordable Care Act. The U.S. Department of Health and Human Services' Council on Graduate Medical Education recommends that a given region have 60 to 80 primary care physicians per 100,000 residents and 85 to 105 specialists. The Inland Empire has about 40 primary care doctors and 70 specialists per 100,000 residents, which is a severe shortage.

These bills will help to increase access to care and help the Inland Empire area of California to prepare and be ready for implementation of the Affordable Care Act. Board staff suggests that the Board support this bill.

FISCAL: None to the Board

SUPPORT: California Department of Insurance; California Medical Association; City of Riverside; Enterprise Media; Riverside County Superintendent of Schools, Kenneth M. Young; Southwest California Legislative Council; University of California at Riverside; UC Riverside Alumni Association; UC Riverside Board of Trustees; and two individuals.

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN SENATE MARCH 18, 2013

SENATE BILL No. 21

Introduced by Senator Roth

December 3, 2012

An act relating to the University of California, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

SB 21, as amended, Roth. University of California: UC Riverside Medical School: funding.

Existing provisions of the California Constitution establish the University of California as a public trust under the administration of the Regents of the University of California. The University of California system includes 10 campuses, which are located in Berkeley, Davis, Irvine, Los Angeles, Merced, Riverside, San Diego, San Francisco, Santa Barbara, and Santa Cruz.

This bill would *annually* appropriate $15,000,000 from the General Fund to the Regents of the University of California for allocation~~, without regard to fiscal year,~~ to the School of Medicine at the University of California, Riverside.

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

Vote: ⅔. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.

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

1 SECTION 1. The sum of fifteen million dollars ($15,000,000)
2 is hereby appropriated *annually* from the General Fund to the
3 Regents of the University of California for allocation~~, without~~
4 ~~regard to fiscal year,~~ to the School of Medicine at the University
5 of California, Riverside.
6 SEC. 2. This act is an urgency statute necessary for the
7 immediate preservation of the public peace, health, or safety within
8 the meaning of Article IV of the Constitution and shall go into
9 immediate effect. The facts constituting the necessity are:
10 In order to provide crucial funding to launch the vital health care
11 mission of the School of Medicine at the University of California,
12 Riverside, it is necessary that this act take effect immediately.

O

SB 62

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 62
Author: Price
Bill Date: April 9, 2013, Amended
Subject: Coroners: Reporting Requirements: Prescription Drug Use
Sponsor: Author
Position: Support if Amended

STATUS OF BILL:

This bill is in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require a coroner to report deaths when the cause of death is determined to be the result of prescription drug use to the Medical Board of California (Board), this bill was amended to only require the reports to be filed with the Board. The initial report must include the name of the decedent, date and place of death, attending physicians, podiatrists, or physician assistants, and all other relevant information available. The initial report shall be followed, within 90 days, by copies of the coroner's report, autopsy protocol, and all other relevant information.

This bill was amended to allow the follow-up coroner's report and autopsy protocol to be filed within 90 days or as soon as possible once the coroner's final report of investigation is complete. The amendments now only require the report to be filed with the Board and only require the initial report to include specified information when that information is known. The amendments specify that the other relevant information should include any information available to identify the prescription drugs, prescribing physicians, and dispensing pharmacy.

The amendments also make similar changes to existing law on the 90-day timeline and confidentiality of the report for mandatory coroner reporting for deaths that may be the result of a physician's, podiatrists' or physician assistant's gross negligence or incompetence.

ANALYSIS:

Existing law, Business and Professions Code Section 802.5, requires a coroner to report to the Board (and the OMBC , BPM, and PAB) when he/she receives information based on findings by a pathologist indicating that a death may be the result of a physician's gross negligence or incompetence. This section requires the coroner to make a determination that the death *may* be the result of the physician's gross negligence or incompetence. Requiring coroners to make the determination, could be the reason the Board has seen a decrease in

coroners reports; the number of reports received by the Board is at an all-time low. Only four reports were received in FY 2011/12, and only one of the reports indicated a drug related death.

The Board has reason to believe that numerous death have occurred in California that are related to prescription drug overdoses. However, complaints regarding drug-related offenses are often hard for the Board to obtain. In most instances, patients who are receiving prescription drugs in a manner that is not within the standard of practice, are unlikely to make a complaint to the Board. Some complaints regarding overprescribing come from anonymous tips, which usually do not have enough information to allow forwarding to the Board's district office for investigation, as there is no patient to obtain records for or not enough information to open an investigation. Family members of patients may make a complaint to the Board; however, the Board must have a patient release in order to obtain medical records or seek a subpoena. Sometimes it is difficult to obtain evidence to warrant a subpoena, or the family is not responsive.

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

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

Requiring coroner reporting of all prescription drug use deaths might be overly broad and interpreted to include deaths that occurred while an individual was taking a non-opioid prescription (i.e., antibiotics). The Board voted to support SB 62 if it is narrowed to only include coroner reporting of deaths related to Schedule II and III controlled substances. Per the committee analyses, the author will be taking amendments to narrow the mandated reporting by coroners to deaths to those in which the cause of death is related to toxicity from a Schedule II, III or IV drug and Schedule II, III, or IV drugs played a contributing factor.

The Board also requested an amendment to ensure that coroners report these deaths to all boards responsible for licensing prescribers. Of note, the bill was recently amended to only require the coroner reports to go to the Board to make it more efficient for coroners, as they would only have to send their reports to one board, not multiple boards; this was a concern

raised by the coroners in meeting with the author's office. The Board could potentially share/disseminate the coroner reports that include a prescriber or dispenser licensed by another board to the appropriate regulatory board under the Department of Consumer Affairs, as is currently done as part of the complaint process.

FISCAL: Using the total data reported in the LA Times articles, the estimated workload created by this bill would result in the need for 1 additional position to handle the upfront review in the Central Complaint Unit, 4 investigators to handle the cases that go to the field for investigation, and 1 additional position in the Discipline Coordination Unit. This additional workload would also result in $441,500 in costs for expert reviewers for the upfront review, investigation, and hearing. Based upon information received by the Attorney General's (AG's) Office, the approximately 50 cases that would be referred to the AG's office would result in approximately $1,803,700 in costs (out of the 50, it is estimated that 35 would settle, or 70%, and the remaining 15 would go to hearing).

SUPPORT: Center for Public Interest Law
The Board (if amended)

OPPOSITION: California Medical Association

POSITION: Recommendation: Support

SB 62 Fiscal Methodology

The LA Times found 3,733 deaths involving prescription medications from 2006 – 2011. In 1,762 of those cases, one or more drugs prescribed for the deceased caused or contributed to the death (indicating physician prescribing).

1,762 divided by 5, equals 350 deaths per year. According to the US Census Bureau information, the 5 counties that the LA Times included in its data (Los Angeles, Orange, San Diego, and Ventura), make up 45% of California's population. This means that 350 deaths per year is only 45% of the what would be seen for California, making the total number of deaths that would be reported to the Board, approximately 700.

Using existing averages, approximately 75% of the cases do not go to the field for investigation, and 25% of the 700 would go to the field for investigation, a total of 175 cases per year.

Regarding the upfront Central Complaint Unit (CCU) review of the 700 cases, the Medical Board estimates that we would need 1 analyst to handle the upfront review of the 700 potential cases.

For the upfront CCU expert review, it equates to 2.0 hours per case for a total of 1400 hours. At the rate of $75 per hour, this equates to $105,000 for CCU expert review.

For the cases that go to the field, the Board is estimating that the workload would generate the need for 4 new investigators in the field, which equates to 40 cases per investigator (because the workload of each case may not be complex due to the known death of a patient), and 1 analyst in the discipline coordination unit (for 50 cases filed per year).

Of the 175 cases that go to the field, 25% will close at the physician interview level. Thus, 130 cases will need to be reviewed by an expert. At $150 per hour and an average of 15 hours per case, this equates to $292,500 for expert review (review medical records, listen/read physician interview, and write report).

For the 175 cases that go to the field, we are estimating that 50 of these cases, or 30% would need to go to the Attorney General's (AG's) Office for prosecution. According to current statistics, approximately 70% or 35 cases would be resolved through stipulation, and the remaining 30% or 15 cases would go to hearing. According to the AG's office for pain management cases that go to hearing, on average these take about 474 hours at $170/hr which equals $1,208,700 for the 15 cases. For the 35 cases that would result in stipulation, according to the AG's office for pain management cases, on average these take about 100 hours at $170/hr, which equals $595,000, for a total AG cost of 1,803,700.

Of the cases that go to the AG's Office, half or 25 will have not expert cost. 10 cases will go to pretrial at 4 hours expert time each, the rate for trial related expert work is $200, this equates to $8,000. 15 cases will go to hearing at 12 hours to prep the expert and for the expert to testify at the hearing at $200 per hour, equates to $36,000.

SB 62 (Price)
Total Cost for the Medical Board of California

Duty	Cost
CCU - 1 Staff Services Analyst	$ 37,000.00
DCU - 1 Assoc. Gov. Program Analyst	$ 58,000.00
Field - 4 Investigators ($60,500 per investigator)	$ 242,000.00
CCU Expert Review	$ 105,000.00
Field Expert Review	$ 292,500.00
AG Costs	$ 1,803,700.00
Expert Pre-Trial and Trial	$ 44,000.00
TOTAL	$2,582,200

AMENDED IN SENATE APRIL 9, 2013

SENATE BILL No. 62

Introduced by Senator Price

January 8, 2013

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

LEGISLATIVE COUNSEL'S DIGEST

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

Existing law requires a coroner to make a report, as specified, when he or she receives information that indicates that a death may be the result of a physician and surgeon's, podiatrist's, or physician assistant's gross negligence or incompetence. *Existing law requires the report to be followed, within 90 days, by copies of the coroner's report, autopsy protocol, and all other relevant information.*

This bill would expand those provisions to require a coroner to make a report when he or she receives information that indicates a death may be the result of prescription drug use and to require the coroner to additionally file the report with the ~~California State Board of Pharmacy~~ *Medical Board of California. The bill would also extend the time during which the coroner's report and other information may follow the report to as soon as possible once the coroner's final report of investigation is complete.* By increasing the duties of county officers, this bill creates a state-mandated local program.

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

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

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

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

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

the Medical Board of California~~, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, or the Physician Assistant Board, and shall also be filed with the California State Board of Pharmacy~~. The initial report shall include, *when known,* the name of the decedent, date and place of death, attending physicians, podiatrists, or physician assistants, and all other relevant information~~available~~, *including, but not limited to, any information available to identify the prescription drugs, prescribing physicians, and dispensing pharmacy.* The initial report shall be followed, within 90 days *or as soon as possible once the coroner's final report of investigation is complete*, by copies of the coroner's report, autopsy protocol, and all other relevant information.

~~(c) A report required by this section shall be confidential. No coroner, physician and surgeon, or medical examiner, nor any authorized agent, shall be liable for damages in any civil action as a result of his or her acting in compliance with this section. No board-certified or board-eligible pathologist, nor any authorized agent, shall be liable for damages in any civil action as a result of his or her providing information under subdivision (a) or (b).~~

SEC. 2. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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SB 117

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 117
Author: Hueso
Bill Date: April 8, 2013, Amended
Subject: Integrative Cancer Treatment
Sponsor: California Citizens for Health Freedom

STATUS OF BILL:

This bill is in the Senate Health Committee. This bill was formerly AB 1278 (Hueso), Assemblyman Hueso is now a Senator, so the bill has changed to a Senate Bill.

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 PROVDE 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.

The Executive Committee voted to recommend that the Board take a Neutral position.

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: Executive Committee Recommendation: Neutral

CALIFORNIA CITIZENS FOR HEALTH FREEDOM
Frank Cuny, Executive Director, Alfredo Hueso, Chairman
2362 Palermo Road, Palermo Ca 95968, WWW.CitizensHealth.org
530-534-9758

April 15, 2013

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

Re: Integrative Cancer Bill, SB 117

Dear Honorable Members of Medical Board:

We are seeking your support for Senate Bill 117, the Integrative Cancer Bill. This Health care bill will enhance and not replace current law. We believe the current law is outdated and the current medical approach in the treatment of cancer is broken. The proposed legislation may improve the manner patients are treated if they are afflicted with cancer. Please refer to the Summary of AB 117, exhibit 1.

We intend to demonstrate with the documents we are providing you that the current cancer health care system is broken. Cancer statistics have changed very little in a generation. Today Cancer accounts for nearly one of every 4 deaths in the United States. Please refer to exhibit 2, Cancer Statistics. Furthermore, we are providing you with a nine page letter of an oncologist that describes better than any one else can how broken the Cancer Health care system really is in California. I shall briefly summarize some of the bullet points that are contained in his letter. Please refer to exhibit 3.

1. Patients need to understand that as long as Medicare pays fee-for service there is a potential for conflict of interest. P.8
2. Doctors are not paid to collaborate with other doctors or their patients. P.1
3. There is no effective chemotherapy treatment for a distressing number of malignancies. P.3
4. When doctors are paid to do more there is always the potential for conflict of interests. P.4
5. He learned that selling Chemotherapy was not a sustainable business plan. P.4
6. He learned that there is wide variation in treatment approaches, and other doctors and insurance companies were not interested in establishing guidelines. P.4 and 5
7. Seventy percent of earnings come from sale of chemotherapy drugs and services. P. 1
8. Financial inducements are to great, concerning sale of certain types of drugs. P.6
9. Need to re-align incentives so that Doctors will do the right things. P.8
10. The reason they have been able to grow a practice as large as ours and provide the level of service we do is because of the revenue we obtain from selling chemotherapy drugs and services. P.3
11. But we are paid more for administering the drugs than we were in the past, so it makes economic sense to administer them more often. P.3
12. I have told patients I know I can make you sick, but I am not certain I can make you better. P.3
13. I hoped that ANCO could rally docs around the idea of evidence-based medicine and take our science and good results to the insurers, who, seeing the wisdom of our arguments, would reward us for being so scientific, thoughtful and restrained. Boy, was I naïve! P.4.

This proposed law is about the what is in the best interests of the patients. The medical profession needs to do a better job of saving more lives, and the quality of life. Who cares if you kill the tumor, and then the patient ends up dieing. Our legislation will provide the framework for the patient to have a better quality of life. For example, active coordinated care handled by advance medical teams can make a world of difference in cancer or patients at risk of cancer. Please refer to exhibit 4. The problem is most doctors do not coordinate with other doctors, and patients are the ones that suffer the results of this lack of coordination.

More significant is that the current law in California violates the basic right of patient to choose the medicine of his or her choice. This basic human right was determined in a case called Schneider versus Revici in 1987, Please refer to exhibits 5. In another case, Andrews versus Ballard, Judge McDonald stated: " and it is the individual making the decision, and no one else, who if he or she survives, must live with the result of that decision. Ones health is a uniquely personal possession. The decision of how to treat that possession is of no less personal nature." Exhibit 6

For those of you that are still skeptical or don't believe any change in the law is necessary, then I challenge you to review the documents we have provided, particularly, the nine page letter of Dr. Peter Eisenberg. If when you read the letter, and you still don't think the Cancer Health care system is broken, then nothing will sway you. I know this much, that if the public saw this letter, they would be outraged by the blatant conflicts of interests, and how some doctors put their financial interests above the interests of their patients. For example, in 2009 Pfizer, a major pharmaceutical company was fined a record 2.3 Billion dollar penalty for illegal drug promotions to doctors. Please refer to exhibit 7.

CONCLUSION

The proposed Integrative cancer bill adequately protects patients, and more importantly, provides patients with the freedom of choice that is a legally protected right. We ask you to support the bill because it is the right thing to do, and it is in the best interests of patients. Thank you for your time, and if you have any questions we will be happy to address them.

Respectfully,

Alfredo Huesa
Chairman
CCFHF

Attachments:

1.Summary of SB 117
2. Cancer Statistics
3. A very Open letter from an Oncologist
4. Coordinated care helps Cancer Patients
5. Galileo's Lawyer, page 33
6. Perceived Legal implications of the decision in the Schneider v. Revici case.
7. Associated Press, Pfizer to Pay record 2.3 Billion Penalty over promotions.

SENATOR BEN HUESO, 40TH DISTRICT

SB 117 – Integrative Cancer Treatment

Summary

Senate Bill 117 provides open access for consumers to receive, and physicians to administer, Integrative Cancer Treatment in California.

Background

Integrative cancer treatment is a multidisciplinary treatment plan that brings together traditional tools for fighting cancer with complementary and alternative therapies. Treatment includes, but is not limited to, nutritional support, naturopathic medicine, homeopathic medicine, mind-body medicine, oncology rehabilitation, pain management, chiropractic care, and spiritual support. In addition, treatment incorporates uses of unconventional medicines that have proven results. For example, research has shown anti-cancer powers in Vitamin C and other natural vitamins and herbs. Some studies have shown how a compound in red grapes may prevent colon cancer and how cruciferous vegetables such as broccoli, cauliflower and cabbage contain a cancer preventing elements.

Integrative cancer treatment not only gives consumers options for care, it also helps patients cope with the common side effects of chemotherapy and radiation, which include muscle tension, aches, pains, nausea, vomiting, and fatigue. Unfortunately, the side effects associated with conventional therapies often cause patients to end their treatments prematurely, or require that doctors take a less aggressive approach. This occurrence decreases with the addition of integrative oncology services.

Furthermore, accessibility to integrative cancer treatment provides a bridge in communication for patients and doctors. According to a press release out of UC Irvine, eighty percent of cancer patients use some form of complementary or alternative medicine, and only half of them tell their doctors about it. The internet-era that we now live in contributes to the problem, making it easy for patients to do their own research and self-medicate with alternative treatments that may not be safe. Open access to integrative cancer treatment provides a safer pathway for patients to receive care and seek consult from a licensed health expert.

Why this bill is needed

California law currently restricts the use of unconventional remedy in the diagnosis, treatment, alleviation, or cure of cancer. In fact, California is the only state to statutorily restrict cancer therapy exclusively to conventional drugs, surgery, and radiation. Past reports and legislative analysis suggests that current law was established to protect the public from fraudulent, misleading, and potentially harmful therapies. It is extremely important to ensure vulnerable patients are not taken advantage of or misled. However, the stringent and outdated nature of existing statute has prevented Californians from capitalizing on new and innovative cancer therapies. Options for integrative care are limited to travel outside of our state borders or participation in a research program. And while, several academic institutions in the state have already invested in integrative treatments for cancer, such as UCLA, UCSF, Scripps, and Bastyr University, open access for consumers to integrative care is essential. California would benefit by joining the several other states and countries currently offering integrative cancer treatment to patients.

SB 117

SB 117 provides cancer patients with more options for care that best suit their needs. Integrative medicine does not replace conventional therapy, rather it is meant to complement it. This bill clarifies the ability of a physician or surgeon to administer or provide integrative cancer treatment in California. In addition, SB 117 specifies that integrative cancer treatment must meet an evidence-based medical standard, as defined in the bill, and includes language that encourages communication with a patient's oncologist, as well as treatment with conventional therapies.

Sponsor

California Citizens for Health Freedom
www.citizenshealth.org

For More Information Call

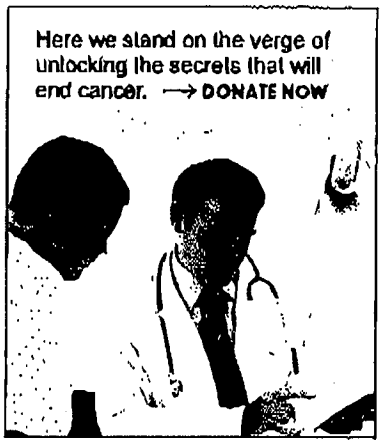
Maria Garcia, Legislative Director
(916) 651-4040
maria.garcia@sen.ca.gov

ST2 STAND UP TO CANCER → THIS IS WHERE THE END OF CANCER BEGINS DONATE NOW SIGN IN OR JOIN TODAY

CANCER STATISTICS

Share this: Like Tweet

Cancer is a worldwide epidemic. These statistics are not just numbers. They represent our loved ones and the need to change the way that cancer research is done so that everyone diagnosed with cancer becomes a survivor.



DID YOU KNOW...

Cancer accounts for nearly 1 of every 4 deaths in the US.

DID YOU KNOW...

There are over 100 different types of cancer.

DID YOU KNOW...

In America more than 1.2 million new patients are diagnosed with cancer every year. A new cancer is diagnosed every 30 seconds in the United States.

DID YOU KNOW...

A one percent reduction in cancer deaths would be worth $500 billion, almost 2.5 times what the U.S. spends each year on the disease.

DID YOU KNOW...

This year, approximately 1.63 million Americans will be diagnosed with cancer and about 572,000 will die of the disease.

DID YOU KNOW...

...that in 2012, cancer will be the leading cause of death in the world?

DID YOU KNOW...

Every three minutes, two people in the US die from cancer.

ST2C MISSION

This is where the end of cancer begins; when we unite in one unstoppable movement and **Stand Up To Cancer.**

Read Our Mission

LAUNCH A STAR
THE STAR CONSTELLATION ◆HONOR ◆REMEMBER ◆SHARE ◆SUPPORT

PARTNERS

GlaxoSmithKline

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gpawelski
Registered Member

Date Joined May 2001
Total Posts : 112

Posted 9/4/2009 4:01 PM (GMT -4)

A Medical Director at California Cancer Care, an oncology practice in Northern California wrote a candid letter to the Health Beat blog by Maggie Mahar. He is a member of The Century Foundation's Working Group on Medicare Reform. A very experienced and successful oncologist who has served on the board of the American Society of Clinical Oncology and the Association of Northern California Oncologists.

Dear Maggie Mahar:

I have been working on this since you asked me some questions about our practice. Maybe it is more than you asked for, but I thought that I'd put my answers in context. Just the other day Stanford University's Alain Enthoven wrote on the Opinion Page of the *New York Times* that we docs ought to be salaried. Though for 30 years I have practiced fee-for-service medicine, had a wonderful career and lived comfortably, I cannot argue! The waste associated with the inherent conflicts of interest in fee-for-service medicine is more than we can afford.

At the same time, the way reimbursement is set up, oncologists couldn't stay in business if we were not paid fee-for-service for selling chemotherapy drugs and services. Some estimate that up to 70% of our earnings come from the sale of chemo drugs.

Maggie, as you know, ***oncologists are not paid to collaborate with their patients or with other doctors. Listening to patients and chatting with them, asking other docs about a patient, going to conferences, e-mailing experts about problems and looking up stuff in a book (old way) or the net (new way) are not billable events.***

Neither is sitting for half an hour at lunchtime with our nurses, medical assistants, research director and the other docs in our office to go over tomorrow's patients, field questions about problems patients have called in, and converse about problems a patient is having. Can you imagine what this daily meeting costs in terms of salary? Can you imagine why others don't do this? Oncology is a team sport and there is evidence that collaborative practice—not only with the patient and her family, but with other docs who are caring for her as well as smart others who bring different areas of expertise to the table, can provide better care.

Do you want to go to a doc and be treated according to his treatment plan after an hour-long visit? Or would you rather that he present your case, along with the pathology slides and the imaging studies, to a group of other docs representing a number of disciplines (medical, surgical and

radiation oncology, diagnostic radiology, pathology, nursing, social work, dietetics, pain control, pulmonary, gastroenterology, etc.) to be viewed and discussed?

Smart docs are not afraid to consult with the smarter (or more experienced) docs at the university and even send patients there to get their treatment if the care is complicated and not well–known to us. But there are plenty of docs who, for one reason or another, choose not to refer their patients to another institution. Of course there are plenty of patients who would rather get their care closer to home, but as a recent article in PLOS pointed out, the doctor has an obligation to inform the patient that he might well get better care elsewhere.

We also are not paid to remember your name. Our office has a large staff because we try to serve the folks we care for. As a result, we have two nurse practitioners, one research person, and six clinical folks assisting our six doctors. Our 8 nurses and nurse practitioners plus 16 full-time staff members (medical records, front office receptionists, clerks, insurance specialists, patient care coordinator, and a CEO earn a total of $125,000 a month.

At one of our yearly retreats, we had Rachel Ramen, the author and friend of our practice, talk to us about service. We learned about the notion that one needs to find out where our patient is and start there. Our care of a patient begins before we even meet them in person. Before the appointment, Thomas, our new patient coordinator, spends 20 to 30 minutes chatting with the prospective patient on the phone obtaining all kinds of information, orienting her to our practice and explaining what to expect. It is not unusual for a new patient to ask me to meet Thomas at her first visit to thank him for his kindness.

Our front office ladies—there are 4 of them; one answers the phone, the other 3 greet and check out patients—know the name of each patient and their family members. They give each person a big hello when they arrive. This might seem silly, but almost every day a patient or family member tells me how great our front office staff is. I recently read an article that talked about how important it is to, not only honor a patient's informed wish for treatment, but to respect her as a person. Patients really don't want to be numbers.

After a patient is seen by the doc—we do the initial consultation– the Nurse-Practioners see folks in follow-up. And there begins a relationship between the patient and our office staff that is as intimate and as close as you can imagine. With anxiety being appropriately and understandable high, patients have all kinds of questions and concerns that we can't and haven't anticipated.
Our medical assistants spend literally the entire day on the phone solving problems. Our small hospital census—5.2 patients a day—is a result of our following through on patient concerns and seeing them in the office before problems become ones that can only be solved in the ER or hospital. We often use the office as an emergency room, but much more

conveniently for our patients and at a much lower price.

It is certainly possible that we are not as efficient as we could be. Our patients receive very speedy responses to their needs. It is possible that the system just cannot accommodate the level of care that we provide at the current cost.

I should point out that the only folks who can really generate revenue are the physicians, nurse practitioners, and the nurses who provide chemotherapy. Folks in the front office, our medical assistants and the hoard of employees who also "care" for our patient's cannot bill for the services they provide. Neither can I bill for innumerable phone calls and tasks I perform at my desk, when I am not sitting face to face with a patient. Similarly, e-mails to other docs asking for advice or coordinating care among other disciplines go unpaid.

The reason oncologists have been able to grow a practice as large as ours and provide the level of service we do is because of the revenue we obtain from selling chemotherapy drugs and services.

Meanwhile, the Medicare fee schedule that reimburses us for the drugs themselves has been cut. We are paid just 6% over the actual sale price (ASP.) And since we are not a 1,200 doctor practice like US Oncology, we do not get the discounts or rebates that they receive from drugmakers. In our case, sometimes the Medicare reimbursement is actually less than what we have to pay for the drug. For instance, we actually lose about $200 every time we give a shot of Neulasta, a drug to increase white blood count and prevent infection in patients receiving chemotherapy.

But we are paid more for administering the drugs than we were in the past, so it makes economic sense to administer them more often. Not every doctor is willing to do that. The practices that shows some restraint and don't treat everyone who walks through the door with chemo are the ones that are suffering.

The truth is that there is no clearly effective chemotherapy for a distressing number of malignances. In those cases, if I find that first line therapy isn't working, I won't automatically offer a second type of chemo. Instead, assuming the patient wants a frank appraisal of her condition, I'll explain the realistic goals and options available. In my experience, and in the community in which I live, patients seem to want to know as much as they can about their illness, even if the news is bad. Delivering terrible news is difficult, time-consuming and extraordinarily painful for all involved. But good decisions depend upon an honest and forthright discussion and providing the patient with the information and tools to make decisions.

I have told patients, "I know that I can make you sick, but I am not certain that I can make you better! . . . In the foreshortened time that you have left, you need to think about what you want to do. Do you want to spend that time in this office, with me and my staff, or is there someplace else you would like to be, something else that you would like to do?"

It has taken me a while to sort out how I feel about the drugs we use. I began practicing in the late 1970s, and I remember the increasing role and influence of chemotherapy. As more drugs became available, with more evidence that they were effective, our optimism increased --and use increased as well.

It became clear to many physicians—consciously or not--that selling chemotherapy was really the business they ought to be in as we were compensated so very well for it. The time one spent with patients was not compensated nearly as well. This is not unlike the rewards bestowed upon those who perform operations (at least historically), pass tubes into orifices (GI) or make holes for tubes (cardiology & orthopedics), purchase and use their own imaging machines etc.

When doctors are paid to "do more" there is always the potential for conflict of interest. Keep in mind that physicians are human beings with the same kinds of responses to financial incentives as everyone else. Despite our training and promise to put our patient's interest first, we succumb to incentives that often come in the form of more revenue.

As time went on and science grew, we became increasingly more successful in providing chemotherapy that actually worked, and it was a lot easier for doctors to sell chemotherapy than it was for them to spend the kind of time necessary to give patients choices.

Keep in mind that in the late '70s and '80s there was not much discussion about "shared decision-making." If a patient had cancer, and we knew that tumors responded to a certain chemotherapy regimen by shrinking, physicians assumed that patients would choose to take it, if it was offered to them. "You have cancer, you need chemo," seemed to be the mantra.

It was not until much more recently that the notion of quality of life, and the fact that just because we shrunk a tumor doesn't mean that people will actually live longer, was clear to us.

Nevertheless by the mid 1980s it occurred to me that selling chemotherapy was not a sustainable business plan. I thought that insurers would figure out that margins on drugs were too high and cut reimbursement. With that in mind, in 1990, I established the Association of Northern California Oncologists (ANCO).
I hoped that ANCO could rally docs around the idea of evidence-based medicine and take our science and good results to the insurers, who, seeing the wisdom of our arguments, would reward us for being so scientific, thoughtful and restrained. Boy, was I naïve! It seemed that docs so valued their independence—and made so much money – that they would not rally around anything.

In the late 1980s, I went to a Clinical Practice Committee Meeting of our professional society and asked them to consider establishing guidelines for treatment. At the time, I was consulting for Blue Shield of California and was impressed with the wide variation in treatments for similar conditions.

I was told under no uncertain terms that my comments and recommendations weren't welcome!

From the insurance side, there also wasn't much interest in decreasing wide variations in how doctors treated similar malignancies. I suspect that insurance companies have an easier time making it more difficult for docs to get paid rather than investing in innovative ways to collaborate with physicians. Moreover, if insurers put time and money into researching the most effective treatments, those guidelines would become public—and would benefit competing insurers.

Ultimately, the job of insurance companies is to pay claims. My sense is that they either pay them or not, and holding up payment is what they know how to do. It would have been nice both for insurers and physicains to agree on treatment pathways, but it didn't happen.

Some years later, in the mid '90s, I sponsored a meeting of 50 N.California oncologists for a weekend. We had speakers representing folks doing quality studies and electronic medical records and the insurance industry, but no docs really waned to compromise, merge practices and establish standard treatment plans.

Why is there so much variaion on how much treatent is given for similar conditoins?

If you ask doctors you'll hear a variety of answers. Here goes:

- *Patient and family expectations. Sometimes, I hear docs say the equivalent to "the patient made me do it," when justifying the administration of futile chemotherapy. But it is my experience that patients almost always want to be told the truth about their illness and its treatment and prognosis. Patients want to be offered reasonable and realistic options for treatment and they rarely choose treatments with a very small chance of success.*
- *Societal expectations. We expect that we can smoke 2 packs a day for 30 years and the doc will fix it. And when, through no fault of their own, people develop cancer, many feel certain that it must be curable. Maybe too much of Dr. Kildare and Welby. We just aren't as good as they are!*
- *The doctor's ideal as healer. After all, why did I go to med school if not to fix people? In fact, my earliest memories of contemplating medicine come from the 1950s when I was single digit years old. I remember thinking that there is nothing medical people wouldn't do or spend to help a sick person! I really did think that! Stuff was cheaper then, and we didn't have as many choices of treatment! There is lots of hype about new treatments. I can remember as a young oncologist, scouring the ASCO abstracts for a new treatment for an illness and being excited about a marginally better drug. Perhaps it is time and age that has made me more cynical, as many of the supposedly "better" treatments just did not turn out to be more effective*
- *Don't "take away hope!" The lamest of reasons for treating*

someone—especially with medicines that make them sick! Hope exists in many forms and skillful medical folks with time to spend with their patient can present alternatives other than:

- *"Take chemo = keep up hope," or*
- *"No chemo = no hope!"*

I prefer to re-frame the discussion around realistic expectations and discuss what it is that the patient is hoping for. Everyone agrees that living forever is not realistic. And talking about quality of life as opposed to quantity of life gets some traction these days, as patients and families understand Q of L better.

So, assuming the patient is open to such a discussion, I can then promise to be aggressive in controlling pain and in managing other symptoms. In the meantime, I will encourage my patient to live each day to the fullest—striving to live as well as possible rather than as long as possible.

However, rationing chemotherapy is not an issue. If, after being carefully taught that treatment is not very effective and has nasty side effects, a patient wishes to proceed with chemotherapy, I will provide it for her.

- *Real, (but sometimes small) chance of success. We do have data on many clinical situations; for example we have evidence of the benefit of first line chemo in advanced non-small cell lung cancer. We know that median survival increases by a couple months. We know that, with treatment, the chance of living a year increases from 15% - 20% to 30% - 40%.*
  But it is difficult to explain some of this material, especially to folks with poor math skills, and it is time-consuming, as well.

  So rather than making it clear that the average patient lives only a couple of month longer—and that the chances of surviving for a year are less than 50/50, it is much easier to say, "Yes, you do have a tough disease, but I think we can help you, so let's start treatment tomorrow!"

  Of course, treating Hodgkin's or another curable disease is something else. But most of the cancers we treat with chemo are not curable. Doctors need to be paid for the time it takes to explain the potential benefits as well as the downside of chemo—so that the patient can make a decision about how he wants to spend the time he has left.

- *Financial inducements. This is a really tough item to discuss, let alone prove. Most of us truly believe that we are doing good and that doing well comes with it. But, I have heard docs say the most incriminating things and do things that are clearly in their own best financial interest. For example, I have heard doctors talk about:*
  - *Treating patients with a 2 hour infusion of pamidronate (a generic drug used to treat cancer that has spread to the bone) rather than a 15 minute infusion of Zometa, because one could make $500 more on the generic pamidronate. Many*

physicians rationalized the use of the more profitable, but longer infusion drug on the basis that, "we have a business to run;" "we'd lose $40,000 a month;" "if we don't do this we will have to close our doors;" and "my patients are mostly Medicare and they don't mind hanging around the office for a longer infusion -- in fact they are really very fond of our staff and like spending time with them." A small study of 184 patients who were randomly assigned to a two hour infusion or a 15 minute infusion revealed that 92% preferred the shorter infusion. (Chern, et al, Supportive Care Cancer, 2004)

- *A physician leader of a drug purchasing group suggested that one might reasonably evaluate regimens to maximize reimbursement. For instance, for stage IV non-small cell lung cancer, he suggested using cisplatin and etoposide (given on days 1, 2 and 3 of a three week course) rather than carboplatin and Taxol (given once every three weeks). He argued that there was data to support the use of cisplatin as a better agent than carboplatin and pointed out that Carboplatin's use was the result of aggressive Bristol-Myers Squibb marketing. In addition, he noted, using cisplatin and etoposide took advantage of the increase in administration fees since patients would have to come 3 days rather than one day in a three week period.*
- *When reminbursement for Gemzar and Taxotere was less than cost, it was reported that some practices took these meds off their shelves until Medicare increased payment. When I asked one doc how he would treat bladder cancer without Gemzar, he said, "I'll use Taxol, it's almost as good!"*
- *Amgen "bundled" Aranesp and Neulasta, tying rebates for the white cell-increasing drug, Neulasta to a practice's use of the red cell-increasing drug, Aranesp. For instance, if a practice used less than 65% of its erythropoietin as Aranesp, it would lose its Neulasta rebate. A loss of this rebate resulted in the practice's purchase of Neulasta at $209 more than Medicare pays. Therefore, if the practice does not buy more than 65% of its erythropoietin from Amgen, it must come up with $209 out of its own pocket to supplement the purchase of Neulasta for its patients. Amgen capitalized on its perception that physicians will buy products that maximize their reimbursement. This was easier than trying to sell its products based on solid clinical superiority.*
- *Sometime ago, we received an e-mail from our "Leukine Sales Consultant" at Berlex who pointed out that if we "move all CSF (colony stimulating factors = meds which increase blood counts) to Leukine" we would "save" $430,000. While Leukine, like other CSFs, does increase the white count it is not FDA-approved for use with most chemotherapy regimens and clinical trials have not been done to show its equivalence*

or superiority to rival drugs.

Maggie, it is my understanding that patients expect physicians to make recommendations based on what it is best for the patient, not what is financially best for the physician. It is my contention that patients suffering from cancer would be appalled to understand that they could have received a 15 minute infusion rather than the two hour infusion but for the fact that the physician made $500 more per infusion.

I have been trying and trying to find a rationale to support the style of medicine with which I am familiar. Unfortunately, I think that the incentives are so mis-aligned and the temptations are so great that docs have a tough time making the right decisions. Look at the increase in diagnostic imaging in those practices that have purchased diagnostic imaging machines. "We have to feed the beast," I have heard.

My simple-minded solution is to re-align incentives so that the docs are paid for doing the right thing. What the right thing is, of course, can be open to interpretation. What patients think is right may be different from what the payer thinks is right. That gives me a headache!

But clearly, we need guidelines for the most effective care – and patients need to know whether their doctors are following the guidelines. Medicare needs to jump on the quality band wagon and support docs' use of quality programs such as ASCO's Quality Oncology Practice Initiative (QOPI), a voluntary program that serves to encourage oncologists to examine their practice and to compare themselves to others. Currently, over 1,500 physicians in more than 400 practice sites are registered and the American Board of Internal Medicine considers QOPI to fulfill an oncologist's requirement for quality improvement in his recertification.

Patients also need to understand that as long as Medicare pays fee-for-service there is a potential for conflict of interest. But patients really do not want to hear about doctors' incentives. An article in Health Affairs in 2000 (Miller and Horowitz) showed that:

1. *Many patients are unaware of the financial incentives their own physicians face. Only about half of the respondents wanted information about the incentives.*
2. *Trust in physicians is high; 84% of patients completely or mostly trusted their physician to put patients' interests first.*
3. *"Many patients stated that the information was not relevant to them because they trusted their physician. In fact, some stated that they would not want the information because it would raise unwelcome doubts."*
4. *"Patients also expressed confidence that they could judge the quality of their care and could change physicians if they were not satisfied."*
5. *"Many patients stated that they would want to learn if the incentives imposed any cost on them."*
6. *"In general, patients expressed strong reluctance to raise the issue [of incentives] with their physicians for a variety of reasons,*

including fear of embarrassing or angering the physician; belief that the topic is too "personal" and "intrusive" to raise; perceived irrelevance to treatment; and desire not to take valuable time away from clinical matters."

I have a real problem in placing the burden of figuring out whether a doc is looking out for a patient's best interest on an ill, frightened and anxious patient. As professionals, we have a sacred responsibility to put patients' interests first.

Ultimately, Medicare may want to reduce the fees it pays "outlier" doctors, reducing the incentive to over-treat. Meanwhile, Medicare needs to pay doctors for the time it takes to really explain the pros and cons of treatment to their patients in depth-- so that patients can make an informed choice—and not just give informed consent.

Dr. Peter Eisenberg
Medical Director
California Cancer Care

Post Edited (gpawelski) : 9/4/2009 3:16:15 PM (GMT-4)

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oscarguy
Registered Member

Date Joined Apr 2006
Total Posts : 566

Posted 9/5/2009 10:48 AM (GMT -4)

Thank you for that candid posting. It's event worse than I thought and I thought it as pretty bad.
Take Care, ...Oscar

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Coordinated care helps cancer patients, says Providence exec

Mail Tribune (Medford, OR)

04-09-13

April 09--Active, coordinated care handled by advanced medical teams can make a world of difference for cancer patients or those at risk for cancer.

Walter Urba, director of the Providence Cancer Center in Portland, told a Chamber of Medford/Jackson County Forum audience Monday that the scope of research, prevention and treatment is rapidly changing.

So is the cost.

The reality facing men is that they have a 1 in 2 chance of dealing with cancer. For women it's one in three, and according to the American Cancer Society, cancer hits more than 20,000 people in Oregon annually. It's still the most feared diagnosis by patients, Urba said.

The 1.6 million Americans -- or one-half of 1 percent of the population -- who will get cancer this year will consume 5 percent of the country's health care spending, he said.

This year, there will be 13.7 million cancer survivors with the number -- driven by baby boom demographics -- growing to 18 million in 2020.

Cancer survivors' care cost twice as much per year, and will be a major contributor to the 27 percent increase for cancer care costs by 2020.

Of the nearly 5,200 new cancer cases Providence doctors encounter each year, about 750 come through its Medford Medical Center on the average.

"We need to manage them properly," Urba said. "We need to make sure there is access for what is available locally and to special research protocol or hospital, with perhaps physicians or equipment that local hospitals don't have. We can't all have expert doctors and nurses and multimillion dollar pieces of equipment at every hospital."

Genome research has enabled better understanding of cancer in recent years, he said.

"We now know that cancer is a genetic disease," Urba said. "It doesn't mean that you're born with it necessarily, but you can be born with genes that are predisposed to cancer. We can test for what those genes are and identify the patients that are at risk."

Activity and habits also can shed light too, as genes mutate over time.

"Whether it's smoking with lung cancer or exposure to sun with melanoma, we can see the mutations that can cause mutation or cause the cells to behave in a different manner," Urba said.

Early detection of changes is what can prevent the spread of life-theatening cells at an early stage, perhaps even before a colonoscopy is needed.

Molecular biology tests of stool or urine samples, costing "a couple hundred dollars" are considerably less expensive than colonoscopies.

"But not everybody can do those studies, so we have to get the samples to the right place," he said. "If we find out too late, that's when we all pay the price."

Patients may have a disease that looks the same for all of them under a microscope, but the subtle variations can make a big difference.

"When you look at the genetics, it's different," Urba said. "You can understand why the same three drugs given to 100 people will only give you 20 percent or 15 percent response. We think it's the same disease, but it's not. We have to be prepared from the very beginning to go to lengths to understand what makes the tumor cells different."

In the area of oral, head and neck cancer, he said, Providence has coordinated its efforts with the Earle A Chiles Research Institute in Portland, Oregon Health & Science University, New York University and the University of California-San Francisco.

"It brings together doctors to give the best patient care, teaching, services to those in need and provide research for the best possible therapy," he said. "Collaboration is really crucial for all of it."

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To [illegible]

GALILEO'S LAWYER

Courtroom Battles in Alternative Health, Complementary Medicine and Experimental Treatments

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in the same building as the district court, in downtown New York at Foley Square.

Then the parties write briefs in support of the appeal. The appellant, the party filing the appeal, writes the first brief. The appellee then responds. And finally, the appellant is given an opportunity to submit a reply brief. In most appeals of civil trials, the judges call for oral argument, and the judges requested it in our case.

Sam was busy with other things and could not spend any significant time on the appeal. By that time, one of Sam's good friends, an extremely able attorney named Matt Dineen, was working with us, and Cathy Helwig was still helping out. Matt, Cathy, and I did the briefs. We argued all kinds of issues like evidentiary errors and the Victor Herbert trick. However, the main thrust was the jury charge and, in particular, the judge's failure to give the express assumption of risk defense.

Sam did the oral argument and it went smoothly, for us anyway. The judges seemed swayed by the fact that Mrs. Schneider voluntarily chose to forgo surgery and instead chose to undergo Revici's questionable treatment. They gave Alice Collopy, who argued the appeal for Mrs. Schneider, a hard time.

In a few months, we received the decision. The Second Circuit overturned the jury verdict, holding that the trial judge committed reversible error by not giving the express assumption of risk defense as a complete bar to recovery. As the Second Circuit stated, "While a patient should be encouraged to exercise care for his own safety, we believe that an informed decision to avoid surgery and conventional chemotherapy is within the patient's right 'to determine what shall be done with his own body.'"[8]

It was a complete victory. Back then, there were not many legal victories in the alternative health community, so news of the Second Circuit's decision spread throughout the country. Sam, and to some extent our firm, was heralded as the great white hope amongst alternative health practitioners. Sam was invited to speak at conferences, and we ended up landing a number of other clients in the field, including the ever-increasingly popular diet doctor, Robert Atkins.

8 For the legally interested, *Schneider v. Revici* is reported at 817 F.2d 987 (2nd Cir. 1987).

Perceived Legal Implications of the Decision in the Schneider v. Revici Case

Catherine J. Frompovich, Ph.D.[1]

The evolution of individual human rights can be seen from 1215 when Magna Carta was signed; to 1789 when the Bastille fell; to 1787 when the U.S. Constitution was signed. In this history society has evolved to afford greater and greater protection for individual human rights. However, the right of a patient to determine his choice of health care and access to non-conventional health care has yet to be firmly articulated. In light of that, *Schneider* v. *Revici* is interesting. Possibly April 30, 1987, the date of the decision on this case, may be added to the list of historic dates of individual human rights.

One would think that because of all the other human rights campaigns fought throughout history in various countries of the world, that the right to freedom of choice in health care would be automatic and without question and/or denial. Perhaps in other countries of the world that may be true, but in the United States of America the unfortunate situation exists that individuals who wish to avail themselves of health care modalities and protocols other than those sanctioned by the American Medical Association are subject to the wrath of the law, legal problems and ultimately litigation, if one wishes to exercise the right of self-determination in health care.

However, the courts have deferred to the values and assumptions of conventional medicine and have not reinforced patients' superior rights to determine treatment of their choice or to have access to health care of their choice. In light of that, *Schneider v. Revici* is significant.

The facts in this case are that Edith Schneider was a breast cancer victim who consulted five conventional physicians all of whom advised her to have her breast amputated and be treated with conventional chemotherapy and radiation. She then having rejected that advice and aware of some of the limitations of breast cancer treatment, the issues involved and the difficulties involved in breast cancer, sought out Dr. Revici. Dr. Revici advised her to have a lumpectomy and that he would treat her with his non-toxic chemotherapy. She underwent his treatments and was in his care for nearly fourteen months. Her cancer did not subside and she ultimately was prevailed upon by family members to return to conventional care which she did; had her breasts amputated and was treated with a very harsh course of chemotherapy and radiation. She then turned around and sued Dr. Revici. The unique thing about the case was that it was not simply malpractice but also fraud. Mrs. Schneider's theory was that Dr. Revici's treatment was not accepted by the medical establishment; that it was fraudulent and malpractice per se. The case went to trial and the jury acquitted Dr. Revici of any claims of fraud or lack of informed consent because it was clear that she made a knowing choice; that she had rejected conventional therapy; and that she was informed that Dr. Revici's therapy was not conventional and that she was not defrauded by him. However, the jury was directed by the judge to find malpractice if Dr. Revici's therapy was not accepted by the medical community. Dr. Revici's lawyers argued no, that in contrast to that, the jury should be instructed that Mrs. Schneider assumed the risk of non-conventional treatment precisely because she was informed and made a choice. These two issues are in conflict: 1) Dr. Revici's obligation to practice medicine established by a medicine endorsed by the establishment versus 2) the patient's right to seek out a doctor who doesn't practice medicine endorsed by the establishment. That issue was the focus of the decision before the Court of Appeals. The Court of Appeals ruled that a patient has a right to

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seek out non-conventional treatment and corresponding with that right then, is the responsibility that the patient assumes the risk in exercising that right.

Mr. Samuel Abady, Esq., attorney for Dr. Revici, in a telephone conversation with me said, "... are you aware that Victor Herbert, M.D., J.D., testified and that the nature of his testimony was simply calumny; that he called Dr. Revici 'one of the cruelest killers in the United States'. He also described his [Dr. Revici's treatment] as snake oil, and he really engaged in character assassination; and that the court of appeals found that this was absolutely outrageous behaviour. The court of appeals said the judge should never have countenanced this kind of testimony."

According to the information which I have been able to gather, the arguments presented by Dr. Revici's attorneys were based on some important historical points of view and challenged that *what is considered today as quackery is tomorrow's orthodox medicine.* The classic example which they had used was the case of Dr. Ignaz Semmelweiss.

In the argument presented by Dr. Revici's attorneys, they put forth that Dr. Ignaz Semmelweiss challenged the establishment and declared that the doctors should wash their hands before surgery. He was driven to suicide because at the time if someone washed their hands and then performed surgery and there was a problem, one could get the doctors to testify that Semmelweiss committed malpractice; whereas if today someone performs surgery and causes septicemia or infection because they failed to create a sterile field and had not washed their hands, on the basis of Semmelweiss you could sue for malpractice. So yesterday's quackery is today's orthodox medicine.

Dr. Revici's attorneys further had argued that since medicine had not established an understanding of the true cause of cancer or an effective cure for cancer, the law could not reify orthodox medicine's cancer treatments as if they were inviable and, therefore, that would be legally improper. They further argued that a doctor's freedom to practice is derived from a patient's rights to treatment. They also argued that it is the patient who decides what kind of treatment the patient seeks and desires and that *the physician and modality is the choice of the patient.*

The U.S. Court of Appeals handed down a decision which has set a precedent for non-conventional treatments and freedom of choice. The court stated:

> "In the case before us, appelles contend it is against public policy for a patient to expressly assume the risk of medical malpractice and thereby dissolve the physician's duty to treat a patient according to medical community standards . . .we see no reason why a patient should not be allowed to make an informed decision to go outside currently approved medical methods in search of an unconventional treatment. While a patient should be encouraged to exercise care for his own safety, we believe that an informed decision to avoid surgery and conventional chemotherapy is within the patient's right 'to determine what shall be done with his own body'."

With those words, *the Court affirmed the patient's rights as having priority over and superior to medical establishment's rights,* and that a patient can obtain non-conventional or unorthodox treatment for cancer in this case which did not include conventional surgery and chemotherapy. This then was a dramatic and resounding decision, in my opinion, in favour of several issues:

> A patient's right to choose treatment for health care regardless of the protocol, i.e., conventional or non-conventional; the ability of the physician to offer non-conventional treatments as a protocol with the patient knowing that such a treatment is not the standard orthodox procedure; and, acknowledges the position in a legal forum for *non-conventional treatment and/or therapies to be addressed as non-fraudulent practices.* The last item being the most important, in my view.

Previously the courts have established the individual's right to determination in health care.

> *Andrews* v. *Ballard* was a classic decision in which the alternate health care modality of acupuncture was the subject of legal action with the individual's right to choice of practitioner. In that case, the court ruled that an individual who was trained in

traditional acupuncture was qualified to render the treatment. In that case Judge McDonald stated:

> "And it is the individual making the decision, and no one else, who if he or she survives, must live with the result of that decision. One's health is a uniquely personal possession. The decision of how to treat that possession is of no less personal nature."

The uniqueness about the decision rendered in the *Schneider v. Revici* case, in my opinion, is the ability of a non-traditional or complementary health care treatment to withstand the rigors of the law and so to speak, land on all four feet. The judges did not refer to the non-traditional cancer therapy treatment as quackery, which is the usual tendency for medical orthodox circles and those in opposition to non-conventional treatments to do. This is a highly significant indicator, in my opinion. This speaks to me from a perspective that the courts are now not only entertaining, but listening very carefully to the issues surrounding health care freedoms and choices since previous case law has decided the individual's right to privacy and to take care of their body as they see fit. The uniqueness of the *Schneider* v. *Revici* case for me is that a precedent has been set in American case law which could have health care/legal ramifications. This case should become the legal keystone around which complementary health care can test the legal waters in great depths. I believe the *Schneider v. Revici* case has set precedents, not only for patient, physician and health care, but for ethics in medicine and law also. I see this case challenging to both plaintiff and defendant arguments. The debating skills of attorneys will be greatly taxed if they choose this case as their citation to illustrate a point of law, in my opinion. I feel this case has a uniqueness about it which can help the complementary/alternate health care treatment and modality protocols in a fashion which no case law heretofore has been able to do.

There has been no Constitutional decision saying that the right of privacy protects an individual at seeking out non-conventional care. That is precisely why *Schneider v. Revici is* an important decision. Although it is not on a Constitutional ground, it at least foreshadows the legal basis under the 1914 decision of *Schloendorf v. New York Hospital* and why perhaps it ought to have Constitutional dimensions.

The United States Court of Appeals for the Tenth Circuit in *Rutherford v. the United States* found the right of privacy protecting individual's choice of non-conventional care; the Supreme Court reversed, but not addressing that issue. The California Court of Appeals in *People* v. *Privitera,* which was a criminal case, the Court of Appeals reversed. Then the Court of Appeals found that the right of privacy protected the patient's rights to determine health care, and the California Supreme Court reversed, and said it didn't. *Schneider* v. *Revici* stands in contrast to Privitera and Rutherford. In both Privitera and Rutherford the mid-level courts of appeals, one a state court and one a federal court, found privacy protected in a cancer patient's right to choice and the Supreme Court of California and the Supreme Court of the United States said no, it didn't. *Schneider v. Revici* says it does!, but in a different context, as a matter of law generally and not in a Constitutional theory. (And that's why our coalition (CANAH) is seeking a Health Care Rights Amendment to the U.S. Constitution.)

For those of you interested in the legal citation for *Schneider* v. *Revici,* it is *817 F.2d 987 (2nd Cir. 1987).* The attorneys for Dr. Emanuel Revici are Samuel Abady and Rick Jaffe of the New York law firm of Abady and Jaffe.

I should like to acknowledge and to thank Mr. Samuel Abady for his telephone interview, legal/technical help to me in writing this article and for the splendid legal job he did in arguing this case.

In this article I have presented my personal opinions and viewpoints from my experience as a Legislative Advocate working for the legalization of alternate health care in the United States of America and as a lobbyist in Washington, D.C. working for that cause in representing the Coalition for Alternative in Nutrition and Health Care, Inc. (CANAH).

See also Book Review p. 33 The Great Medical Monopoly Wars.

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Pfizer to pay record $2.3B penalty over promotions

AP Associated Press

Repeat offender Pfizer paying record $2.3B settlement for illegal drug promotions

By Devin Barrett, Associated Press Writer
On Wednesday September 2, 2009, 3:47 pm EDT

Buzz up! 336 Print

Companies: Pfizer Inc. | Wyeth

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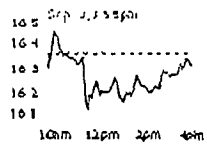
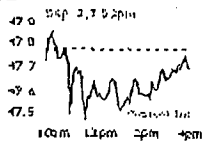
PFE	16.20	-0.10
WYE	47.56	-0.23





Announcing the penalty as a warning to all drug manufacturers, Justice Department officials said the overall settlement is the largest ever paid by a drug company for alleged violations of federal drug rules, and the $1.2 billion criminal fine is the largest ever in any U.S. criminal case. The total includes $1 billion in civil penalties and a $100 million criminal forfeiture.

Authorities called Pfizer a repeat offender, noting it is the company's fourth such settlement of government charges in the last decade. The allegations surround the marketing of 13 different drugs, including big sellers such as Viagra, Zoloft, and Lipitor.

As part of its illegal marketing, Pfizer invited doctors to consultant meetings at resort locations, paying their expenses and providing perks, prosecutors said.

"They were entertained with golf, massages, and other activities," said Mike Loucks, the U.S. attorney in Massachusetts.

Loucks said that even as Pfizer was negotiating deals on past misconduct, they were continuing to violate the very same laws with other drugs.

To prevent backsliding this time, Pfizer's conduct will be specially monitored by the Health and Human Service Department inspector general for five years.

In an unusual twist, the head of the Justice Department, Attorney General Eric Holder, did not participate in the record settlement, because he had represented Pfizer on these issues while in private practice.

Associate Attorney General Thomas Perrelli said the settlement illustrates ways the Justice Department "can help the American public at a time when budgets are tight and health care costs are rising."

Perrelli announced the settlement terms at a news conference with federal prosecutors and FBI, and Health and Human Services Department officials.

The settlement ends an investigation that also resulted in guilty pleas from two former Pfizer sales managers.

Officials said the U.S. industry has paid out more than $11 billion in such settlements over the past decade, but one consumer advocate voiced hope that Wednesday's penalty was so big it would curb the abuses.

"There's so much money in selling pills, that there's a tremendous temptation to cheat," said Bill Vaughan, an analyst at Consumers Union, the nonprofit publisher of Consumer Reports.

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"There's a kind of mentality in this sector that (settlements) are the cost of doing business and we can cheat. This penalty is so huge I think consumers can have some hope that maybe these guys will tighten up and run a better ship."

The government said the company promoted four prescription drugs, including the pain killer Bextra, as treatments for medical conditions different from those the drugs had been approved for by federal regulators. Authorities said Pfizer's salesmen and women created phony doctor requests for medical information in order to send unsolicited information to doctors about unapproved uses and dosages.

Use of drugs for so-called "off-label" medical conditions is not uncommon, but drug manufacturers are prohibited from marketing drugs for uses that have not been approved by the Food and Drug Administration. They said the junkets and other company-paid perks were designed to promote Bextra and other drugs, to doctors for unapproved uses and dosages, backed by false and misleading claims about safety and effectiveness.

Bextra, for instance, was approved for arthritis, but Pfizer promoted it for acute pain and surgical pain, and in dosages above the approved maximum. In 2005, Bextra, one of a class of painkillers known as Cox-2 inhibitors, was pulled from the U.S. market amid mounting evidence it raised the risk of heart attack, stroke and death.

A Pfizer subsidiary, Pharmacia and Upjohn Inc., which was acquired in 2003, has entered an agreement to plead guilty to one count of felony misbranding. The criminal case applied only to Bextra.

The $1 billion in civil penalties was related to Bextra and a number of other medicines.

A portion of the civil penalty will be distributed to 49 states and the District of Columbia, according to agreements with each state's Medicaid program.

Pfizer's top lawyer, Amy Schulman, said the settlements "bring final closure to significant legal matters and help to enhance our focus on what we do best — discovering, developing and delivering innovative medicines."

In her statement, Schulman said: "We regret certain actions taken in the past, but are proud of the action we've taken to strengthen our internal controls and pioneer new procedures."

In financial filings in January, the company had indicated that it would pay $2.3 billion over the allegations.

The civil settlement announced Wednesday covered Pfizer's promotions of Bextra, blockbuster nerve pain and epilepsy treatment Lyrica, schizophrenia medicine Geodon, antibiotic Zyvox and nine other medicines. The agreement with the Justice Department resolves the investigation into promotion of all those drugs, Pfizer said.

The government said Pfizer also paid kickbacks to market a host of big-name drugs: Aricept, Celebrex, Lipitor, Norvasc, Relpax, Viagra, Zithromax, Zoloft, and Zyrtec.

The allegations came to light thanks largely to five Pfizer employees and one Pennsylvania doctor, who will now share $102 million of the settlement money.

FBI Assistant Director Kevin Perkins praised the whistleblowers who decided to "speak out against a corporate giant that was blatantly violating the law and misleading the public through false marketing claims."

To rein in the abuses, the government's five-year monitoring will force Pfizer to notify doctors about Wednesday's agreement, encourage them to report any similar behavior, and publicly post any payments or perks it gives to doctors.

Under terms of the settlement, Pfizer must pay $1 billion to compensate Medicaid, Medicare, and other federal health care programs. Some of that money will be shared among the states: New York, for example, will receive $66 million, according to the state's attorney general, Andrew Cuomo.

When Pfizer originally disclosed the settlement figure, it also announced plans to acquire rival Wyeth for $68 billion. That deal, which would bolster Pfizer's position as the world's top drug maker by revenue, is expected to close before year's end.

Shares of Pfizer dropped 14 cents to $16.24 in midday trading.

AP Business Writer Linda A. Johnson in Trenton, N.J. contributed to this report.

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AMENDED IN SENATE APRIL 8, 2013

SENATE BILL **No. 117**

Introduced by Senator ~~Rubio~~ *Hueso*

January 17, 2013

An act to amend ~~Sections 116275, 116475, and 116590~~ *Section 2234.1* of, and to ~~add~~ *repeal* Section ~~116276 to,~~ *2257 of, the Business and Professions Code, and to amend Sections 109270, 109285, 109295, 109300, 109350, and 109375 of, and to add Article 2.5 (commencing with Section 109400) to Chapter 4 of Part 4 of Division 104 of,* the Health and Safety Code, relating to ~~drinking water.~~ *health care.*

LEGISLATIVE COUNSEL'S DIGEST

SB 117, as amended, ~~Rubio~~ *Hueso*. ~~Drinking water: State Water Resources Control Board.~~ *Integrative cancer treatment.*

Existing law prohibits the sale, prescription, or administration of a drug, medicine, compound, or device to be used in the diagnosis, treatment, alleviation, or cure of cancer unless it has been approved by the federal Food and Drug Administration or by the State Department of Public Health, as specified, and makes a violation of that provision a misdemeanor. The Medical Practice Act provides for the licensure and regulation of physicians and surgeons by the Medical Board of California and requires the board to take action against a licensee who is charged with unprofessional conduct. The act immunizes a physician and surgeon from discipline for providing advice or treatment that constitutes alternative or complementary medicine if the treatment or advice meets certain requirements. The Osteopathic Act provides for the licensure and regulation of osteopathic physicians and surgeons by the Osteopathic Medical Board of California and requires the board to enforce the Medical Practice Act with respect to its licensees.

This bill would prohibit a physician and surgeon, including an osteopathic physician and surgeon, from recommending, prescribing, or providing integrative cancer treatment, as defined, to cancer patients unless certain requirements are met. The bill would specify that a failure of a physician and surgeon to comply with these requirements constitutes unprofessional conduct and cause for discipline by the applicable licensing board. The bill would require the State Department of Public Health to investigate violations of these provisions and to hold hearings with respect to compliance with these provisions. The bill would make conforming changes to other related provisions.

~~Existing law, the California Safe Drinking Water Act, provides for the operation of public water systems, and imposes on the State Department of Public Health various responsibilities and duties. Existing law requires the department to conduct research, studies, and demonstration projects relating to the provision of a dependable, safe supply of drinking water, to adopt regulations to implement the California Safe Drinking Water Act, and to enforce provisions of the federal Safe Drinking Water Act.~~

~~This bill would transfer the various duties and responsibilities imposed on the department by the California Safe Drinking Water Act to the State Water Resources Control Board and make conforming changes.~~

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

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

1 *SECTION 1. Section 2234.1 of the Business and Professions*
2 *Code is amended to read:*
3 2234.1. (a) A physician and surgeon shall not be subject to
4 discipline pursuant to subdivision (b), (c), or (d) of Section 2234
5 solely on the basis that the treatment or advice he or she rendered
6 to a patient is alternative or complementary medicine, including
7 the treatment of persistent Lyme Disease, if that treatment or advice
8 meets ~~all~~ *one* of the following requirements*, as applicable*:
9 *(1) The treatment or advice is for a condition other than cancer*
10 *and meets all of the following requirements:*
11 ~~(1)~~
12 *(A)* It is provided after informed consent and a good-faith prior
13 examination of the patient, and medical indication exists for the
14 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~~of~~ *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 ~~it~~ *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 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.

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, in whole or in part, the conventional treatment for treating cancer in California.

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

(3) All or part of 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 one of the following requirements is met:

(a) The treatment is recognized by the Physician's Data Query of the National Cancer Institute.

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

(c) The treatment has 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.

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 his or her licensing board. That person shall not be subject to Section 109335 or 109370.

All matter omitted in this version of the bill appears in the bill as introduced in the Senate, January 17, 2013. (JR11)

O

SB 304

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 304
Author: Price
Bill Date: April 16, 2013, Amended
Subject: Healing Arts: Boards
Sponsor: Author

STATUS OF BILL:

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

DESCRIPTION OF CURRENT LEGISLATION:

This bill is the bill that would include language on a portion of the new issues from the Board's 2012 Sunset Review Report, and eventually, extend the Board's sunset date. This bill would also remove the sunset date from the provisions in existing law related to vertical enforcement.

ANALYSIS:

The Board included new issues in its 2012 Sunset Review Report to the Legislature and it its 2013 Supplemental Report. This report was submitted to the Legislature and the Legislature prepared a background paper that raised 39 issues, some of them related to the new issues included in the Board's Sunset Review Report. Here are the new issues that were included in the Board's Sunset Review Report that would require legislation:

- Revise existing law, Business and Professions (B&P) Code Section 2177, in order to accommodate the upcoming two parts of the United States Medical Licensing Examination Step 3 examination, and any new evolving examination requirement - **This bill does include language to accommodate two parts of the USMLE Step 3 examination**
- Require all licensees who have an email address to provide the Board with an email address, and specify that the email address shall be confidential - **This bill does include language that would require licensees who have an email address to provide the Board with an email address by July 1, 2014 and would specify that the email address is confidential and not subject to public disclosure.**
- The Board recommended that the requirement in existing law for the Board to post a physician's approved postgraduate training be eliminated - The Committee directed the Board to further discuss this proposal with stakeholders, including those stakeholders representing consumer interests and advise the Committee of the results of those

discussions, and submit language if appropriate.

- The Board recommended that it be clarified in statute that residents in California accredited resident/fellowship programs are exempt from corporate practice laws related to how they are paid – **This bill does include language that clarifies that the corporate practice laws do not apply to physicians enrolled in an approved residency postgraduate training programs or fellowship programs.**
- The Board recommended that a section be added to existing law to require coroners to report all deaths related to prescription drug overdoses to the Board – this language is contained in SB 62 (Price), which the Board currently has a support if amended position on.
- The Board recommended that legislation be introduced to provide an adequate funding source for CURES, so it can be funded and upgraded (e.g. all individuals who prescribe or dispense medications, pharmaceutical companies, and the public). The prescribers/dispensers would include physicians, dentists, pharmacists, veterinarians, nurse practitioners, physician assistants, osteopathic physicians, optometrists, and podiatrists. This funding source would support the necessary enhancements to the computer system and provide for adequate staffing to run the system – The CURES funding and upgrading language is included in SB 809 (DeSaulnier and Steinberg).
- The Board recommended that medical malpractice reports received pursuant to Section 801.01 be excluded from the requirements of in existing law that require review by a medical expert with the expertise necessary to evaluate the specific standard of care issue raised in the complaint – **This bill does include language to exclude 801.01 reports from upfront review.**
- The Board recommended that, in the interest of consumer protection, legislation be written to require that regulations be adopted for physician availability in all clinical settings and for the Board to establish by regulation the knowledge, training, and ability a physician must possess in order to supervise other health care providers – This issue was not addressed in the Committee's background paper and language is not included in this bill.
- The Board recommended that the law be amended to allow a facility only 15 days to provide medical records, upon request, if the facility has electronic health records (EHRs) – **This bill does include language to require health care facilities that have EHRs to provide the authorizing patient's certified medical records to the Board within 15 days of receiving the requires and would subject the health care facility to penalties if the timeline is not adhered to.**
- The Board recommended an amendment to existing law to require the California Department of Public Health (CDPH) and hospital accrediting agencies to send reportable peer review incidents found during an inspection of the facility to the Board and to require these entities to notify the Board if a hospital is not performing peer review - The Board was directed to further discuss this proposal with the Committee, and consideration should be given to the Board entering into an arrangement or a MOU with CDPH and hospital accrediting agencies to send reportable peer review incidents found during an inspection of the facility to the MBC; and to further require that these entities notify the Board if a hospital is not performing peer review. This bill does not

include language to address this issue.

- The Board recommended elimination of the ten year posting requirement in existing law in order to ensure transparency to the public – In the Committee's background paper, it was recommended that in the interest of transparency and disclosure of information to the public, existing law should be amended to remove the 10 year limit on how long information should be posted on the MBC's Internet Website; however, this bill does not include language that would remove the 10 year limit on posting information.
- The Board recommended amending existing law to require a respondent to provide the full expert witness report and to clarify the timeframes in existing law for providing the reports, such as 90 days from the filing of an accusation – **This bill does include language that would require the complete expert witness report to be provided and that would require the expert testimony information to be provided within 90 days from the filing of a notice of defense.**
- The Board recommended that the provision in existing law that requires the Board to approve non-ABMS specialty boards be deleted. The Board suggested that the law should continue to require physicians to advertise as board certified only if they have been certified by ABMS boards and the four additional boards currently approved by the Board – **This bill does delete provisions in existing law that require the Board to approve non-ABMS specialty boards and only allows physicians to advertise that they have been certified by a non-ABMS board approved by the Board if it was approved prior to January 1, 2014.**
- The Board in suggested that the transfer of the registered dispensing optician (RDO) Program to the Optometry Board or DCA should be examined – The Committee suggested that the Board initiate discussions with all stakeholders and report back to the Committees with findings by July 1, 2014. This bill does not include language to address this issue.
- The Board made suggestions related to the Licensed Midwifery Program, that the issue of physician supervision and obtaining lab accounts and medical supplies should be addressed through legislation – The Committee agreed and AB 1308, which is sponsored by the American Congress of Obstetricians and Gynecologists has been introduced and will be brought to the Board for a position.
- The Board recommended that the issue of midwife students/apprenticeships needs to be clarified in legislation, due to confusion in the midwifery community – **This bill includes language that would define a "bona fide student" as an individual who is enrolled and participating in a midwifery education program or who is enrolled in a program of supervised clinical training as part of the instruction of a three year postsecondary midwifery education program approved by the Board.**
- The Board recommended that the issue of midwife assistants needs to be addressed in legislation, and what duties the assistant may legally perform, as it has been brought to the attention of the Board that licensed midwives use midwife assistants and currently, there is no definition for a midwife assistant or the specific training requirements or the duties that a midwife assistant may perform – The Committee directed the Board to provide more information regarding the proposal to address the issue of midwife

assistants in legislation. This bill does not include language to address this issue.

- The Board suggested that existing law be amended in to include certified nurse midwives (CNM) as being able to supervise midwifery students – **This bill does include language that would allow a CNM to supervise a midwifery student.**
- The Board recommended that language be added to existing law to allow the Board the authority to issue a cease practice order in cases where a licensee fails to comply with an order to compel a physical or mental examination - **This bill does include language that would allow the Board to issue a cease practice order when a licensee fails to comply with an order issued under Section 820 to compel a physical or mental examination.**
- The Board recommended that existing law be amended to include American Osteopathic Association-Healthcare Facilities Accreditation Program as an approved accreditation agency for hospitals offering accredited postgraduate training programs – **This item that was suggested in the Supplemental Report, but was not addressed by the background paper as it was included after the paper was drafted and language was not included in this bill.**
- The Board recommended that the Vertical Enforcement Program be continued and stated that the Board and the Health Quality Enforcement Section (HQES) will continue to work together to establish best practices and identify areas where improvements can be made – **This bill would delete the sunset date in the vertical enforcement statutes, making vertical enforcement permanent. This bill would also require the Board, in consultation with the Department of Justice and the Department of Consumer Affairs to report and make recommendations to the Governor and the Legislature on the Vertical Enforcement Program by March 1, 2015.**

This bill would also extend the timeframe in which an accusation must be filed once an interim suspension order (ISO) is issued. Currently, in order for the Board to stop a physician from practicing while the physician is under investigation, the Board must request an Interim Suspension Order (ISO), which must be granted by an Administrative Law Judge (ALJ). In existing law there is a 15-day time restraint in law to file an accusation after being granted an ISO, and a 30-day time restraint between the accusation being filed and a hearing being set, which means an investigation must be nearly complete in order to file for an ISO. This bill would extend the timeframe to file an accusation from 15 days to 30 days, which would help to further the Board's mission of consumer protection.

This bill would address many of the new issues raised in the Board's 2012 Sunset Review Report and the 2013 Supplemental Report and includes language to make the legislative changes suggested by the Board to accommodate the continuing evolution of medical training and testing, to improve the efficiencies of the Board's Licensing and Enforcement Programs, and most importantly, to enhance consumer protection. There are some issues that the committee background paper didn't address or that recommended that the Board's changes be made, but that the changes aren't included in this bill, i.e., removing the 10-year posting requirement in existing law. More importantly, this bill no longer extends the

Board's sunset date, which must be extended in order for the Board to continue. Board staff is suggesting that the Board support this bill if it is amended to extend the sunset date and possibly include more new issues recommended by the Board.

FISCAL: None

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Support if Amended

AMENDED IN SENATE APRIL 16, 2013

SENATE BILL **No. 304**

Introduced by Senator Price
(Principal coauthor: Assembly Member Gordon)

February 15, 2013

An act to amend Sections ~~2001, 2020, 2569, 3010.5, and 3014.6 of~~ *651, 2021, 2177, 2220.08, 2225.5, 2334, 2514, and 2569 of, and to add Sections 2291.5 and 2403 to,* the Business and Professions Code, *and to amend Sections 11529, 12529.6, and 12529.7 of, and to amend and repeal Sections 12529 and 12529.5 of, the Government Code,* relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 304, as amended, Price. Healing arts: boards.

~~Existing law provides for the licensure and regulation of various healing arts licensees by various boards, as defined, within the Department of Consumer Affairs, including the Medical Board of California. Existing law requires the Governor to appoint members to the board, as provided. Existing law authorizes the board to employ an executive director. Existing law provides that those provisions will be repealed on January 1, 2014. Under existing law, the board is subject to evaluation by the Joint Sunset Review Committee.~~

~~This bill would instead repeal those provisions on January 1, 2018, and subject the board to review by the appropriate policy committees of the Legislature.~~

Existing law makes it unlawful for a healing arts practitioner to disseminate, or cause to be disseminated, any form of public communication containing a false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of, or likely to induce, the

rendering of professional services or furnishing of products in connection with the professional practice or business for which he or she is licensed. Existing law provides for the licensure of physicians and surgeons by the Medical Board of California. Existing law prohibits a physician and surgeon's advertisements from including a statement that he or she is certified or eligible for certification by a private or public board or parent association, including a multidisciplinary board or association, as defined, unless that board or association meets at least one of several standards, including being a board or association with equivalent requirements approved by that physician and surgeon's licensing board. A violation of these requirements is a crime.

This bill would limit the application of that exception to a board or association with equivalent requirements approved by that physician and surgeon's licensing board prior to January 1, 2014. The bill would establish that the exception continues to apply to a multidisciplinary board or association approved by the Medical Board of California prior to January 1, 2014.

Because the bill would specify additional provisions regarding the advertising practices of healing art practitioners, the violation of which would be a crime, it would impose a state-mandated local program.

Existing law authorizes the Medical Board of California, if it publishes a directory, as specified, to require persons licensed, as specified, to furnish specified information to the board for purposes of compiling the directory.

This bill would require that an applicant and licensee who has an electronic mail address report to the board that electronic mail address no later than July 1, 2014. The bill would provide that the electronic mail address is to be considered confidential, as specified.

Existing law requires an applicant for a physician and surgeon's certificate to obtain a passing score on step 3 of the United States Medical Licensing Examination with not more than 4 attempts, subject to an exception.

This bill would require an applicant to have obtained a passing score on all parts of that examination with not more than 4 attempts, subject to the exception.

Existing law requires that a complaint, with exceptions, received by the board determined to involve quality of care, before referral to a field office for further investigation, meet certain criteria.

This bill would expand the types of reports that are exempted from that requirement.

Existing law provides for a civil penalty of up to $1,000 per day, as specified, to be imposed on a health care facility that fails to comply with a patient's medical record request, as specified, within 30 days.

This bill would shorten the time limit for compliance to 15 days for those health care facilities that have electronic health records.

Under existing law, if a healing arts practioner may be unable to practice his or her profession safely due to mental or physical illness, the licensing agency may order the licentiate to be examined by specified professionals.

This bill would require that a physician and surgeon's failure to comply with an order related to these examination requirements shall result in the issuance of notification from the board to cease the practice of medicine immediately until the ordered examinations have been completed and would provide that continued failure to comply would be grounds for suspension or revocation of his or her certificate.

Existing law prohibits a party from bringing expert testimony in a matter brought by the board unless certain information is exchanged in written form with counsel for the other party, as specified, within 30 calendar days prior to the commencement of the hearing. Existing law provides that the information exchanged include a brief narrative statement of the testimony the expert is expected to bring.

This bill would instead require that information to be exchanged within 90 days from the filing of a notice of defense and would instead require the information to include a complete expert witness report.

Existing law establishes that corporations and other artificial legal entities have no professional rights, privileges, or powers.

This bill would provide that those provisions do not apply to physicians and surgeons enrolled in approved residency postgraduate training programs or fellowship programs.

Existing law, the Licensed Midwifery Practice Act of 1993, licenses and regulates licensed midwives by the Medical Board of California. Existing law specifies that a midwife student meeting certain conditions is not precluded from engaging in the practice of midwifery as part of his or her course of study, if certain conditions are met, including, that the student is under the supervision of a licensed midwife.

This bill would require that to engage in those practices, the student is to be enrolled and participating in a midwifery education program or enrolled in a program of supervised clinical training, as provided. The bill would add that the student is permitted to engage in those

practices if he or she is under the supervision of a licensed nurse-midwife.

Existing law provides for the regulation of registered dispensing opticians by the Medical Board of California and requires that the powers and duties of the board in that regard be subject to review by the Joint Sunset Review Committee as if those provisions were scheduled to be repealed on January 1, 2014.

This bill would instead make the powers and duties of the board subject to review by the appropriate policy committees of the Legislature as if those provisions were scheduled to be repealed on January 1, 2018.

Existing law authorizes the administrative law judge of the Medical Quality Hearing Panel to issue an interim order related to licenses, as provided. Existing law requires that in all of those cases in which an interim order is issued, and an accusation is not filed and served within 15 days of the date in which the parties to the hearing have submitted the matter, the order be dissolved.

This bill would extend the time in which the accusation must be filed and served to 30 days from the date on which the parties to the hearing submitted the matter.

Existing law establishes the Health Quality Enforcement Section within the Department of Justice to carry out certain duties. Existing law provides for the funding for the section, and for the appointment of a Senior Assistant Attorney General to the section to carry out specified duties. Existing law requires that all complaints or relevant information concerning licensees that are within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, or the Board of Psychology be made available to the Health Quality Enforcement Section. Existing law establishes the procedures for processing the complaints, assisting the boards or committees in establishing training programs for their staff, and for determining whether to bring a disciplinary proceeding against a licensee of the boards. Existing law provides for the repeal of those provisions, as provided, on January 1, 2014.

This bill would extend the operation of those provisions indefinitely.

Existing law establishes a vertical enforcement and prosecution model for cases before the Medical Board of California. Existing law requires that a complaint referred to a district office of the board for investigation also be simultaneously and jointly assigned to an investigator and to the deputy attorney general in the Health and Quality Enforcement Section, as provided. Existing law provides for the repeal of those

provisions, as provided, on January 1, 2014. Existing law requires the board to report to the Governor and Legislature on the vertical prosecution model by March 1, 2012.

This bill would extend the operation of those provisions indefinitely and would extend the date that report is due to March 1, 2015.

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 provides for the licensure and regulation of optometrists by the State Board of Optometry. Existing law requires that the board consist of specified members and authorizes the board to appoint an executive officer. Existing law repeals those provisions on January 1, 2014 and subjects the board to review by the Joint Sunset Review Committee.~~

~~This bill would instead repeal those provisions on January 1, 2018, and require that the board be subject to review by the appropriate policy committees of the Legislature.~~

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

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

1 ~~SECTION 1. Section 2001 of the Business and Professions~~
2 ~~Code is amended to read:~~
3 ~~2001. (a) There is in the Department of Consumer Affairs a~~
4 ~~Medical Board of California that consists of 15 members, seven~~
5 ~~of whom shall be public members.~~
6 ~~(b) The Governor shall appoint 13 members to the board, subject~~
7 ~~to confirmation by the Senate, five of whom shall be public~~
8 ~~members. The Senate Committee on Rules and the Speaker of the~~
9 ~~Assembly shall each appoint a public member.~~
10 ~~(c) This section shall remain in effect only until January 1, 2018,~~
11 ~~and as of that date is repealed, unless a later enacted statute, that~~
12 ~~is enacted before January 1, 2018, deletes or extends that date.~~
13 ~~Notwithstanding any other law, the repeal of this section renders~~
14 ~~the board subject to review by the appropriate policy committees~~
15 ~~of the Legislature.~~

~~SEC. 2. Section 2020 of the Business and Professions Code is amended to read:~~

~~2020. (a) The board may employ an executive director exempt from the provisions of the Civil Service Act and may also employ investigators, legal counsel, medical consultants, and other assistance as it may deem necessary to carry this chapter into effect. The board may fix the compensation to be paid for services subject to the provisions of applicable state laws and regulations and may incur other expenses as it may deem necessary. Investigators employed by the board shall be provided special training in investigating medical practice activities.~~

~~(b) The Attorney General shall act as legal counsel for the board for any judicial and administrative proceedings and his or her services shall be a charge against it.~~

~~(c) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.~~

SECTION 1. Section 651 of the Business and Professions Code is amended to read:

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

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

(1) Contains a misrepresentation of fact.

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

(3) (A) Is intended or is likely to create false or unjustified expectations of favorable results, including the use of any photograph or other image that does not accurately depict the

results of the procedure being advertised or that has been altered in any manner from the image of the actual subject depicted in the photograph or image.

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

(C) Use of any photograph or other image of an actual patient that depicts or purports to depict the results of any procedure, or presents "before" and "after" views of a patient, without specifying in a prominent location in easily readable type size what procedures were performed on that patient is a violation of subdivision (a). Any "before" and "after" views (i) shall be comparable in presentation so that the results are not distorted by favorable poses, lighting, or other features of presentation, and (ii) shall contain a statement that the same "before" and "after" results may not occur for all patients.

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

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

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

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

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

(c) Any price advertisement shall be exact, without the use of phrases, including, but not limited to, "as low as," "and up," "lowest prices," or words or phrases of similar import. Any advertisement that refers to services, or costs for services, and that uses words of comparison shall be based on verifiable data

substantiating the comparison. Any person so advertising shall be prepared to provide information sufficient to establish the accuracy of that comparison. Price advertising shall not be fraudulent, deceitful, or misleading, including statements or advertisements of bait, discount, premiums, gifts, or any statements of a similar nature. In connection with price advertising, the price for each product or service shall be clearly identifiable. The price advertised for products shall include charges for any related professional services, including dispensing and fitting services, unless the advertisement specifically and clearly indicates otherwise.

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

(e) Any person so licensed may not use any professional card, professional announcement card, office sign, letterhead, telephone directory listing, medical list, medical directory listing, or a similar professional notice or device if it includes a statement or claim that is false, fraudulent, misleading, or deceptive within the meaning of subdivision (b).

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

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

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

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

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

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

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

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

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

(C) A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California may include a statement that he or she limits his or her practice to specific fields, but shall not include a statement that he or she is certified or eligible for certification by a private or public board or parent association, ~~including, but not limited to, a multidisciplinary board or association,~~ unless that board or association is (i) an American Board of Medical Specialties member board, (ii) a board or association with equivalent requirements approved by that physician and surgeon's licensing ~~board,~~ *board prior to January 1, 2014,* or (iii) a board or association with an Accreditation Council for Graduate Medical Education approved postgraduate training program that provides complete training in that specialty or subspecialty. A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by an organization other than a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" in reference to that certification, unless the physician and surgeon is also licensed under Chapter 4 (commencing with Section 1600) and the use of the term "board certified" in reference to that certification is in accordance with subparagraph (A). A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" unless the full name of the certifying board is also used and given comparable prominence with the term "board certified" in the statement.

~~For purposes of this subparagraph, a "multidisciplinary board or association" means an educational certifying body that has a psychometrically valid testing process, as determined by the Medical Board of California, for certifying medical doctors and other health care professionals that is based on the applicant's education, training, and experience.~~

A multidisciplinary board or association approved by the Medical Board of California prior to January 1, 2014, shall retain that approval.

For purposes of the term "board certified," as used in this subparagraph, the terms "board" and "association" mean an organization that is an American Board of Medical Specialties member board, an organization with equivalent requirements approved by a physician and surgeon's licensing ~~board,~~ *board prior to January 1, 2014,* or an organization with an Accreditation Council for Graduate Medical Education approved postgraduate training program that provides complete training in a specialty or subspecialty.

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

(D) A doctor of podiatric medicine licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California may include a statement that he or she is certified or eligible or qualified for certification by a private or public board or parent association, including, but not limited to, a multidisciplinary board or association, if that board or association meets one of the following requirements: (i) is approved by the Council on Podiatric Medical Education, (ii) is a board or association with equivalent requirements approved by the California Board of Podiatric Medicine, or (iii) is a board or association with the Council on Podiatric Medical Education approved postgraduate training programs that provide training in podiatric medicine and podiatric surgery. A doctor of podiatric medicine licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" unless the full name of the certifying board is also used and given comparable prominence with the term

"board certified" in the statement. A doctor of podiatric medicine licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by an organization other than a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" in reference to that certification.

For purposes of this subparagraph, a "multidisciplinary board or association" means an educational certifying body that has a psychometrically valid testing process, as determined by the California Board of Podiatric Medicine, for certifying doctors of podiatric medicine that is based on the applicant's education, training, and experience. For purposes of the term "board certified," as used in this subparagraph, the terms "board" and "association" mean an organization that is a Council on Podiatric Medical Education approved board, an organization with equivalent requirements approved by the California Board of Podiatric Medicine, or an organization with a Council on Podiatric Medical Education approved postgraduate training program that provides training in podiatric medicine and podiatric surgery.

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

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

(7) A statement of names of schools and postgraduate clinical training programs from which the practitioner has graduated, together with the degrees received.

(8) A statement of publications authored by the practitioner.

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

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

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

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

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

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

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

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

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

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

Each of the healing arts boards and committees and examining committees within Division 2 shall, by regulation, define those efficacious services to be advertised by businesses or professions under their jurisdiction for the purpose of determining whether advertisements are false or misleading. Until a definition for that service has been issued, no advertisement for that service shall be disseminated. However, if a definition of a service has not been issued by a board or committee within 120 days of receipt of a request from a licensee, all those holding the license may advertise the service. Those boards and committees shall adopt or modify regulations defining what services may be advertised, the manner in which defined services may be advertised, and restricting advertising that would promote the inappropriate or excessive use of health services or commodities. A board or committee shall not, by regulation, unreasonably prevent truthful, nondeceptive price or otherwise lawful forms of advertising of services or commodities, by either outright prohibition or imposition of onerous disclosure requirements. However, any member of a board or committee acting in good faith in the adoption or enforcement of any regulation shall be deemed to be acting as an agent of the state.

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

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

SEC. 2. Section 2021 of the Business and Professions Code is amended to read:

2021. (a) If the board publishes a directory pursuant to Section 112, it may require persons licensed pursuant to this chapter to furnish any information as it may deem necessary to enable it to compile the directory.

(b) Each licensee shall report to the board each and every change of address within 30 days after each change, giving both the old and new address. If an address reported to the board at the time of application for licensure or subsequently is a post office box, the applicant shall also provide the board with a street address. If another address is the licensee's address of record, he or she may request that the second address not be disclosed to the public.

(c) Each licensee shall report to the board each and every change of name within 30 days after each change, giving both the old and new names.

(d) Each applicant and licensee who has an electronic mail address shall report to the board that electronic mail address no later than July 1, 2014. The electronic mail address shall be considered confidential and not subject to public disclosure.

~~(d)~~

(e) The board shall annually send an electronic notice to each applicant and licensee ~~who has chosen to receive correspondence via electronic mail~~ that requests confirmation from the applicant or licensee that his or her electronic mail address is current. ~~An applicant or licensee that does not confirm his or her electronic mail address shall receive correspondence at a mailing address provided pursuant to subdivision (b).~~

SEC. 3. Section 2177 of the Business and Professions Code is amended to read:

2177. (a) A passing score is required for an entire examination or for each part of an examination, as established by resolution of the board.

(b) Applicants may elect to take the written examinations conducted or accepted by the board in separate parts.

(c) (1) An applicant shall have obtained a passing score on *all parts of* Step 3 of the United States Medical Licensing Examination within not more than four attempts in order to be eligible for a physician's and surgeon's certificate.

(2) Notwithstanding paragraph (1), an applicant who obtains a passing score on *all parts of* Step 3 of the United States Medical Licensing Examination in more than four attempts and who meets the requirements of Section 2135.5 shall be eligible to be considered for issuance of a physician's and surgeon's certificate.

SEC. 4. Section 2220.08 of the Business and Professions Code is amended to read:

2220.08. (a) Except for reports received by the board pursuant to Section *801.01 or* 805 that may be treated as complaints by the board and new complaints relating to a physician and surgeon who is the subject of a pending accusation or investigation or who is on probation, any complaint determined to involve quality of care, before referral to a field office for further investigation, shall meet the following criteria:

(1) It shall be reviewed by one or more medical experts with the pertinent education, training, and expertise to evaluate the specific standard of care issues raised by the complaint to determine if further field investigation is required.

(2) It shall include the review of the following, which shall be requested by the board:

(A) Relevant patient records.

(B) The statement or explanation of the care and treatment provided by the physician and surgeon.

(C) Any additional expert testimony or literature provided by the physician and surgeon.

(D) Any additional facts or information requested by the medical expert reviewers that may assist them in determining whether the care rendered constitutes a departure from the standard of care.

(b) If the board does not receive the information requested pursuant to paragraph (2) of subdivision (a) within 10 working days of requesting that information, the complaint may be reviewed by the medical experts and referred to a field office for investigation without the information.

(c) Nothing in this section shall impede the board's ability to seek and obtain an interim suspension order or other emergency relief.

SEC. 5. Section 2225.5 of the Business and Professions Code is amended to read:

2225.5. (a) (1) A licensee who fails or refuses to comply with a request for the certified medical records of a patient, that is accompanied by that patient's written authorization for release of records to the board, within 15 days of receiving the request and authorization, shall pay to the board a civil penalty of one thousand dollars ($1,000) per day for each day that the documents have not been produced after the 15th day, up to ten thousand dollars ($10,000), unless the licensee is unable to provide the documents within this time period for good cause.

(2) A health care facility shall comply with a request for the certified medical records of a patient that is accompanied by that patient's written authorization for release of records to the board together with a notice citing this section and describing the penalties for failure to comply with this section. Failure to provide the authorizing patient's certified medical records to the board within 30 days of receiving the request, authorization, and notice shall subject the health care facility to a civil penalty, payable to the board, of up to one thousand dollars ($1,000) per day for each day that the documents have not been produced after the 30th day, up to ten thousand dollars ($10,000), unless the health care facility is unable to provide the documents within this time period for good cause. *For health care facilities that have electronic health records, failure to provide the authorizing patient's certified medical*

records to the board within 15 days of receiving the request, authorization, and notice shall subject the health care facility to a civil penalty, payable to the board, of up to one thousand dollars ($1,000) per day for each day that the documents have not been produced after the 15th day, up to ten thousand dollars ($10,000), unless the health care facility is unable to provide the documents within this time period for good cause. This paragraph shall not require health care facilities to assist the board in obtaining the patient's authorization. The board shall pay the reasonable costs of copying the certified medical records.

(b) (1) A licensee who fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the board shall pay to the board a civil penalty of one thousand dollars ($1,000) per day for each day that the documents have not been produced after the date by which the court order requires the documents to be produced, up to ten thousand dollars ($10,000), unless it is determined that the order is unlawful or invalid. Any statute of limitations applicable to the filing of an accusation by the board shall be tolled during the period the licensee is out of compliance with the court order and during any related appeals.

(2) Any licensee who fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the board is guilty of a misdemeanor punishable by a fine payable to the board not to exceed five thousand dollars ($5,000). The fine shall be added to the licensee's renewal fee if it is not paid by the next succeeding renewal date. Any statute of limitations applicable to the filing of an accusation by the board shall be tolled during the period the licensee is out of compliance with the court order and during any related appeals.

(3) A health care facility that fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of patient records to the board, that is accompanied by a notice citing this section and describing the penalties for failure to comply with this section, shall pay to the board a civil penalty of up to one thousand dollars ($1,000) per day for each day that the documents have not been produced, up to ten thousand dollars ($10,000), after the date by which the court order requires the documents to be produced, unless it is determined that the order is unlawful or invalid. Any statute of limitations applicable to the

filing of an accusation by the board against a licensee shall be tolled during the period the health care facility is out of compliance with the court order and during any related appeals.

(4) Any health care facility that fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the board is guilty of a misdemeanor punishable by a fine payable to the board not to exceed five thousand dollars ($5,000). Any statute of limitations applicable to the filing of an accusation by the board against a licensee shall be tolled during the period the health care facility is out of compliance with the court order and during any related appeals.

(c) Multiple acts by a licensee in violation of subdivision (b) shall be punishable by a fine not to exceed five thousand dollars ($5,000) or by imprisonment in a county jail not exceeding six months, or by both that fine and imprisonment. Multiple acts by a health care facility in violation of subdivision (b) shall be punishable by a fine not to exceed five thousand dollars ($5,000) and shall be reported to the State Department of Public Health and shall be considered as grounds for disciplinary action with respect to licensure, including suspension or revocation of the license or certificate.

(d) A failure or refusal of a licensee to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the board constitutes unprofessional conduct and is grounds for suspension or revocation of his or her license.

(e) Imposition of the civil penalties authorized by this section shall be in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Division 3 of Title 2 of the Government Code).

(f) For purposes of this section, "certified medical records" means a copy of the patient's medical records authenticated by the licensee or health care facility, as appropriate, on a form prescribed by the board.

(g) For purposes of this section, a "health care facility" means a clinic or health facility licensed or exempt from licensure pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.

SEC. 6: Section 2291.5 is added to the Business and Professions Code, to read:

2291.5. A physician and surgeon's failure to comply with an order issued under Section 820 shall result in the issuance of notification from the board to cease the practice of medicine immediately upon the receipt of that notification. The physician and surgeon shall cease the practice of medicine until the ordered examinations have been completed. A physician and surgeon's continued failure to comply with an order issued under Section 820 shall constitute grounds for suspension or revocation of his or her certificate.

SEC. 7. Section 2334 of the Business and Professions Code is amended to read:

2334. (a) Notwithstanding any other provision of law, with respect to the use of expert testimony in matters brought by the Medical Board of California, no expert testimony shall be permitted by any party unless the following information is exchanged in written form with counsel for the other ~~party, as ordered by the Office of Administrative Hearings:~~ *party within 90 days from the filing of a notice of defense:*

(1) A curriculum vitae setting forth the qualifications of the expert.

(2) ~~A brief narrative statement of the general substance of the testimony that the expert is expected to give, including any opinion testimony and its basis.~~ *A complete expert witness report.*

(3) A representation that the expert has agreed to testify at the hearing.

(4) A statement of the expert's hourly and daily fee for providing testimony and for consulting with the party who retained his or her services.

~~(b) The exchange of the information described in subdivision (a) shall be completed at least 30 calendar days prior to the commencement date of the hearing.~~

~~(c)~~

(b) The Office of Administrative Hearings may adopt regulations governing the required exchange of the information described in this section.

SEC. 8. Section 2403 is added to the Business and Professions Code, to read:

2403. The provisions of Section 2400 do not apply to physicians and surgeons enrolled in approved residency postgraduate training programs or fellowship programs.

SEC. 9. Section 2514 of the Business and Professions Code is amended to read:

2514. *(a)* Nothing in this chapter shall be construed to prevent a bona fide student ~~who is enrolled or participating in a midwifery education program or who is enrolled in a program of supervised clinical training~~ from engaging in the practice of midwifery in this state, as part of his or her course of study, if both of the following conditions are met:

~~(a)~~

(1) The student is under the supervision of a licensed ~~midwife,~~ *midwife or certified nurse-midwife,* who holds a clear and unrestricted license in this state, who is present on the premises at all times client services are provided, and who is practicing pursuant to Section 2507 *or 2746.5*, or a physician and surgeon.

~~(b)~~

(2) The client is informed of the student's status.

(b) For the purposes of this section, a "bona fide student" means an individual who is enrolled and participating in a midwifery education program or who is enrolled in a program of supervised clinical training as part of the instruction of a three year postsecondary midwifery education program approved by the board.

~~SEC. 3.~~

SEC. 10. Section 2569 of the Business and Professions Code is amended to read:

2569. Notwithstanding any other law, the powers and duties of the board, as set forth in this chapter, shall be subject to review by the appropriate policy committees of the Legislature. The review shall be performed as if this chapter were scheduled to be repealed as of January 1, 2018.

SEC. 11. Section 11529 of the Government Code is amended to read:

11529. (a) The administrative law judge of the Medical Quality Hearing Panel established pursuant to Section 11371 may issue an interim order suspending a license, or imposing drug testing, continuing education, supervision of procedures, or other license restrictions. Interim orders may be issued only if the affidavits in support of the petition show that the licensee has engaged in, or is about to engage in, acts or omissions constituting a violation of the Medical Practice Act or the appropriate practice act governing

each allied health profession, or is unable to practice safely due to a mental or physical condition, and that permitting the licensee to continue to engage in the profession for which the license was issued will endanger the public health, safety, or welfare.

(b) All orders authorized by this section shall be issued only after a hearing conducted pursuant to subdivision (d), unless it appears from the facts shown by affidavit that serious injury would result to the public before the matter can be heard on notice. Except as provided in subdivision (c), the licensee shall receive at least 15 days' prior notice of the hearing, which notice shall include affidavits and all other information in support of the order.

(c) If an interim order is issued without notice, the administrative law judge who issued the order without notice shall cause the licensee to be notified of the order, including affidavits and all other information in support of the order by a 24-hour delivery service. That notice shall also include the date of the hearing on the order, which shall be conducted in accordance with the requirement of subdivision (d), not later than 20 days from the date of issuance. The order shall be dissolved unless the requirements of subdivision (a) are satisfied.

(d) For the purposes of the hearing conducted pursuant to this section, the licentiate shall, at a minimum, have the following rights:

(1) To be represented by counsel.

(2) To have a record made of the proceedings, copies of which may be obtained by the licentiate upon payment of any reasonable charges associated with the record.

(3) To present written evidence in the form of relevant declarations, affidavits, and documents.

The discretion of the administrative law judge to permit testimony at the hearing conducted pursuant to this section shall be identical to the discretion of a superior court judge to permit testimony at a hearing conducted pursuant to Section 527 of the Code of Civil Procedure.

(4) To present oral argument.

(e) Consistent with the burden and standards of proof applicable to a preliminary injunction entered under Section 527 of the Code of Civil Procedure, the administrative law judge shall grant the interim order where, in the exercise of discretion, the administrative law judge concludes that:

(1) There is a reasonable probability that the petitioner will prevail in the underlying action.

(2) The likelihood of injury to the public in not issuing the order outweighs the likelihood of injury to the licensee in issuing the order.

(f) In all cases where an interim order is issued, and an accusation is not filed and served pursuant to Sections 11503 and 11505 within ~~15~~ *30* days of the date in which the parties to the hearing on the interim order have submitted the matter, the order shall be dissolved.

Upon service of the accusation the licensee shall have, in addition to the rights granted by this section, all of the rights and privileges available as specified in this chapter. If the licensee requests a hearing on the accusation, the board shall provide the licensee with a hearing within 30 days of the request, unless the licensee stipulates to a later hearing, and a decision within 15 days of the date the decision is received from the administrative law judge, or the board shall nullify the interim order previously issued, unless good cause can be shown by the Division of Medical Quality for a delay.

(g) Where an interim order is issued, a written decision shall be prepared within 15 days of the hearing, by the administrative law judge, including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached.

(h) Notwithstanding the fact that interim orders issued pursuant to this section are not issued after a hearing as otherwise required by this chapter, interim orders so issued shall be subject to judicial review pursuant to Section 1094.5 of the Code of Civil Procedure. The relief which may be ordered shall be limited to a stay of the interim order. Interim orders issued pursuant to this section are final interim orders and, if not dissolved pursuant to subdivision (c) or (f), may only be challenged administratively at the hearing on the accusation.

(i) The interim order provided for by this section shall be:

(1) In addition to, and not a limitation on, the authority to seek injunctive relief provided for in the Business and Professions Code.

(2) A limitation on the emergency decision procedure provided in Article 13 (commencing with Section 11460.10) of Chapter 4.5.

SEC. 12. Section 12529 of the Government Code, as amended by Section 112 of Chapter 332 of the Statutes of 2012, is amended to read:

12529. (a) There is in the Department of Justice the Health Quality Enforcement Section. The primary responsibility of the section is to investigate and prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Psychology, or any committee under the jurisdiction of the Medical Board of California.

(b) The Attorney General shall appoint a Senior Assistant Attorney General of the Health Quality Enforcement Section. The Senior Assistant Attorney General of the Health Quality Enforcement Section shall be an attorney in good standing licensed to practice in the State of California, experienced in prosecutorial or administrative disciplinary proceedings and competent in the management and supervision of attorneys performing those functions.

(c) The Attorney General shall ensure that the Health Quality Enforcement Section is staffed with a sufficient number of experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions against the licensees of the board.

(d) Funding for the Health Quality Enforcement Section shall be budgeted in consultation with the Attorney General from the special funds financing the operations of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Psychology, and the committees under the jurisdiction of the Medical Board of California, with the intent that the expenses be proportionally shared as to services rendered.

~~(e) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.~~

SEC. 13. Section 12529 of the Government Code, as amended by Section 113 of Chapter 332 of the Statutes of 2012, is repealed.

~~12529. (a) There is in the Department of Justice the Health Quality Enforcement Section. The primary responsibility of the section is to prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Psychology,~~

~~or any committee under the jurisdiction of the Medical Board of California, and to provide ongoing review of the investigative activities conducted in support of those prosecutions, as provided in subdivision (b) of Section 12529.5.~~

~~(b) The Attorney General shall appoint a Senior Assistant Attorney General of the Health Quality Enforcement Section. The Senior Assistant Attorney General of the Health Quality Enforcement Section shall be an attorney in good standing licensed to practice in the State of California, experienced in prosecutorial or administrative disciplinary proceedings and competent in the management and supervision of attorneys performing those functions.~~

~~(c) The Attorney General shall ensure that the Health Quality Enforcement Section is staffed with a sufficient number of experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions against the licensees of the board.~~

~~(d) Funding for the Health Quality Enforcement Section shall be budgeted in consultation with the Attorney General from the special funds financing the operations of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Psychology, and the committees under the jurisdiction of the Medical Board of California, with the intent that the expenses be proportionally shared as to services rendered.~~

~~(e) This section shall become operative January 1, 2014.~~

SEC. 14. Section 12529.5 of the Government Code, as amended by Section 114 of Chapter 332 of the Statutes of 2012, is amended to read:

12529.5. (a) All complaints or relevant information concerning licensees that are within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, or the Board of Psychology shall be made available to the Health Quality Enforcement Section.

(b) The Senior Assistant Attorney General of the Health Quality Enforcement Section shall assign attorneys to work on location at the intake unit of the boards described in subdivision (d) of Section 12529 to assist in evaluating and screening complaints and to assist in developing uniform standards and procedures for processing complaints.

(c) The Senior Assistant Attorney General or his or her deputy attorneys general shall assist the boards or committees in designing and providing initial and in-service training programs for staff of the boards or committees, including, but not limited to, information collection and investigation.

(d) The determination to bring a disciplinary proceeding against a licensee of the boards shall be made by the executive officer of the boards or committees as appropriate in consultation with the senior assistant.

~~(e) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.~~

SEC. 15. Section 12529.5 of the Government Code, as amended by Section 115 of Chapter 332 of the Statutes of 2012, is repealed.

~~12529.5. (a) All complaints or relevant information concerning licensees that are within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, or the Board of Psychology shall be made available to the Health Quality Enforcement Section.~~

~~(b) The Senior Assistant Attorney General of the Health Quality Enforcement Section shall assign attorneys to assist the boards in intake and investigations and to direct discipline-related prosecutions. Attorneys shall be assigned to work closely with each major intake and investigatory unit of the boards, to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations.~~

~~A deputy attorney general of the Health Quality Enforcement Section shall frequently be available on location at each of the working offices at the major investigation centers of the boards, to provide consultation and related services and engage in case review with the boards' investigative, medical advisory, and intake staff. The Senior Assistant Attorney General and deputy attorneys general working at his or her direction shall consult as appropriate with the investigators of the boards, medical advisors, and executive staff in the investigation and prosecution of disciplinary cases.~~

~~(c) The Senior Assistant Attorney General or his or her deputy attorneys general shall assist the boards or committees in designing and providing initial and in-service training programs for staff of~~

~~the boards or committees, including, but not limited to, information collection and investigation.~~

~~(d) The determination to bring a disciplinary proceeding against a licensee of the boards shall be made by the executive officer of the boards or committees as appropriate in consultation with the senior assistant.~~

~~(e) This section shall become operative January 1, 2014.~~

SEC. 16. Section 12529.6 of the Government Code is amended to read:

12529.6. (a) The Legislature finds and declares that the Medical Board of California, by ensuring the quality and safety of medical care, performs one of the most critical functions of state government. Because of the critical importance of the board's public health and safety function, the complexity of cases involving alleged misconduct by physicians and surgeons, and the evidentiary burden in the board's disciplinary cases, the Legislature finds and declares that using a vertical enforcement and prosecution model for those investigations is in the best interests of the people of California.

(b) Notwithstanding any other provision of law, as of January 1, 2006, each complaint that is referred to a district office of the board for investigation shall be simultaneously and jointly assigned to an investigator and to the deputy attorney general in the Health Quality Enforcement Section responsible for prosecuting the case if the investigation results in the filing of an accusation. The joint assignment of the investigator and the deputy attorney general shall exist for the duration of the disciplinary matter. During the assignment, the investigator so assigned shall, under the direction but not the supervision of the deputy attorney general, be responsible for obtaining the evidence required to permit the Attorney General to advise the board on legal matters such as whether the board should file a formal accusation, dismiss the complaint for a lack of evidence required to meet the applicable burden of proof, or take other appropriate legal action.

(c) The Medical Board of California, the Department of Consumer Affairs, and the Office of the Attorney General shall, if necessary, enter into an interagency agreement to implement this section.

(d) This section does not affect the requirements of Section 12529.5 as applied to the Medical Board of California where

complaints that have not been assigned to a field office for investigation are concerned.

(e) It is the intent of the Legislature to enhance the vertical enforcement and prosecution model as set forth in subdivision (a). The Medical Board of California shall do all of the following:

(1) Increase its computer capabilities and compatibilities with the Health Quality Enforcement Section in order to share case information.

(2) Establish and implement a plan to locate its enforcement staff and the staff of the Health Quality Enforcement Section in the same offices, as appropriate, in order to carry out the intent of the vertical enforcement and prosecution model.

(3) Establish and implement a plan to assist in team building between its enforcement staff and the staff of the Health Quality Enforcement Section in order to ensure a common and consistent knowledge base.

~~(f) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.~~

SEC. 17. Section 12529.7 of the Government Code is amended to read:

12529.7. By March 1, ~~2012,~~ *2015,* the Medical Board of California, in consultation with the Department of Justice and the Department of Consumer Affairs, shall report and make recommendations to the Governor and the Legislature on the vertical enforcement and prosecution model created under Section 12529.6.

SEC. 18. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

~~SEC. 4. Section 3010.5 of the Business and Professions Code is amended to read:~~

~~3010.5. (a) There is in the Department of Consumer Affairs a State Board of Optometry in which the enforcement of this~~

~~chapter is vested. The board consists of 11 members, five of whom shall be public members.~~

~~Six members of the board shall constitute a quorum.~~

~~(b) The board shall, with respect to conducting investigations, inquiries, and disciplinary actions and proceedings, have the authority previously vested in the board as created pursuant to Section 3010. The board may enforce any disciplinary actions undertaken by that board.~~

~~(c) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date. Notwithstanding any other law, the repeal of this section renders the board subject to review by the appropriate policy committees of the Legislature.~~

~~SEC. 5. Section 3014.6 of the Business and Professions Code is amended to read:~~

~~3014.6. (a) The board may appoint a person exempt from civil service who shall be designated as an executive officer and who shall exercise the powers and perform the duties delegated by the board and vested in him or her by this chapter.~~

~~(b) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.~~

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SB305

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 305
Author: Price
Bill Date: April 15, 2013, Amended
Subject: Healing Arts: Boards
Sponsor: Author

STATUS OF BILL:

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

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow all boards under the Department of Consumer Affairs (DCA) that require licensees to submit fingerprints, including the Medical Board of California (the Board), to request from a local or state agency, certified records of all arrests and convictions, certified records regarding probation, and any and all other related documentation needed to complete an applicant or licensee investigation. This bill would specify that a local or state agency may provide these records and that a board may receive these records.

This bill would also extend the sunset date of the Board's registered dispensing optician (RDO) program until January 1, 2018.

ANALYSIS:

Currently, the Medical Board does receive records of arrests and convictions. However, records regarding probation and records from other state and local agencies would be beneficial for the Medical Board to receive and use in applicant and licensee investigations. This bill would clarify that a local or state agency may provide the records and that a board may receive the records.

This bill would also extend the sunset date of the Board's RDO program.

Clarifying in statute that state and local agencies can provide boards under DCA with certified arrest, conviction, and probation records, and other documentation needed to complete an applicant or licensee investigation would be beneficial to the Board's Enforcement Program. There is sometime question on what documents can be shared from agency to agency, and this bill would clarify that information can be shared with specified boards, in order to help with a board's investigation. This will further the Board's mission of consumer protection; Board staff suggests that the Board support this bill.

The Board in its Sunset Review Report suggested the transfer of the RDO Program to the Optometry Board or DCA should be examined. The Senate and Assembly Business and Professions Committees have suggested that the Board initiate discussions with all stakeholders and report back to the Committees with findings by July 1, 2014. The Board will pursue this recommendation.

FISCAL: None

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN SENATE APRIL 15, 2013

SENATE BILL No. 305

Introduced by Senator Price
(Principal coauthor: Assembly Member Gordon)

February 15, 2013

An act to amend Sections 2450, 2450.3, *2569, 3010.5, 3014.6,* 3685, 3686, 3710, ~~and~~ 3716, *and 3765*of, *and to add Section 144.5 to,* the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 305, as amended, Price. Healing arts: boards.

Existing law requires specified regulatory boards within the Department of Consumer Affairs to require an applicant for licensure to furnish to the board a full set of fingerprints in order to conduct a criminal history record check.

This bill would additionally authorize those boards to request and receive from a local or state agency certified records of all arrests and convictions, certified records regarding probation, and any and all other related documentation needed to complete an applicant or licensee investigation and would authorize a local or state agency to provide those records to the board upon request.

Existing law, the Osteopathic Act, ~~establishes the Osteopathic Medical Board of California, which issues certificates to, and regulates, osteopathic physicians and surgeons.~~ *provides for the licensure and regulation of osteopathic physicians and surgeons by the Osteopathic Medical Board of California.*

This bill would require that the powers and duties of the board, as provided, be subject to review by the appropriate policy committees of the Legislature. The bill would require that *the* review be performed as

if ~~those~~ *these* provisions were scheduled to be repealed as of January 1, 2018.

Existing law, the Naturopathic Doctors Act, *until January 1, 2014,* provides for the licensure and regulation of naturopathic doctors by the Naturopathic Medicine Committee within the Osteopathic Medical Board of California. ~~Existing law repeals these provisions on January 1, 2014.~~ Existing law also specifies that the *repeal of the* committee ~~is subject~~ *subjects it* to review by the appropriate policy committees of the Legislature.

This bill would ~~instead repeal those provisions on January 1, 2018,~~ *extend the operation of these provisions until January 1, 2018,* and make conforming changes.

Existing law provides for the regulation of dispensing opticians, as defined, by the Medical Board of California.

This bill would require that the powers and duties of the board, as provided, be subject to review by the appropriate policy committees of the Legislature. The bill would require that the review be performed as if these provisions were scheduled to be repealed as of January 1, 2018.

Existing law, *the Optometry Practice Act, provides for the licensure and regulation of optometrists by the State Board of Optometry. The Respiratory Care Act* provides for the licensure and regulation of respiratory care practitioners by the Respiratory Care Board of California. ~~Existing law~~ *Each of those acts* authorizes the board to employ an executive officer. Existing law repeals these provisions on January 1, 2014 and subjects the ~~board~~ *boards* to review by the Joint ~~Sunset Review Committee~~ *Committee on Boards, Commissions, and Consumer Protection.*

This bill would ~~instead repeal those provisions on January 1, 2018,~~ *extend the operation of these provisions until January 1, 2018,* and provide that the ~~committee is subject to~~ *repeal of these provisions subjects the boards to* review by the appropriate policy committees of the Legislature.

The Respiratory Care Act also prohibits a person from engaging in the practice of respiratory care unless he or she is a licensed respiratory care practitioner. However, the act does not prohibit specified acts, including, among others, the performance of respiratory care services in case of an emergency or self-care by a patient.

This bill would additionally authorize the performance of pulmonary function testing by persons who are currently employed by Los Angeles

county hospitals and have performed pulmonary function testing for at least 15 years.

This bill would make legislative findings and declarations as to the necessity of a special statute for the persons described above.

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

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

1 *SECTION 1. Section 144.5 is added to the Business and*
2 *Professions Code, to read:*
3 *144.5. Notwithstanding any other law, a board described in*
4 *Section 144 may request, and is authorized to receive, from a local*
5 *or state agency certified records of all arrests and convictions,*
6 *certified records regarding probation, and any and all other related*
7 *documentation needed to complete an applicant or licensee*
8 *investigation. A local or state agency may provide those records*
9 *to the board upon request.*
10 ~~SECTION 1.~~
11 *SEC. 2.* Section 2450 of the Business and Professions Code is
12 amended to read:
13 2450. There is a Board of Osteopathic Examiners of the State
14 of California, established by the Osteopathic Act, which shall be
15 known as the Osteopathic Medical Board of California which
16 enforces this chapter relating to persons holding or applying for
17 physician's and surgeon's certificates issued by the Osteopathic
18 Medical Board of California under the Osteopathic Act.
19 Persons who elect to practice using the term of suffix "M.D.,"
20 as provided in Section 2275, shall not be subject to this article,
21 and the Medical Board of California shall enforce the provisions
22 of this chapter relating to persons who made the election.
23 Notwithstanding any other law, the powers and duties of the
24 Osteopathic Medical Board of California, as set forth in this article
25 and under the Osteopathic Act, shall be subject to review by the
26 appropriate policy committees of the Legislature. The review shall
27 be performed as if this chapter were scheduled to be repealed as
28 of January 1, 2018.
29 ~~SEC. 2.~~
30 *SEC. 3.* Section 2450.3 of the Business and Professions Code
31 is amended to read:

2450.3. There is within the jurisdiction of the Osteopathic Medical Board of California a Naturopathic Medicine Committee authorized under the Naturopathic Doctors Act (Chapter 8.2 (commencing with Section 3610)). This section shall become inoperative on January 1, 2018, and, as of that date is repealed, unless a later enacted statute that is enacted before January 1, 2018, deletes or extends that date. Notwithstanding any other provision of law, the repeal of this section renders the Naturopathic Medicine Committee subject to review by the appropriate policy committees of the Legislature.

SEC. 4. Section 2569 of the Business and Professions Code is amended to read:

2569. ~~The~~ *Notwithstanding any other law, the* powers and duties of the board, as set forth in this chapter, shall be subject to ~~the~~ review ~~required by Division 1.2 (commencing with Section 473).~~ *by the appropriate policy committees of the Legislature.* The review shall be performed as if this chapter were scheduled to be repealed as of January 1, ~~2014, as described in Section 473.1.~~ *2018.*

SEC. 5. Section 3010.5 of the Business and Professions Code is amended to read:

3010.5. (a) There is in the Department of Consumer Affairs a State Board of Optometry in which the enforcement of this chapter is vested. The board consists of 11 members, five of whom shall be public members.

Six members of the board shall constitute a quorum.

(b) The board shall, with respect to conducting investigations, inquiries, and disciplinary actions and proceedings, have the authority previously vested in the board as created pursuant to Section 3010. The board may enforce any disciplinary actions undertaken by that board.

(c) This section shall remain in effect only until January 1, ~~2014,~~ *2018,* and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, ~~2014,~~ *2018,* deletes or extends that date. ~~The~~ *Notwithstanding any other law, the* repeal of this section renders the board subject to ~~the~~ review ~~required by Division 1.2 (commencing with Section 473).~~ *by the appropriate policy committees of the Legislature.*

SEC. 6. Section 3014.6 of the Business and Professions Code is amended to read:

3014.6. (a) The board may appoint a person exempt from civil service who shall be designated as an executive officer and who shall exercise the powers and perform the duties delegated by the board and vested in him or her by this chapter.

(b) This section shall remain in effect only until January 1, ~~2014,~~ *2018,* and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, ~~2014,~~ *2018,* deletes or extends that date.

~~SEC. 3.~~

SEC. 7. Section 3685 of the Business and Professions Code is amended to read:

3685. Notwithstanding any other law, the repeal of this chapter renders the committee subject to review by the appropriate policy committees of the Legislature.

~~SEC. 4.~~

SEC. 8. Section 3686 of the Business and Professions Code is amended to read:

3686. This chapter shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.

~~SEC. 5.~~

SEC. 9. Section 3710 of the Business and Professions Code is amended to read:

3710. (a) The Respiratory Care Board of California, hereafter referred to as the board, shall enforce and administer this chapter.

(b) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date. Notwithstanding any other law, the repeal of this section renders the board subject to review by the appropriate policy committees of the Legislature.

~~SEC. 6.~~

SEC. 10. Section 3716 of the Business and Professions Code is amended to read:

3716. The board may employ an executive officer exempt from civil service and, subject to the provisions of law relating to civil service, clerical assistants and, except as provided in Section 159.5, other employees as it may deem necessary to carry out its powers and duties.

This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.

SEC. 11. Section 3765 of the Business and Professions Code is amended to read:

3765. This act does not prohibit any of the following activities:

(a) The performance of respiratory care that is an integral part of the program of study by students enrolled in approved respiratory therapy training programs.

(b) Self-care by the patient or the gratuitous care by a friend or member of the family who does not represent or hold himself or herself out to be a respiratory care practitioner licensed under the provisions of this chapter.

(c) The respiratory care practitioner from performing advances in the art and techniques of respiratory care learned through formal or specialized training.

(d) The performance of respiratory care in an emergency situation by paramedical personnel who have been formally trained in these modalities and are duly licensed under the provisions of an act pertaining to their speciality.

(e) Respiratory care services in case of an emergency. "Emergency," as used in this subdivision, includes an epidemic or public disaster.

(f) Persons from engaging in cardiopulmonary research.

(g) Formally trained licensees and staff of child day care facilities from administering to a child inhaled medication as defined in Section 1596.798 of the Health and Safety Code.

(h) The performance by a person employed by a home medical device retail facility or by a home health agency licensed by the State Department of Health Services of specific, limited, and basic respiratory care or respiratory care related services that have been authorized by the board.

(i) The performance of pulmonary function testing by persons who are currently employed by Los Angeles county hospitals and have performed pulmonary function testing for at least 15 years.

SEC. 12. The Legislature finds and declares that a special law, as set forth in Section 11 of this act, is necessary and that a general law cannot be made applicable within the meaning of Section 16 of Article IV of the California Constitution because of the unique circumstances relating to persons who are currently employed by

1 *Los Angeles county hospitals and have performed pulmonary*
2 *function testing for at least 15 years.*

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SB 352

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 352
Author: Pavley
Bill Date: April 10, 2013, Introduced
Subject: Medical Assistants: Supervision
Sponsor: California Academy of Physician Assistants (CAPA)

STATUS OF BILL:

This bill is on the Senate Third Reading File.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow a physician assistants (PAs), nurse practitioner (NPs) and certified nurse-midwives (CNMs) 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, NPs, and CNMs 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 CNMs 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 suggested 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. The Executive Committee voted to support this bill if it is amended per staff recommendations.

FISCAL: None

SUPPORT: CAPA (sponsor)

OPPOSITION: None on file

POSITION: Executive Committee Recommendation: Support if Amended

AMENDED IN SENATE APRIL 10, 2013

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 amended, 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. *Existing law requires the Board of Registered Nursing to issue a certificate to practice nurse-midwifery to a qualifying applicant who is licensed pursuant to the Nursing Practice Act.*

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 *certified* nurse-midwife. The bill would also delete several obsolete references and make other *conforming,* technical, *and* 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:

SECTION 1. Section 2069 of the Business and Professions Code is amended to read:

2069. (a) (1) Notwithstanding any other ~~provision of~~ law, a medical assistant may administer medication only by intradermal, subcutaneous, or intramuscular injections and perform skin tests and additional technical supportive services upon the specific authorization and supervision of a licensed physician and surgeon or a licensed podiatrist. A medical assistant may also perform all these tasks and services ~~in a clinic licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code~~ upon the specific authorization of a physician assistant, a nurse practitioner, or a *certified* nurse-midwife.

(2) The supervising physician and surgeon ~~at a clinic described in paragraph (1)~~ may, at his or her discretion, in consultation with the nurse practitioner, *certified* nurse-midwife, or physician assistant, provide written instructions to be followed by a medical assistant in the performance of tasks or supportive services. These written instructions may provide that the supervisory function for the medical assistant for these tasks or supportive services may be delegated to the nurse practitioner, *certified* nurse-midwife, or physician assistant within the standardized procedures or protocol, and that tasks may be performed when the supervising physician and surgeon is not onsite, ~~so long as~~ *if either of* the following apply:

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

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

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

(1) "Medical assistant" means a person who may be unlicensed, who performs basic administrative, clerical, and technical supportive services in compliance with this section and Section 2070 for a licensed physician and surgeon or a licensed podiatrist,

or group thereof, for a medical or podiatry corporation, for a physician assistant, a nurse practitioner, or a *certified* nurse-midwife as provided in subdivision (a), or for a health care service plan, who is at least 18 years of age, and who has had at least the minimum amount of hours of appropriate training pursuant to standards established by the ~~Division of Licensing~~ *board.* The medical assistant shall be issued a certificate by the training institution or instructor indicating satisfactory completion of the required training. A copy of the certificate shall be retained as a record by each employer of the medical assistant.

(2) "Specific authorization" means a specific written order prepared by the supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the *certified* nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed on a patient, which shall be placed in the patient's medical record, or a standing order prepared by the supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the *certified* nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed, the duration of which shall be consistent with accepted medical practice. A notation of the standing order shall be placed on the patient's medical record.

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

(A) A licensed physician and surgeon.

(B) A licensed podiatrist.

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

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

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

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

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

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

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

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

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

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

~~SECTION 1. Section 2069 of the Business and Professions Code is amended to read:~~

~~2069. (a) (1) Notwithstanding any other law, a medical assistant may administer medication only by intradermal, subcutaneous, or intramuscular injections and perform skin tests and additional technical supportive services upon the specific authorization and supervision of a licensed physician and surgeon or a licensed podiatrist. A medical assistant may also perform all these tasks and services upon the specific authorization of a physician assistant, a nurse practitioner, or a nurse-midwife.~~

~~(2) The supervising physician and surgeon may, at his or her discretion, in consultation with the nurse practitioner, nurse-midwife, or physician assistant, provide written instructions~~

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

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

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

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

~~(1) "Medical assistant" means a person who may be unlicensed, who performs basic administrative, clerical, and technical supportive services in compliance with this section and Section 2070 for a licensed physician and surgeon or a licensed podiatrist, or group thereof, for a medical or podiatry corporation, for a physician assistant, a nurse practitioner, or a nurse-midwife as provided in subdivision (a), or for a health care service plan, who is at least 18 years of age, and who has had at least the minimum amount of hours of appropriate training pursuant to standards established by the board. The medical assistant shall be issued a certificate by the training institution or instructor indicating satisfactory completion of the required training. A copy of the certificate shall be retained as a record by each employer of the medical assistant.~~

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

~~supervising podiatrist, or the physician assistant, the nurse practitioner, or the nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed, the duration of which shall be consistent with accepted medical practice. A notation of the standing order shall be placed on the patient's medical record.~~

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

~~(A) A licensed physician and surgeon.~~

~~(B) A licensed podiatrist.~~

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

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

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

~~(1) The licensure of medical assistants.~~

~~(2) The administration of local anesthetic agents by a medical assistant.~~

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

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

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

1 ~~(4) A medical assistant to perform any clinical laboratory test~~
2 ~~or examination for which he or she is not authorized by Chapter~~
3 ~~3 (commencing with Section 1200).~~
4 ~~(5) A nurse practitioner, nurse-midwife, or physician assistant~~
5 ~~to be a laboratory director of a clinical laboratory, as those terms~~
6 ~~are defined in paragraph (8) of subdivision (a) of Section 1206~~
7 ~~and subdivision (a) of Section 1209.~~

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SB 491

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 491
Author: Hernandez
Bill Date: April 16, 2013, amended
Subject: Nurse Practitioners
Sponsor: Author

STATUS OF BILL:

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

DESCRIPTION OF CURRENT LEGISLATION:

This bill would make findings and declarations related to the role and importance of nurse practitioners (NPs). This bill would establish independent practice for NPs by removing provisions in existing law that require physician supervision through standardized procedures, collaboration or consultation with a physician. This bill would also expand the scope of practice for a NP and would allow a NP to order, furnish or prescribe drugs.

ANALYSIS:

This bill is part of a package of bills intended to expand the scope of NPs, pharmacists, and optometrists. Currently, NPs operate under standardized procedures, that are overseen by a supervising physician. NPs are advanced practice registered nurses (RNs) who have pursued higher education and certification as a NP. There are approximately 17,000 NPs licensed by the Board of Registered Nursing in California.

This bill would make findings and declarations regarding the role and importance of NPs. This bill would establish independent practice for NPs by removing provisions in existing law that require physician supervision through standardized procedures, collaboration or consultation with a physician. This bill would require a NP to maintain malpractice insurance. This bill would expand the scope of a NP and would allow a NP to do the following:

- Assess patients, synthesize and analyze data, and apply principles of health care.
- Manage the physical and psychosocial health status of patients.
- Analyze multiple sources of data, identify alternative possibilities as to the nature of a health care problem, and select, implement, and evaluate appropriate treatment.
- Examine patients and establish a medical diagnosis by client history, physical examination, and other criteria.
- Order, furnish, or prescribe drugs or devices, as specified.
- Refer patients to other health care providers, as specified.

- Delegate to a medical assistant.
- Perform additional acts that require education and training that are recognized by the nursing profession as proper to be performed by a NP.
- Order hospice care as appropriate.
- Perform procedures that are necessary and consistent with the NPs training and education.

As stated in the bullets above, this bill will allow NPs to refer a patient to a physician or other licensed health care provider if the referral will protect the health and welfare of the patient, and must consult with a physician or other licensed health care provider if a situation or condition occurs in a patient that is beyond the NPs knowledge and experience.

As stated in the bullets above, this bill would allow a NP to furnish order or prescribe drugs or devices if they are consistent with the practitioners education preparation or for which clinical competency has been established and maintained and the BRN has certified that the NP has satisfactorily completed a course in pharmacology covering the drugs or devices. An NP would not be allowed to furnish, order or prescribe a dangerous drug without an appropriate prior examination and a medical indication, unless one of the following applies:

- The NP was a designated practitioner serving in the absence of the patient's physician, podiatrist, or NP and the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but no longer than 72 hours.
- The NP transmitted the order for drugs to a RN or licensed vocational nurse (LVN) in an inpatient facility and the NP consulted with the RN or LVN who reviewed the patients records and the NP was designated as the practitioner to serve in the absence of the patient's physician, podiatrist or NP.
- The NP was a designated practitioner serving in the absence of the patient's physician, podiatrist, or NP and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount for more than one renewal.

Beginning on and after July 1, 2016, this bill would require an applicant for initial qualification or certification as a NP to hold a national certification as a NP from a national certifying body recognized by the BRN

According to the author, this bill will establish independent practice for NPs and enable them to perform all tasks and functions consistent with their education and training and would allow NPs to choose to see Medi-Cal patients. According to the author, the Institutes of Medicine and the National Council of State Boards of Nursing have recommended full practice for NPs. The author believe this package of bills will allow for better utilization of the existing infrastructure of trained medical providers to bridge the provider gap through expanded practice.

This bill significantly expands the scope of practice of a NP by establishing independent practice and deleting all provisions in existing law that currently require physician supervision, oversight, collaboration or consultation. NPs are well qualified to provide medical care when practicing under standardized procedures and physician supervision; however, the standardized procedures and physician supervision, collaboration, and consultation are in existing law to ensure that the patient care provided by a NP includes physician involvement and oversight, as physicians should be participating in the patient's care in order to ensure consumer protection. It is also unknown how this bill would affect corporate practice, as the bill does not address this issue. The Board's primary mission is consumer protection and by significantly expanding the scope of practice for a NP, patient care and consumer protection could be compromised. Board staff suggests that the Board oppose this bill, or oppose this bill unless it is amended to require collaboration with physicians.

FISCAL: None

SUPPORT: United Nurses Associations of California
Bay Area Council

OPPOSITION: California Medical Association
Various Individuals

POSITION: Recommendation: Oppose

AMENDED IN SENATE APRIL 16, 2013

AMENDED IN SENATE APRIL 1, 2013

SENATE BILL No. 491

Introduced by Senator Hernandez

February 21, 2013

An act to amend Sections 2835.5, 2835.7, 2836.1, 2836.2, and 2836.3 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 491, as amended, Hernandez. Nurse practitioners.

Existing law, the Nursing Practice Act, provides for the licensure and regulation of nurse practitioners by the Board of Registered Nursing. Existing law requires an applicant for initial qualification or certification as a nurse practitioner who has never been qualified or certified as a nurse practitioner in California or in any other state to meet specified requirements, including possessing a master's degree in nursing, a master's degree in a clinical field related to nursing, or a graduate degree in nursing, and to have satisfactorily completed a nurse practitioner program approved by the board. Existing law authorizes the implementation of standardized procedures that authorize a nurse practitioner to perform certain acts, including, among others, ordering durable medical equipment, and, in consultation with a physician and surgeon, ~~approve, sign, modify, or add~~ *approving, signing, modifying, or adding* to a plan of treatment or plan for an individual receiving home health services or personal care services.

This bill would revise these provisions by deleting the requirement that those acts be performed pursuant to a standardized procedure or in consultation with a physician and surgeon. The bill would also authorize a nurse practitioner to perform specified additional acts, including,

among others, ~~diagnosing patients, performing therapeutic procedures,~~ *examining patients and establishing a medical diagnosis* and prescribing drugs and devices. The bill would require that, on and after July 1, 2016, an applicant for initial qualification or certification as a nurse practitioner hold a national certification as a nurse practitioner from a national certifying body recognized by the board.

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

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

1 SECTION 1. The Legislature finds and declares all of the
2 following:
3 (a) Nurse practitioners are a longstanding, vital, safe, effective,
4 and important part of the state's health care delivery system. They
5 are especially important given California's shortage of physicians,
6 with just 16 of 58 counties having the federally recommended ratio
7 of physicians to residents.
8 (b) Nurse practitioners will play an especially important part in
9 the implementation of the federal Patient Protection and Affordable
10 Care Act, which will bring an estimated five million more
11 Californians into the health care delivery system, because they
12 will provide for greater access to primary care services in all areas
13 of the state. This is particularly true for patients in medically
14 underserved urban and rural communities.
15 (c) Due to the excellent safety and efficacy record that nurse
16 practitioners have earned, the Institute of Medicine of the National
17 Academy of Sciences has recommended full independent practice
18 for nurse practitioners. Currently, 17 states allow nurse practitioners
19 to practice to the full extent of their training and education with
20 independent practice.
21 (d) Furthermore, nurse practitioners will assist in addressing
22 the primary care provider shortage by removing delays in the
23 provision of care that are created when dated regulations require
24 a physician's signature or protocol before a patient can initiate
25 treatment or obtain diagnostic tests that are ordered by a nurse
26 practitioner.
27 SEC. 2. Section 2835.5 of the Business and Professions Code
28 is amended to read:

2835.5. (a) A registered nurse who is holding himself or herself out as a nurse practitioner or who desires to hold himself or herself out as a nurse practitioner shall, within the time prescribed by the board and prior to his or her next license renewal or the issuance of an initial license, submit educational, experience, and other credentials and information as the board may require for it to determine that the person qualifies to use the title "nurse practitioner," pursuant to the standards and qualifications established by the board.

(b) Upon finding that a person is qualified to hold himself or herself out as a nurse practitioner, the board shall appropriately indicate on the license issued or renewed, that the person is qualified to use the title "nurse practitioner." The board shall also issue to each qualified person a certificate evidencing that the person is qualified to use the title "nurse practitioner."

(c) A person who has been found to be qualified by the board to use the title "nurse practitioner" prior to January 1, 2005, shall not be required to submit any further qualifications or information to the board and shall be deemed to have met the requirements of this section.

(d) On and after January 1, 2008, an applicant for initial qualification or certification as a nurse practitioner under this article who has not been qualified or certified as a nurse practitioner in California or any other state shall meet the following requirements:

(1) Hold a valid and active registered nursing license issued under this chapter.

(2) Possess a master's degree in nursing, a master's degree in a clinical field related to nursing, or a graduate degree in nursing.

(3) Satisfactorily complete a nurse practitioner program approved by the board.

(e) On and after July 1, 2016, an applicant for initial qualification or certification as a nurse practitioner shall, in addition, hold a national certification as a nurse practitioner from a national certifying body recognized by the board.

SEC. 3. Section 2835.7 of the Business and Professions Code is amended to read:

2835.7. (a) Notwithstanding any other law, in addition to any other practices authorized in statute or regulation, a nurse practitioner may do any of the following:

(1) Order durable medical equipment. Notwithstanding that authority, nothing in this paragraph shall operate to limit the ability of a third-party payer to require prior approval.

(2) After performance of a physical examination by the nurse practitioner, certify disability pursuant to Section 2708 of the Unemployment Insurance Code.

(3) For individuals receiving home health services or personal care services, approve, sign, modify, or add to a plan of treatment or plan of care.

(4) Assess patients, synthesize and analyze data, and apply principles of health care ~~at an advanced level~~.

(5) Manage the physical and psychosocial health status of patients.

(6) Analyze multiple sources of data, identify alternative possibilities as to the nature of a health care problem, and select, implement, and evaluate appropriate treatment.

~~(7) Make independent decisions in treating health conditions.~~

~~(8) Diagnose patients and perform diagnostic and therapeutic procedures.~~

(7) Examine patients and establish a medical diagnosis by client history, physical examination, and other criteria.

~~(9)~~

(8) Order, furnish, or prescribe drugs or devices pursuant to Section 2836.1.

~~(10)~~

(9) Refer patients to other health care providers ~~when appropriate due to the limits of the nurse practitioner's knowledge, experience, or educational preparation.~~ *as provided in subdivision (b).*

~~(11)~~

(10) Delegate to a medical assistant.

~~(12)~~

(11) Perform additional acts that require education and training and that are recognized by the nursing profession as proper to be performed by a nurse practitioner.

~~(13)~~

(12) Order hospice care as appropriate.

~~(14)~~

(13) Perform procedures that are necessary and consistent with the nurse practitioner's training and education.

(b) A nurse practitioner shall refer a patient to a physician or another licensed health care provider if the referral will protect the health and welfare of the patient, and shall consult with a physician or other licensed health care provider if a situation or condition occurs in a patient that is beyond the nurse practitioner's knowledge and experience.

~~(b)~~

(c) A nurse practitioner shall maintain medical malpractice insurance.

SEC. 4. Section 2836.1 of the Business and Professions Code is amended to read:

2836.1. *(a)* Neither this chapter nor any other provision of law shall be construed to prohibit a nurse practitioner from furnishing, ordering, or prescribing drugs or devices when ~~all~~ *both* of the following apply:

~~(a)~~

(1) The drugs or devices that are furnished, ordered, or prescribed are consistent with the practitioner's educational preparation or for which clinical competency has been established and maintained.

~~(b) (1)~~

(2) (A) The board has certified in accordance with Section 2836.3 that the nurse practitioner has satisfactorily completed a course in pharmacology covering the drugs or devices to be furnished, ordered, or prescribed under this section.

~~(2)~~

(B) Nurse practitioners who are certified by the board and hold an active furnishing number and who are registered with the United States Drug Enforcement Administration, shall complete, as part of their continuing education requirements, a course including Schedule II controlled substances based on the standards developed by the board. The board shall establish the requirements for satisfactory completion of this subdivision.

~~(c)~~

(b) A nurse practitioner shall not furnish, order, or prescribe a dangerous drug, as defined in Section 4022, without an appropriate prior examination and a medical indication, unless one of the following applies:

(1) The nurse practitioner was a designated practitioner serving in the absence of the patient's physician and surgeon, podiatrist,

or nurse practitioner, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

(2) The nurse practitioner transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

(A) The nurse practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

(B) The nurse practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon, podiatrist, or nurse practitioner, as the case may be.

(3) The nurse practitioner was a designated practitioner serving in the absence of the patient's physician and surgeon, podiatrist, or nurse practitioner, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

(4) The licensee was acting in accordance with subdivision (b) of Section 120582 of the Health and Safety Code.

~~(d)~~

(c) Use of the term "furnishing" in this section, in health facilities defined in Section 1250 of the Health and Safety Code, shall include the ordering of a drug or device.

~~(e)~~

(d) "Drug order" or "order" for purposes of this section means an order for medication which is dispensed to or for an ultimate user, issued by a nurse practitioner as an individual practitioner, within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by nurse practitioners; and (2) the signature of a nurse practitioner on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

SEC. 5. Section 2836.2 of the Business and Professions Code is amended to read:

1 2836.2. All nurse practitioners who are authorized pursuant to
2 Section 2836.1 to prescribe, furnish, or issue drug orders for
3 controlled substances shall register with the United States Drug
4 Enforcement Administration.
5 SEC. 6. Section 2836.3 of the Business and Professions Code
6 is amended to read:
7 2836.3. (a) The furnishing of drugs or devices by nurse
8 practitioners is conditional on issuance by the board of a number
9 to the nurse applicant who has successfully completed the
10 requirements of *paragraph (2) of* subdivision (b) of Section 2836.1.
11 The number shall be included on all transmittals of orders for drugs
12 or devices by the nurse practitioner. The board shall make the list
13 of numbers issued available to the Board of Pharmacy. The board
14 may charge the applicant a fee to cover all necessary costs to
15 implement this section.
16 (b) The number shall be renewable at the time of the applicant's
17 registered nurse license renewal.
18 (c) The board may revoke, suspend, or deny issuance of the
19 numbers for incompetence or gross negligence in the performance
20 of functions specified in Sections 2836.1 and 2836.2.

O

SB 492

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 492
Author: Hernandez
Bill Date: April 16, 2013 amended
Subject: Optometrist Practice: Licensure
Sponsor: Author

STATUS OF BILL:

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

DESCRIPTION OF CURRENT LEGISLATION:

This bill would delete the definition of the practice of optometry in existing law and would expand the scope of an optometrist by allowing an optometrist: to examine, prevent, diagnose, and treat any disease, condition, or disorder of the visual system, the human eye, and adjacent and related structures of the visual system; to perform minor surgical and nonsurgical primary care procedures; and to prescribe drugs, including narcotics, among other allowances.

ANALYSIS:

This bill is part of a package of bills intended to expand the scope of NPs, pharmacists, and optometrists. Currently, optometrists measure and correct vision and prescribe fit lenses, as well as provide some basic primary care services.

This bill would delete the definition of the practice of optometry in existing law and would expand the scope of an optometrist by allowing an optometrist to do the following:

- Examine, prevent, diagnose, and treat any disease, condition, or disorder of the visual system, the human eye, and adjacent and related structures of the visual system.
- Use or prescribe appropriate drugs, including narcotic substances other than those listed in Schedule I.
- Perform minor surgical and nonsurgical primary care procedures requiring no more than topical or local anesthetic, or both, consistent with an optometrist's education and training.
- Use or prescribe visual therapy, ocular exercises or vision habilitation, and rehabilitation services.
- Perform or order appropriate laboratory and diagnostic imaging tests.
- Administer immunizations.
- Diagnose other common primary care conditions that have ocular manifestations.

This bill would also allow an optometrist who is operating under a protocol with a physician, a health care facility, or participating in a medical home, accountable care organization, or other system of care in which the patient is being treated, to initiate treatment and manage medications for diagnosed conditions of the visual system and other common primary care conditions that have ocular manifestations.

This bill would require the State Board of Optometry (SBO) to establish, by regulation, educational and examination requirements for licensure to ensure the competence of optometrists. This bill would require applicants to successfully complete Part 1, Part II, and Part III examinations of the National Board of Examiners in Optometry in order to be licensed as an optometrist. This bill would also require applicants to successfully complete an examination in California law and ethics to be developed and administered by SBO. This bill would also allow SBO to require applicants to pass additional examinations to ensure the competency of optometrists to utilize diagnostic and therapeutic pharmaceutical agents, if not otherwise covered by the required examinations.

This bill significantly expands the scope of practice of an optometrist by allowing optometrists to examine, prevent, diagnose, and treat <u>any</u> disease, condition, or disorder of the visual system, human eye and "adjacent related structures of the visual system". This bill would allow an optometrist to prescribe controlled substances, as well as perform minor surgical and nonsurgical primary care procedures. This is a significant expansion of the scope of practice of an optometrist, that requires no physician supervision or consultation. Optometrists do not currently have the appropriate education, training, or experience to provide the types of services this bill would allow them to provide; this could put patients at serious risk of harm and significantly impact consumer protection. The Board's primary mission is consumer protection and by significantly expanding the scope of practice for an optometrist, patient care and consumer protection would be compromised. Board staff suggests that the Board oppose this bill.

FISCAL: None

SUPPORT: None known (at this time)

OPPOSITION: California Medical Association
Various Individuals

POSITION: Recommendation: Oppose

AMENDED IN SENATE APRIL 16, 2013

AMENDED IN SENATE APRIL 1, 2013

SENATE BILL No. 492

Introduced by Senator Hernandez

February 21, 2013

An act to repeal and add Sections 3041 and 3041.2 of the Business and Professions Code, relating to optometry.

LEGISLATIVE COUNSEL'S DIGEST

SB 492, as amended, Hernandez. Optometrist: practice: licensure.

The Optometry Practice Act creates the State Board of Optometry, which licenses optometrists and regulates their practice. Existing law defines the practice of optometry to include, among other things, the prevention and diagnosis of disorders and dysfunctions of the visual system, and the treatment and management of certain disorders and dysfunctions of the visual system, as well as the provision of rehabilitative optometric services, and doing certain things, including, but not limited to, the examination of the human eyes, the determination of the powers or range of human vision, and the prescribing of contact and spectacle lenses. Existing law provides that the State Board of Optometry is required, by regulation, to establish educational and examination requirements for licensure to ensure the competence of optometrists to practice. Any violation of the act is a crime.

This bill would delete the definition of the practice of optometry and would instead provide that a licensed optometrist would be authorized to perform certain health-related services, including, but not limited to, examining, preventing, diagnosing, and treating any disease, condition, or disorder of the visual system, the human eye, and adjacent and related structures *of the visual system*, prescribing appropriate drugs, including

narcotics, and administering immunizations *and to diagnose other common primary care conditions that have ocular manifestations. The bill would also authorize an optometrist, who is operating under a protocol with a physician and surgeon or a health care facility, or participating in a specified system of care in which the patient is being otherwise treated, to initiate treatment and manage medications for those diagnosed conditions.* The bill would require the board to require applicants for licensure to successfully complete specified examinations, and would authorize the board to require the passage of additional examinations with regard to competency to utilize diagnostic and therapeutic pharmaceutical agents, if not covered by the required examinations.

Because this bill would change the definition of a crime, it would create a state-mandated local program.

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

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

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

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

1 SECTION 1. Section 3041 of the Business and Professions
2 Code is repealed.
3 SEC. 2. Section 3041 is added to the Business and Professions
4 Code, to read:
5 3041. (a) An optometrist license authorizes the holder to do
6 all of the following:
7 (1) Examine, prevent, diagnose, and treat any disease, condition,
8 or disorder of the visual system, the human eye, and adjacent and
9 related structures *of the visual system.*
10 (2) The use or prescription of appropriate drugs, including
11 narcotic substances other than those listed in Schedule 1.
12 (3) The performance of *minor* surgical and nonsurgical primary
13 *eye* care procedures requiring no more than topical or local
14 anesthetic, or both, *consistent with an optometrist's education and*
15 *training.*

(4) The use or prescription of visual therapy, ocular exercises or vision habilitation, and rehabilitation services.

(5) The performance or ordering of appropriate laboratory and diagnostic imaging tests.

(b) An optometrist may administer immunizations.

(c) In addition to diagnosing and treating conditions of the visual system pursuant to subdivision (a), an optometrist may diagnose other *common primary care* conditions that have ocular manifestations~~, initiate treatment, and, in consultation with a physician, manage medications for these conditions~~.

(d) In addition to the authority provided in subdivisions (a) to (c), inclusive, an optometrist who is operating under a protocol with a physician and surgeon or a health care facility, or participating in a medical home, accountable care organization, or other system of care in which the patient is being otherwise treated, may initiate treatment and manage medications for conditions diagnosed pursuant to subdivision (c).

SEC. 3. Section 3041.2 of the Business and Professions Code is repealed.

SEC. 4. Section 3041.2 is added to the Business and Professions Code, to read:

3041.2. (a) The State Board of Optometry shall establish, by regulation, educational and examination requirements for licensure to ensure the competence of optometrists to practice.

(b) On and after January 1, 2014, the board shall require each applicant for licensure to successfully complete the Part I, Part II, and Part III examinations of the National Board of Examiners in Optometry.

(c) On and after January 1, 2014, the board shall require each applicant for licensure to successfully complete an examination in California law and ethics developed and administered by the board.

(d) On and after January 1, 2014, the board may require passage of additional examinations to ensure the competency of licentiates to utilize diagnostic and therapeutic pharmaceutical agents, if not otherwise covered by the examinations required pursuant to subdivisions (a) and (b).

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIIIB of the California Constitution because 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.

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SB 493

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 493
Author: Hernandez
Bill Date: April 1, 2013 amended
Subject: Pharmacy Practice
Sponsor: Author

STATUS OF BILL:

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

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow a pharmacists to furnish medication, order and interpret tests, and furnish self-administered hormonal contraceptives, initiate and administer vaccines, and furnish prescription smoking cessation drugs and devices. This bill would establish an Advanced Practice Pharmacist (APP) recognition. This bill would allow an APP to perform physical assessments and if operating under a protocol, it would allow an APP to initiate, adjust, or discontinue drug therapy and participate in the evaluation and management of disease and health conditions.

ANALYSIS:

This bill is part of a package of bills intended to expand the scope of NPs, pharmacists, and optometrists. Currently, pharmacists provide patient care that optimized medication therapy.

This bill expands the scope of a pharmacist by allowing a pharmacist to do the following:

- Provide training and education to patients about drug therapy, disease management, and disease prevention.
- Participate in multidisciplinary review of patient progress, including access to medical records.
- Furnish emergency contraception drug therapy and self-administered hormonal contraceptives in accordance with standardized procedures or protocols developed and approved by the Board of Pharmacy (BOP) and the Medical Board of California (Board).
- Furnish prescription smoking cessation drugs and devices - The pharmacist must maintain records of drugs and devices furnished for three years, notify the patient's primary care provider, be certified in smoking cessation therapy, and complete one

hour of continuing education focused on smoking cessation therapy biennially.

- Furnish Prescription medications not requiring a diagnosis that are recommended by the federal Centers for Disease Control and Prevention for individuals traveling outside of the United States.
- Independently initiate and administer vaccines listed on the routine immunization schedules recommended by the federal Advisory Committee on Immunization Practices - A pharmacist must complete an immunization training program, be certified in basic life support, and comply with all state and federal recordkeeping reporting requirements, in order to initiate and administer an immunization.

This bill would require the BOP and the Board to develop standardized procedures or protocols for emergency contraception drug therapy and self-administered hormonal contraceptives. This bill would authorize both the BOP and the Board to ensure compliance with procedures or protocols, with respect to the appropriate licensees.

This bill would establish an APP, which means a pharmacist who as been recognized as APP by BOP. An APP may perform physical assessments; order and interpret drug therapy-related tests; and refer patients to other health care providers. An APP who is acting in collaboration with the patient's health care providers, operating under a protocol with a physician, health care facility, or health plan or disability insurer, or participating in a medical home, accountable care organization, or other system of care, may do the following:

- Initiate, adjust, or discontinue drug therapy. Adjust means changing the dosage, duration, frequency, or potency of a drug. An APP must transmit written notification to the patient's diagnosing provider or enter the appropriate information in a patient record system shared with the prescriber. This bill would also require a pharmacist to register with the federal Drug Enforcement Administration.
- Participate in the evaluation and management of diseases and health conditions in collaboration with other health care providers.

This bill would require a pharmacist who seeks recognition as an APP to meet the following requirements:

- Hold an active license to practice pharmacy that is in good standing.
- Either earn certification in a relevant area of practice from an organization approved by a BOP-recognized accrediting agency or another entity recognized by BOP; or complete a one-year postgraduate residency where at least 50 percent of the experience includes the provision of direct patient care services with interdisciplinary teams; or have actively managed patients for at least one year under a collaborative practice agreement or protocol with a physician, APP, pharmacist practicing collaborative drug therapy management, or a health system.
- File an application with BOP for recognition as an APP and pay the applicable fee to BOP.
- An APP must complete 10 hours of continuing education each renewal cycle in one or more areas of practice relevant to the pharmacists clinical practice.

This bill would expand the scope of a pharmacist and create a new APP recognition category. Currently, pharmacists do provide education to patients regarding drug therapy, and allowing this to be expanded would help in the implementation of the Affordable Care Act. Allowing pharmacists to furnish self-administered hormonal contraceptives in accordance with standardized procedures developed by BOP, the Board, and stakeholders and allowing pharmacists to furnish some smoking cessation drugs and devices also makes sense and is in line with their scope (some drugs that are known to have side effects could be exempted from this provision). Allowing pharmacists to initiate and administer routine vaccines also seems to reasonable.

However, allowing for an APP recognition and allowing an APP to initiate, adjust, or discontinue drug therapy is a significant expansion of the scope of practice. The APP would only be required to notify the prescribing physician if the drug therapy was discontinued or adjusted. The criteria for APP recognition is very broad, and could be as little as working with another APP for a year. This would allow the APP to make treatment decisions without having the benefit of knowing of the patient's medical history or the reason behind the physician's decision for the particular drug therapy choice. This is a significant expansion of the scope of practice of pharmacist, and allowing an APP to discontinue or adjust the drug therapy could put patients at serious risk of harm and significantly impact consumer protection. The Board's primary mission is consumer protection and by significantly expanding the scope of practice for a pharmacist, patient care and consumer protection could be compromised. Board staff suggests that the Board oppose this bill unless it is amended to remove the APP recognition and related expanded scope expansion from the bill, or is significantly amended to require physician supervision or collaboration so it would not allow totally independent practice regarding the drug therapy and prescribing authority.

FISCAL: Minimal and absorbable workload to help develop standardized procedures.

SUPPORT: None known (at this time)

OPPOSITION: California Medical Association
Various Individuals

POSITION: Recommendation: Oppose Unless Amended

AMENDED IN SENATE APRIL 1, 2013

SENATE BILL No. 493

Introduced by Senator Hernandez

February 21, 2013

An act to amend ~~Section 4050 of~~ *Sections 733, 4050, 4051, 4052, 4052.3, and 4060 of, and to add Sections 4016.5, 4052.6, 4052.8, 4052.9, 4210, and 4233 to,* the Business and Professions Code, relating to ~~pharmacies~~ *pharmacy.*

LEGISLATIVE COUNSEL'S DIGEST

SB 493, as amended, Hernandez. Pharmacy practice.

The Pharmacy Law provides for the licensing and regulation of pharmacists by the California State Board of Pharmacy in the Department of Consumer Affairs~~, and states that pharmacy practice is a dynamic, patient-oriented health service that applies a scientific body of knowledge to improve and promote patient health by means of appropriate drug use and drug-related therapy~~. *The law specifies the functions pharmacists are authorized to perform, including to administer, orally or topically, drugs and biologicals pursuant to a prescriber's order, and to administer immunizations pursuant to a protocol with a prescriber. Pharmacists may also furnish emergency contraception drug therapy pursuant to standardized procedures if they have completed a training program. A violation of the Pharmacy Law is a crime.*

~~This bill would make a technical, nonsubstantive change to that provision.~~

This bill, instead, would authorize a pharmacist to administer drugs and biological products that have been ordered by a prescriber. The bill would expand other functions pharmacists are authorized to

perform, including, among other things, to furnish self-administered hormonal contraceptives, prescription smoking-cessation drugs, and prescription medications not requiring a diagnosis that are recommended for international travelers, as specified. Additionally, the bill would authorize pharmacists to order and interpret tests for the purpose of monitoring and managing the efficacy and toxicity of drug therapies, and to independently initiate and administer routine vaccinations, as specified. This bill also would establish board recognition for an advanced practice pharmacist, as defined, would specify the criteria for that recognition, and would specify additional functions that may be performed by an advanced practice pharmacist, including, among other things, performing physical assessments, and certain other functions, as specified. Because a violation of these provisions would be a crime, the bill would impose a state-mandated local program.

The bill would make other conforming and technical changes.

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. Section 733 of the Business and Professions Code*
2 *is amended to read:*
3 733. (a) ~~No~~ *A* licentiate shall *not* obstruct a patient in obtaining
4 a prescription drug or device that has been legally prescribed or
5 ordered for that patient. A violation of this section constitutes
6 unprofessional conduct by the licentiate and shall subject the
7 licentiate to disciplinary or administrative action by his or her
8 licensing agency.
9 (b) Notwithstanding any other ~~provision of~~ law, a licentiate
10 shall dispense drugs and devices, as described in subdivision (a)
11 of Section 4024, pursuant to a lawful order or prescription unless
12 one of the following circumstances exists:

(1) Based solely on the licentiate's professional training and judgment, dispensing pursuant to the order or the prescription is contrary to law, or the licentiate determines that the prescribed drug or device would cause a harmful drug interaction or would otherwise adversely affect the patient's medical condition.

(2) The prescription drug or device is not in stock. If an order, other than an order described in Section 4019, or prescription cannot be dispensed because the drug or device is not in stock, the licentiate shall take one of the following actions:

(A) Immediately notify the patient and arrange for the drug or device to be delivered to the site or directly to the patient in a timely manner.

(B) Promptly transfer the prescription to another pharmacy known to stock the prescription drug or device that is near enough to the site from which the prescription or order is transferred, to ensure the patient has timely access to the drug or device.

(C) Return the prescription to the patient and refer the patient. The licentiate shall make a reasonable effort to refer the patient to a pharmacy that stocks the prescription drug or device that is near enough to the referring site to ensure that the patient has timely access to the drug or device.

(3) The licentiate refuses on ethical, moral, or religious grounds to dispense a drug or device pursuant to an order or prescription. A licentiate may decline to dispense a prescription drug or device on this basis only if the licentiate has previously notified his or her employer, in writing, of the drug or class of drugs to which he or she objects, and the licentiate's employer can, without creating undue hardship, provide a reasonable accommodation of the licentiate's objection. The licentiate's employer shall establish protocols that ensure that the patient has timely access to the prescribed drug or device despite the licentiate's refusal to dispense the prescription or order. For purposes of this section, "reasonable accommodation" and "undue hardship" shall have the same meaning as applied to those terms pursuant to subdivision (*l*) of Section 12940 of the Government Code.

(c) For the purposes of this section, "prescription drug or device" has the same meaning as the definition in Section 4022.

(d) ~~The provisions of this section shall apply to the~~ *This section applies to emergency contraception* drug therapy *and*

self-administered hormonal contraceptives described in Section 4052.3.

(e) This section imposes no duty on a licentiate to dispense a drug or device pursuant to a prescription or order without payment for the drug or device, including payment directly by the patient or through a third-party payer accepted by the licentiate or payment of any required copayment by the patient.

(f) The notice to consumers required by Section 4122 shall include a statement that describes patients' rights relative to the requirements of this section.

SEC. 2. Section 4016.5 is added to the Business and Professions Code, to read:

4016.5. "Advanced practice pharmacist" means a licensed pharmacist who has been recognized as an advanced practice pharmacist by the board, pursuant to Section 4210. A board-recognized advanced practice pharmacist is entitled to practice advanced practice pharmacy as described in Section 4052.6, within or outside of a licensed pharmacy as authorized by this chapter.

~~SECTION 1.~~

SEC. 3. Section 4050 of the Business and Professions Code is amended to read:

4050. (a) In recognition of and consistent with the decisions of the appellate courts of this state, the Legislature hereby declares the practice of pharmacy to be a profession.

(b) Pharmacy practice is a dynamic, patient-oriented health service that applies a scientific body of knowledge to improve and promote patient health by means of appropriate drug use, drug-related therapy, and communication for clinical and consultative purposes. Pharmacy practice is continually evolving to include more sophisticated and comprehensive patient care activities.

(c) The Legislature further declares that pharmacists are health care providers who have the authority to provide health care services.

SEC. 4. Section 4051 of the Business and Professions Code is amended to read:

4051. (a) Except as otherwise provided in this chapter, it is unlawful for any person to manufacture, compound, furnish, sell, or dispense ~~any~~ *a* dangerous drug or dangerous device, or to

dispense or compound ~~any~~ *a* prescription pursuant to Section 4040 of a prescriber unless he or she is a pharmacist under this chapter.

(b) Notwithstanding any other law, a pharmacist may authorize the initiation of a prescription, pursuant to Section 4052.1, 4052.2, ~~or~~ 4052.3, *or 4052.6,* and otherwise provide clinical advice ~~or~~, *services,* information, or patient consultation, *as set forth in this chapter,* if all of the following conditions are met:

(1) The clinical advice ~~or~~, *services,* information, or patient consultation is provided to a health care professional or to a patient.

(2) The pharmacist has access to prescription, patient profile, or other relevant medical information for purposes of patient and clinical consultation and advice.

(3) Access to the information described in paragraph (2) is secure from unauthorized access and use.

SEC. 5. Section 4052 of the Business and Professions Code is amended to read:

4052. (a) Notwithstanding any other ~~provision of~~ law, a pharmacist may:

(1) Furnish a reasonable quantity of compounded drug product to a prescriber for office use by the prescriber.

(2) Transmit a valid prescription to another pharmacist.

(3) Administer~~, orally or topically, drugs and biologicals pursuant to a prescriber's order~~ *drugs and biological products that have been ordered by a prescriber.*

(4) Perform procedures or functions in a licensed health care facility as authorized by Section 4052.1.

(5) Perform procedures or functions as part of the care provided by a health care facility, a licensed home health agency, a licensed clinic in which there is a physician oversight, a provider who contracts with a licensed health care service plan with regard to the care or services provided to the enrollees of that health care service plan, or a physician, as authorized by Section 4052.2.

(6) Perform procedures or functions as authorized by Section 4052.6.

~~(6)~~

(7) Manufacture, measure, fit to the patient, or sell and repair dangerous devices, or furnish instructions to the patient or the patient's representative concerning the use of those devices.

~~(7)~~

(8) Provide consultation, *training, and education* to patients ~~and~~ *about drug therapy, disease management, and disease prevention.*

(9) Provide professional information, including clinical or pharmacological information, advice, or consultation to other health care professionals, *and participate in multidisciplinary review of patient progress, including appropriate access to medical records.*

~~(8) Furnish emergency~~

(10) Furnish the following medications:

(A) Emergency contraception drug therapy *and self-administered hormonal contraceptives,* as authorized by Section 4052.3.

(B) Prescription smoking-cessation drugs and devices, as authorized by Section 4052.9.

(C) Prescription medications not requiring a diagnosis that are recommended by the federal Centers for Disease Control and Prevention for individuals traveling outside of the United States.

~~(9)~~

(11) Administer immunizations pursuant to a protocol with a prescriber.

(12) Order and interpret tests for the purpose of monitoring and managing the efficacy and toxicity of drug therapies.

(b) A pharmacist who is authorized to issue an order to initiate or adjust a controlled substance therapy pursuant to this section shall personally register with the federal Drug Enforcement Administration.

~~(c) Nothing in this section shall affect the requirements of existing law relating to maintaining the confidentiality of medical records.~~

~~(d) Nothing in this section shall affect the requirements of existing law relating to the licensing of a health care facility.~~

(c) This section does not affect the applicable requirements of law relating to either of the following:

(1) Maintaining the confidentiality of medical records.

(2) The licensing of a health care facility.

SEC. 6. Section 4052.3 of the Business and Professions Code is amended to read:

4052.3. (a) *(1) Notwithstanding any other law, a pharmacist may furnish self-administered hormonal contraceptives in accordance with standardized procedures or protocols developed*

and approved by both the board and the Medical Board of California in consultation with the American Congress of Obstetricians and Gynecologists, the California Pharmacists Association, and other appropriate entities. The standardized procedure or protocol shall require that the patient use a self-screening tool, based on the United States Medical Eligibility Criteria (USMEC) for Contraceptive Use developed by the federal Centers for Disease Control and Prevention, and that the pharmacist refer the patient to the patient's primary care provider or, if the patient does not have a primary care provider, to nearby clinics.

(2) The board and the Medical Board of California are both authorized to ensure compliance with this subdivision, and each board is specifically charged with the enforcement of this subdivision with respect to its respective licensees. This subdivision does not expand the authority of a pharmacist to prescribe any prescription medication.

(b) (1) Notwithstanding any other ~~provision of~~ law, a pharmacist may furnish emergency contraception drug therapy in accordance with either of the following:

~~(1)~~

(A) Standardized procedures or protocols developed by the pharmacist and an authorized prescriber who is acting within his or her scope of practice.

~~(2)~~

(B) Standardized procedures or protocols developed and approved by both the board and the Medical Board of California in consultation with the American ~~College~~ *Congress* of Obstetricians and Gynecologists, the California ~~Pharmacist~~ *Pharmacists* Association, and other appropriate entities. ~~Both the~~ *The* board and the Medical Board of California ~~shall have authority~~ *are both authorized* to ensure compliance with this clause, and ~~both boards are~~ *each board is* specifically charged with the enforcement of this provision with respect to ~~their~~ *its* respective licensees. ~~Nothing in this clause shall be construed to~~ *This subdivision does not* expand the authority of a pharmacist to prescribe any prescription medication.

~~(b)~~

(2) Prior to performing a procedure authorized under this ~~paragraph~~ *subdivision*, a pharmacist shall complete a training

program on emergency contraception that consists of at least one hour of approved continuing education on emergency contraception drug therapy.

~~(c)~~

(3) A pharmacist, pharmacist's employer, or pharmacist's agent ~~may~~ *shall* not directly charge a patient a separate consultation fee for emergency contraception drug therapy services initiated pursuant to this ~~paragraph~~ *subdivision*, but may charge an administrative fee not to exceed ten dollars ($10) above the retail cost of the drug. Upon an oral, telephonic, electronic, or written request from a patient or customer, a pharmacist or pharmacist's employee shall disclose the total retail price that a consumer would pay for emergency contraception drug therapy. As used in this ~~subparagraph~~ *paragraph*, total retail price includes providing the consumer with specific information regarding the price of the emergency contraception drugs and the price of the administrative fee charged. This limitation is not intended to interfere with other contractually agreed-upon terms between a pharmacist, a pharmacist's employer, or a pharmacist's agent, and a health care service plan or insurer. Patients who are insured or covered and receive a pharmacy benefit that covers the cost of emergency contraception shall not be required to pay an administrative fee. These patients shall be required to pay copayments pursuant to the terms and conditions of their coverage. ~~The provisions of this subparagraph shall cease to be operative~~ *This paragraph shall become inoperative* for dedicated emergency contraception drugs ~~when~~ *if* these drugs are reclassified as over-the-counter products by the federal Food and Drug Administration.

~~(d)~~

(4) A pharmacist ~~may~~ *shall* not require a patient to provide individually identifiable medical information that is not specified in Section 1707.1 of Title 16 of the California Code of Regulations before initiating emergency contraception drug therapy pursuant to this ~~section~~ *subdivision*.

~~(e)~~

(c) For each emergency contraception drug therapy *or self-administered hormonal contraception* initiated pursuant to this section, the pharmacist shall provide the recipient of the ~~emergency contraception drugs~~ *drug* with a standardized factsheet that includes, but is not limited to, the indications *and*

contraindications for use of the drug, the appropriate method for using the drug, the need for medical followup, and other appropriate information. The board shall develop this form in consultation with the State Department of Public Health, the American ~~College~~ *Congress* of Obstetricians and Gynecologists, the California Pharmacists Association, and other health care organizations. ~~The provisions of this section do~~ *This section does* not preclude the use of existing publications developed by nationally recognized medical organizations.

SEC. 7. Section 4052.6 is added to the Business and Professions Code, to read:

4052.6. (a) A pharmacist recognized by the board as an advanced practice pharmacist may do all of the following:

(1) Perform physical assessments.

(2) Order and interpret drug therapy-related tests.

(3) Refer patients to other health care providers.

(b) In addition to the authority provided in subdivision (a), a pharmacist recognized as an advanced practice pharmacist who is acting in collaboration with a patient's health care providers, operating under a protocol with a physician, health care facility, or health plan or disability insurer, or participating in a medical home, accountable care organization, or other system of care, may do both of the following:

(1) Initiate, adjust, or discontinue drug therapy. As used in this section, "adjust" means changing the dosage, duration, frequency, or potency of a drug.

(2) Participate in the evaluation and management of diseases and health conditions in collaboration with other health care providers.

(c) A pharmacist who adjusts or discontinues drug therapy shall promptly transmit written notification to the patient's diagnosing prescriber or enter the appropriate information in a patient record system shared with the prescriber. A pharmacist who initiates drug therapy shall promptly transmit written notification to, or enter the appropriate information into, a patient record system shared with the patient's primary care provider or diagnosing provider, as appropriate.

(d) This section shall not interfere with a physician's order to dispense a prescription drug as written, or other order of similar meaning.

(e) Prior to initiating or adjusting a controlled substance therapy pursuant to this section, a pharmacist shall personally register with the federal Drug Enforcement Administration.

SEC. 8. Section 4052.8 is added to the Business and Professions Code, to read:

4052.8. (a) In addition to the authority provided in paragraph (9) of subdivision (a) of Section 4052, a pharmacist may independently initiate and administer vaccines listed on the routine immunization schedules recommended by the federal Advisory Committee on Immunization Practices (ACIP), in compliance with individual ACIP vaccine recommendations, and published by the federal Centers for Disease Control and Prevention (CDC) for persons three years of age and older.

(b) In order to initiate and administer an immunization described in subdivision (a), a pharmacist shall do all of the following:

(1) Complete an immunization training program endorsed by the CDC or the Accreditation Council for Pharmacy Education that, at a minimum, includes hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines, and shall maintain that training.

(2) Be certified in basic life support.

(3) Comply with all state and federal recordkeeping and reporting requirements, including providing documentation to the patient's primary care provider and entering information in the appropriate immunization registry designated by the immunization branch of the State Department of Public Health.

(c) A pharmacist administering immunizations pursuant to this section, or paragraph (9) of subdivision (a) of Section 4052, may also initiate and administer epinephrine or diphenhydramine by injection for the treatment of a severe allergic reaction.

SEC. 9. Section 4052.9 is added to the Business and Professions Code, to read:

4052.9. A pharmacist may furnish prescription smoking-cessation drugs and devices, and provide smoking-cessation services if all of the following conditions are met:

(a) The pharmacist maintains records of all prescription drugs and devices furnished for a period of at least three years for

purposes of notifying other health care providers and monitoring the patient.

(b) The pharmacist notifies the patient's primary care provider of any drugs or devices furnished to the patient. If the patient does not have a primary care provider, the pharmacist provides the patient with a written record of the drugs or devices furnished and advises the patient to consult a physician of the patient's choice.

(c) The pharmacist is certified in smoking-cessation therapy by an organization recognized by the board.

(d) The pharmacist completes one hour of continuing education focused on smoking-cessation therapy biennially.

SEC. 10. Section 4060 of the Business and Professions Code is amended to read:

4060. ~~No~~ *A* person shall *not* possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to ~~either~~ Section 4052.1 ~~or~~, 4052.2, *or 4052.6*. This section ~~shall~~ *does* not apply to the possession of any controlled substance by a manufacturer, wholesaler, pharmacy, pharmacist, physician, podiatrist, dentist, optometrist, veterinarian, naturopathic doctor, certified nurse-midwife, nurse practitioner, or physician assistant, ~~when~~ *if* in stock in containers correctly labeled with the name and address of the supplier or producer.

~~Nothing in this section authorizes~~

This section does not authorize a certified nurse-midwife, a nurse practitioner, a physician assistant, or a naturopathic doctor, to order his or her own stock of dangerous drugs and devices.

SEC. 11. Section 4210 is added to the Business and Professions Code, to read:

4210. (a) A person who seeks recognition as an advanced practice pharmacist shall meet all of the following requirements:

(1) Hold an active license to practice pharmacy issued pursuant to this chapter that is in good standing.

(2) Satisfy any one of the following criteria:

(A) Earn certification in a relevant area of practice from an organization approved by a board-recognized accrediting agency or another entity recognized by the board.

(B) Complete a one-year postgraduate residency where at least 50 percent of the experience includes the provision of direct patient care services with interdisciplinary teams.

(C) Have actively managed patients for at least one year under a collaborative practice agreement or protocol with a physician, advanced practice pharmacist, pharmacist practicing collaborative drug therapy management, or health system.

(3) File an application with the board for recognition as an advanced practice pharmacist.

(4) Pay the applicable fee to the board.

(b) An advanced practice pharmacist recognition issued pursuant to this section shall be valid for two years, coterminous with the certificate holder's license to practice pharmacy.

SEC. 12. Section 4233 is added to the Business and Professions Code, to read:

4233. A pharmacist who is recognized as an advanced practice pharmacist shall complete 10 hours of continuing education each renewal cycle in addition to the requirements of Section 4231. The subject matter shall be in one or more areas of practice relevant to the pharmacist's clinical practice.

SEC. 13. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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SB 670

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 670
Author: Steinberg
Bill Date: April 8, 2013, Amended
Subject: Physicians: Drug Prescribing Privileges: Investigation
Sponsor: Author

STATUS OF BILL:

This bill is in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would authorize the Medical Board of California (the Board) to inspect the medical records of a patient who dies of a prescription drug overdose without the consent of the patient's next of kin or a court order. This bill would make it unprofessional conduct, for a licensee who is under investigation, if the licensee fails to attend and participate in an interview of the Board within 30 days of notification from the Board. Lastly, this bill would allow the Board to impose limitations on the authority of a physician to prescribe, furnish, administer, or dispense controlled substances during a pending investigation if there is a reasonable suspicion that the physician is overprescribing drugs or whose prescribing has resulted in the death of a patient.

ANALYSIS:

Currently, if the Board is investigating a physician whose patient has died, the Board must receive written authorization by the patient's next of kin in order to obtain the patient's medical records. The Board needs the medical records in order to determine if a physician is prescribing appropriately. If the Board cannot obtain the medical records, it has to go to court to get those records through a subpoena and it must be proven that there is a compelling state need in order to obtain those records through a subpoena. In the past, prescription drug monitoring data (from CURES) has not been successful in compelling the state to release those records.

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

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

This bill would allow the Board to obtain medical records without a written release by the patient's next of kin or a court order if the board receives a report from a coroner or a peer review report that involves the death of a patient from a prescription drug overdose. This will allow the Board to move forward with its investigation in a more expedient manner, and help to ensure consumer protection.

In the Board's 2012 Sunset Review Report, information was included related to existing law regarding unprofessional conduct and physician interviews. Existing law provides that it only constitutes unprofessional conduct if a physician repeatedly fails to come to the interview that has been scheduled by "mutual agreement" of the physician and the Board. Although the existing statute was well intended, it has been infective in reducing the time it takes to complete an interview with a licensee and in fact may have resulted in physicians failing to agree to any interview with the Board. The report recommended that no more than thirty days should elapse between the time the interview is requested and completed.

This bill would require a physician to attend and participate in an interview within 30 days of notification from the Board.

Requiring the interview to be conducted within 30 days will significantly reduce the timeline for the physician interview and will force the physician to agree to an interview time.

Currently, in order for the Board to stop a physician from practicing while the physician is under investigation, the Board must request an Interim Suspension Order (ISO), which must be granted by an Administrative Law Judge (ALJ). An ISO is considered extraordinary relief and the Board must prove that a physician's continued practice presents an immediate danger to public health, safety, or welfare. In addition, there is a 15-day time restraint in law to file an accusation after being granted an ISO, and a 30-day time restraint between the accusation being filed and a hearing being set, which means an investigation must be nearly complete in order to file for an ISO. The Board can currently only restrict a physician from prescribing if the physician is under probation and limits on prescribing are part of the terms and conditions of that probation that has been adopted or stipulated to by the Board.

This bill would require the Board to impose limitations on the authority of physician to prescribe, furnish, administer, or dispense controlled substances during a pending investigation if there is a reasonable suspicion that the physician has overprescribed drugs or engaged in prescribing behavior that has resulted in the death of a patient.

This would give the Board authority to stop physicians from prescribing drugs if the Board is investigating the physician and believes the physician is overprescribing or their prescribing has resulted in the death of the patient. However, the process for when and in what circumstances that Board could put this type of a restriction on the physicians would need to be spelled out in this bill or in regulations. Also, it is not clear in the bill if there would be due process given to the physician if the Board were to impose limitations on a physician's prescribing privileges.

The author introduced this bill due to the Los Angeles Times investigation that uncovered significant issues with physicians, overprescribing and patient deaths. This bill will help to speed up investigations in cases where patients have died as a result of prescription drug overdose. This bill will also make improvements to the Board's enforcement process, which will result in timelier investigations. Board staff suggests that the Board support this bill if it is amended to make it clear when and how the Board can impose limitations on a physician's prescribing privileges and the due process afforded to the physician.

FISCAL: Minimal and absorbable

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Support if Amended

AMENDED IN SENATE APRIL 8, 2013

SENATE BILL No. 670

Introduced by Senator Steinberg

February 22, 2013

An act *to amend Sections 2225 and 2234 of, and to add Section 2221.5 to, the Business and Professions Code, and* to amend Section 11529 of the Government Code, relating to ~~administrative adjudication~~ *healing arts.*

LEGISLATIVE COUNSEL'S DIGEST

SB 670, as amended, Steinberg. ~~Medical Quality Hearing Panel: limitation on licensee authority: controlled substances.~~ *Physicians and surgeons: drug prescribing privileges: investigation.*

(1) Existing law authorizes investigators and representatives of the Medical Board of California, among others, to inquire into any alleged violation of the Medical Practice Act or any other federal or state law, regulation, or rule relevant to the practice of medicine or podiatric medicine, and to inspect documents relevant to those investigations, including the inspection and copying of any document relevant to an investigation where patient consent is given.

Existing law requires specified persons, including the administrator of a peer review body, to file a report with the board within 15 days after the effective date of any specified action taken against a licensee for a medical disciplinary cause or reason. Existing law also requires a coroner to make a report to the board, among other specified entities, when he or she receives information that indicates that a death may be the result of a physician and surgeon's, podiatrist's, or physician assistant's gross negligence or incompetence.

This bill would authorize the board, if it receives a report pursuant to either of the provisions described above that involves the death of a patient from a prescription drug overdose, to inspect and copy the medical records of the deceased patient without the consent of the patient's next of kin or a court order in order to determine the extent to which the death was the result of a prescriber's inappropriate conduct.

(2) Existing law requires the board to take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct is defined for this purpose to include, among other things, the repeated failure by a licensee who is the subject of a board investigation, in the absence of good cause, to attend and participate in an interview scheduled by the mutual agreement of the licensee and the board.

This bill would revise that definition of unprofessional conduct to include the failure by a licensee who is the subject of a board investigation, in the absence of good cause, to attend and participate in an interview scheduled within 30 days of notification from the board.

(3) Existing law, the Administrative Procedure Act, authorizes the administrative law judge of the Medical Quality Hearing Panel to issue an interim order suspending a license, or imposing drug testing, continuing education, supervision of procedures, or other licensee restrictions.

This bill would further authorize the administrative law judge to issue an interim order limiting the authority to prescribe, furnish, administer, or dispense controlled substances. The bill would also ~~declare the intent of the Legislature to enact legislation that would significantly reduce the time in which a disciplinary proceeding against a physician is adjudicated, if the proceeding involves a patient who has died as a result of the overprescribing of controlled substances~~ *require the board, notwithstanding the authority of an administrative law judge to issue an interim order, to impose limitations on the authority of a physician and surgeon to prescribe, furnish, administer, or dispense controlled substances during a pending investigation if there is a reasonable suspicion that the physician and surgeon has engaged in overprescribing drugs or other behavior related to his or her drug prescribing privileges that has resulted in the death of a patient.*

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

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

~~SECTION 1. It is the intent of the Legislature to enact legislation that would significantly reduce the time in which a disciplinary proceeding against a physician is adjudicated, if the proceeding involves a patient who has died as a result of the overprescribing of controlled substances.~~

SECTION 1. Section 2221.5 is added to the Business and Professions Code, to read:

2221.5. Notwithstanding Section 11529 of the Government Code, the board shall impose limitations on the authority of a physician and surgeon to prescribe, furnish, administer, or dispense controlled substances during a pending investigation if there is a reasonable suspicion that the physician and surgeon has engaged in either of the following:

(a) Overprescribing drugs.

(b) Other behavior related to his or her drug prescribing privileges that has resulted in the death of a patient.

SEC. 2. Section 2225 of the Business and Professions Code is amended to read:

2225. (a) Notwithstanding Section 2263 and any other ~~provision of~~ law making a communication between a physician and surgeon or a doctor of podiatric medicine and his or her patients a privileged communication, those provisions shall not apply to investigations or proceedings conducted under this chapter. Members of the board, the Senior Assistant Attorney General of the Health Quality Enforcement Section, members of the California Board of Podiatric Medicine, and deputies, employees, agents, and representatives of the board or the California Board of Podiatric Medicine and the Senior Assistant Attorney General of the Health Quality Enforcement Section shall keep in confidence during the course of investigations, the names of any patients whose records are reviewed and ~~may~~ *shall* not disclose or reveal those names, except as is necessary during the course of an investigation, unless and until proceedings are instituted. The authority of the board or the California Board of Podiatric Medicine and the Health Quality Enforcement Section to examine records of patients in the office of a physician and surgeon or a doctor of podiatric medicine is limited to records of patients who have complained to the board or the California Board of Podiatric Medicine about that licensee.

(b) Notwithstanding any other ~~provision of~~ law, the Attorney General and his or her investigative agents, and investigators and

representatives of the board or the California Board of Podiatric Medicine, may inquire into any alleged violation of the Medical Practice Act or any other federal or state law, regulation, or rule relevant to the practice of medicine or podiatric medicine, whichever is applicable, and may inspect documents relevant to those investigations in accordance with the following procedures:

(1) Any document relevant to an investigation may be inspected, and copies may be obtained, where patient consent is given.

(2) Any document relevant to the business operations of a licensee, and not involving medical records attributable to identifiable patients, may be inspected and copied ~~where~~ *if* relevant to an investigation of a licensee.

(c) Notwithstanding subdivision (b) or any other law, if the board receives a report pursuant to Section 802.5 or 805 that involves the death of a patient from a prescription drug overdose, the board may inspect and copy the medical records of the deceased patient without the consent of the patient's next of kin or a court order in order to determine the extent to which the death was the result of a prescriber's inappropriate conduct.

~~(c)~~

(d) In all cases ~~where~~ *in which* documents are inspected or copies of those documents are received, their acquisition or review shall be arranged so as not to unnecessarily disrupt the medical and business operations of the licensee or of the facility where the records are kept or used.

~~(d) Where~~

(e) If documents are lawfully requested from licensees in accordance with this section by the Attorney General or his or her agents or deputies, or investigators of the board or the California Board of Podiatric Medicine, ~~they~~ *the documents* shall be provided within 15 business days of receipt of the request, unless the licensee is unable to provide the documents within this time period for good cause, including, but not limited to, physical inability to access the records in the time allowed due to illness or travel. Failure to produce requested documents or copies thereof, after being informed of the required deadline, shall constitute unprofessional conduct. The board may use its authority to cite and fine a physician and surgeon for any violation of this section. This remedy is in addition to any other authority of the board to sanction a licensee for a delay in producing requested records.

~~(e)~~

(f) Searches conducted of the office or medical facility of any licensee shall not interfere with the recordkeeping format or preservation needs of any licensee necessary for the lawful care of patients.

SEC. 3. Section 2234 of the Business and Professions Code is amended to read:

2234. The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption ~~which~~ *that* is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct ~~which~~ *that* would have warranted the denial of a certificate.

(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

(h) The ~~repeated~~ failure by a certificate holder, in the absence of good cause, to attend and participate in an interview scheduled ~~by the mutual agreement of the certificate holder and~~ *within 30 days of notification from* the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

~~SEC. 2.~~

SEC. 4. Section 11529 of the Government Code is amended to read:

11529. (a) The administrative law judge of the Medical Quality Hearing Panel established pursuant to Section 11371 may issue an interim order suspending a license, imposing drug testing, continuing education, supervision of procedures, limitations on the authority to prescribe, furnish, administer, or dispense controlled substances, or other license restrictions. Interim orders may be issued only if the affidavits in support of the petition show that the licensee has engaged in, or is about to engage in, acts or omissions constituting a violation of the Medical Practice Act or the appropriate practice act governing each allied health profession, or is unable to practice safely due to a mental or physical condition, and that permitting the licensee to continue to engage in the profession for which the license was issued will endanger the public health, safety, or welfare.

(b) All orders authorized by this section shall be issued only after a hearing conducted pursuant to subdivision (d), unless it appears from the facts shown by affidavit that serious injury would result to the public before the matter can be heard on notice. Except as provided in subdivision (c), the licensee shall receive at least 15 days' prior notice of the hearing, which notice shall include affidavits and all other information in support of the order.

(c) If an interim order is issued without notice, the administrative law judge who issued the order without notice shall cause the licensee to be notified of the order, including affidavits and all other information in support of the order by a 24-hour delivery service. That notice shall also include the date of the hearing on the order, which shall be conducted in accordance with the requirement of subdivision (d), not later than 20 days from the date of issuance. The order shall be dissolved unless the requirements of subdivision (a) are satisfied.

(d) For the purposes of the hearing conducted pursuant to this section, the licentiate shall, at a minimum, have the following rights:

(1) To be represented by counsel.

(2) To have a record made of the proceedings, copies of which may be obtained by the licentiate upon payment of any reasonable charges associated with the record.

(3) To present written evidence in the form of relevant declarations, affidavits, and documents.

The discretion of the administrative law judge to permit testimony at the hearing conducted pursuant to this section shall be identical to the discretion of a superior court judge to permit testimony at a hearing conducted pursuant to Section 527 of the Code of Civil Procedure.

(4) To present oral argument.

(e) Consistent with the burden and standards of proof applicable to a preliminary injunction entered under Section 527 of the Code of Civil Procedure, the administrative law judge shall grant the interim order ~~where~~ *if*, in the exercise of discretion, the administrative law judge concludes that:

(1) There is a reasonable probability that the petitioner will prevail in the underlying action.

(2) The likelihood of injury to the public in not issuing the order outweighs the likelihood of injury to the licensee in issuing the order.

(f) In all cases ~~where~~ *in which* an interim order is issued, and an accusation is not filed and served pursuant to Sections 11503 and 11505 within 15 days of the date ~~in~~ *on* which the parties to the hearing on the interim order have submitted the matter, the order shall be dissolved.

Upon service of the accusation the licensee shall have, in addition to the rights granted by this section, all of the rights and privileges available as specified in this chapter. If the licensee requests a hearing on the accusation, the board shall provide the licensee with a hearing within 30 days of the request, unless the licensee stipulates to a later hearing, and a decision within 15 days of the date the decision is received from the administrative law judge, or the board shall nullify the interim order previously issued, unless good cause can be shown by the Division of Medical Quality for a delay.

(g) ~~Where~~ *If* an interim order is issued, a written decision shall be prepared within 15 days of the hearing, by the administrative law judge, including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached.

(h) Notwithstanding the fact that interim orders issued pursuant to this section are not issued after a hearing as otherwise required by this chapter, interim orders so issued shall be subject to judicial review pursuant to Section 1094.5 of the Code of Civil Procedure. The relief ~~which~~ *that* may be ordered shall be limited to a stay of the interim order. Interim orders issued pursuant to this section are final interim orders and, if not dissolved pursuant to subdivision (c) or (f), may only be challenged administratively at the hearing on the accusation.

(i) The interim order provided for by this section shall be:

(1) In addition to, and not a limitation on, the authority to seek injunctive relief provided for in the Business and Professions Code.

(2) A limitation on the emergency decision procedure provided in Article 13 (commencing with Section 11460.10) of Chapter 4.5.

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SB 809

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: California Attorney General Kamala Harris

STATUS OF BILL:

This bill is in the Senate Governance and Finance 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 or a flat fee of $9. 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.

The Executive Committee voted to recommend 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:
California Attorney General Kamala Harris (Sponsor)
California Medical Association (if amended)
California Narcotics Officers Association
California Pharmacists Association
California Police Chiefs Association
California State Sheriffs' Association
Center for Public Interest Law (CPIL)
City and County of San Francisco
Healthcare Distribution Management Association
Troy and Alanna Pack Foundation
University of California

OPPOSITION: Pharmaceutical Research and Manufacturers of America

POSITION: Executive Committee Recommendation: Support in Concept with noted concerns:

- Fee increase should be biennial versus annual and should be a flat fee.
- An implementation schedule for the fee increase should be addressed, as it is impossible to implement on the day the bill is signed.
- 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

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,

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: ⅔. 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

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

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

805.8. (a) (1) The Medical Board of California, the Dental Board of California, the California State Board of Pharmacy, the 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 shall increase the licensure, certification, and renewal fees charged to practitioners under their supervision who are authorized pursuant to Section 11150 of the Health and Safety Code to prescribe or dispense Schedule II, Schedule III, or Schedule IV controlled substances by up to 1.16 percent annually, but in no case shall the fee increase exceed the reasonable costs associated with maintaining CURES for the purpose of regulating prescribers and dispensers of controlled substances licensed or certificated by these boards.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) Quantity of the controlled substance dispensed.

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

(7) Number of refills ordered.

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

(9) Date of origin of the prescription.

(10) Date of dispensing of the prescription.

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

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

11165.1. (a) (1) A licensed health care practitioner eligible to prescribe Schedule II, Schedule III, or Schedule IV controlled substances or a pharmacist ~~may~~ *shall* provide a notarized application developed by the Department of Justice to obtain approval to access information stored on the Internet regarding the controlled substance history of a patient maintained within the Department of Justice, ~~and~~ *and, upon approval,* the department ~~may~~ *shall* release to that practitioner or pharmacist, the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES Prescription Drug Monitoring Program (PDMP).

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

(i) Materially falsifying an application for a subscriber.

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

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

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

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

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

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

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

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

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

(2) Upon the Department of Justice issuing the notification described in paragraph (3) and approval of the application required pursuant to subdivision (a), licensed health care practitioners eligible to prescribe Schedule II, Schedule III, or Schedule IV controlled substances and pharmacists shall access and consult the electronic history of controlled substances dispensed to an individual under his or her care prior to prescribing or dispensing a Schedule II, Schedule III, or Schedule IV controlled substance.

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

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

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

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

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

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

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

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

(b) "Insurer" means a health insurer licensed pursuant to Part 2 (commencing with Section 10110) of Division 2 of the Insurance Code, a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), and a workers' compensation insurer licensed pursuant to Part 3 (commencing with Section 11550) of Division 2 of the Insurance Code.

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

4196) of Chapter 9 of Division 2 of the Business and Professions Code, or an individual regulated by the Medical Board of California, the Dental Board of California, the California State Board of Pharmacy, the 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, or the California Board of Podiatric Medicine.

42003. (a) For the privilege of doing business in this state, an annual tax is hereby imposed on all qualified manufacturers in an amount of ____ dollars ($____), for the purpose of establishing and maintaining enforcement of the Controlled Substance Utilization Review and Evaluation System (CURES), established pursuant to Section 11165 of the Health and Safety Code.

(b) For the privilege of doing business in this state, a tax is hereby imposed on a one time basis on all insurers in an amount of ____ dollars ($____), for the purpose of upgrading CURES.

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

42007. The board shall administer and collect the tax imposed by this part pursuant to the Fee Collection Procedures Law (Part 30 (commencing with Section 55001)). For purposes of this part, the references in the Fee Collection Procedures Law (Part 30 (commencing with Section 55001)) to "fee" shall include the tax imposed by this part and references to "feepayer" shall include a person required to pay the tax imposed by this part.

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

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

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

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.

O

SCR 8

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SCR 8
Author: DeSaulnier
Bill Date: April 15, 2013, Amended
Subject: Prescription Drug Abuse Awareness Month
Sponsor: Author
Position: Support

STATUS OF BILL:

This resolution has been resolved and concurred to by the Senate and the Assembly.

DESCRIPTION OF CURRENT LEGISLATION:

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

ANALYSIS:

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

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

The epidemic of prescription drug abuse and overdoses is plaguing the nation, as well as California. This bill would help to increase awareness of the prescription drug abuse problem in California and would encourage participation in prescription medication abuse prevention programs. The Board has taken a support position on this resolution, which has been resolved by the Senate and the Assembly.

FISCAL: None to the Board.

SUPPORT: National Coalition Against Prescription Drug Abuse
The Board

OPPOSITION: None on file

AMENDED IN ASSEMBLY APRIL 15, 2013

Senate Concurrent Resolution No. 8

Introduced by Senator DeSaulnier
(Coauthors: Senators *Block, Cannella, Correa,* Hancock, *Hill,* Lieu, ~~and Price~~ *Monning, Pavley, Price, Walters, and Wolk*)
(Coauthors: Assembly Members Ammiano, Bloom, Blumenfield, Brown, Fox, Nestande, V. Manuel Pérez, Quirk-Silva, Salas, Ting, Wagner, Waldron, and Wilk)

January 14, 2013

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

LEGISLATIVE COUNSEL'S DIGEST

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

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

Fiscal committee: no.

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

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

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

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

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

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

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

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

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

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

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

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MEDICAL BOARD OF CALIFORNIA
Status of Pending Regulations

Subject	Current Status	Date Approved by Board	Date Notice Published by OAL	Date of Public Hearing	Date of Final Adoption by Board	Date to DCA (and other control agencies) for Final Review *	Date to OAL for Review **	Date to Sec. of State***
Misdemeanor Convictions	3/1/13 Returned by Agency to MBC for review and changes 3/25/13 Modified Text mailed; 15-day comment period ends 4/17/13 4/26/13 Board to review/approve changes	2/03/12	3/09/12 (90 day extension granted until 6/05/13)	5/04/12	5/04/12			
Physician Availability related to the use of lasers	Delivered to OAL 3/4/13	7/20/12	8/31/12	10/26/12	10/26/12	At DCA for review and approval. Sent to Agency 2/12/13 Agency signed off on 2/27/13.	Delivered to OAL 3/4/13	
Polysom Basic Life Support (to amend 1379.50)	10/26/12 Hearing held 11/14/12 Modified text mailed; 15-day comment period ended 12/04/12. 3/4/13 delivered to DCA for review and approval 3/18/13 DCA returned for updates	7/20/12	8/31/12	10/26/12	10/26/12	Returned to DCA with updates on 3/26/13		

Prepared by Chris Valine
Updated April 2, 2013
For questions, call (916) 263-2466

*DCA is allowed 30 calendar days for review
**OAL is allowed 30 working days for review
***Eff. Date depends on when OAL makes their approval decision

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

FY 2012-13 Governor's Budget	ACTUAL 2011-12	CURRENT YEAR 2012-13	BY 2013-14	BY+1 2014-15	BY+2 2015-16
BEGINNING BALANCE	$ 30,246	$ 24,613	$ 20,835	$ 16,243	$ 8,535
Prior Year Adjustment	$ 752	$ -	$ -	$ -	$ -
Adjusted Beginning Balance	$ 30,998	$ 24,613	$ 20,835	$ 16,243	$ 8,535
REVENUES AND TRANSFERS					
Revenues:					
125600 Other regulatory fees	$ 355	$ 287	$ 288	$ 288	$ 288
125700 Other regulatory licenses and permits	$ 5,946	$ 5,646	$ 5,647	$ 5,647	$ 5,647
125800 Renewal fees	$ 46,269	$ 45,445	$ 45,481	$ 45,481	$ 45,481
125900 Delinquent fees	$ 120	$ 98	$ 98	$ 98	$ 98
142500 Miscellaneous services to the public	$ 31	$ 30	$ 30	$ 30	$ 30
150300 Income from surplus money investments	$ 115	$ 88	$ 60	$ 42	$ 69
160400 Sale of fixed assets	$ 3	$ -	$ -	$ -	$ -
161000 Escheat of unclaimed checks and warrants	$ 16	$ -	$ -	$ -	$ -
161400 Miscellaneous revenues	$ 2	$ 19	$ 19	$ 19	$ 19
164300 Penalty assessments - Probation Monitoring		$ 900	$ 900	$ 900	$ 900
Totals, Revenues	$ 52,857	$ 52,513	$ 52,523	$ 52,505	$ 52,532
Transfers:					
GENERAL FUND LOAN*	$ (9,000)				
TOTALS, REVENUES AND TRANSFERS	$ 43,857	$ 52,513	$ 52,523	$ 52,505	$ 52,532
TOTAL RESOURCES	$ 74,855	$ 77,126	$ 73,358	$ 68,748	$ 61,067
EXPENDITURES					
Disbursements:					
0840 State Controller (State Operations)	$ 58	$ 67		$ -	$ -
8880 FSCU (State Operations)	$ 2	$ 302	$ 259		
FISCAL	$ 126	$			
1110 Program Expenditures (State Operations)	$ 50,056	$ 55,922 **	$ 55,673	$ 57,993	$ 57,980
2013-2014 Proposed BCP					
BreEZe Costs			$ 1,183		
Anticipated Future Costs					
Antcipated BreEZe Cost				$ 1,300	$ 1,300
Northern Operation Safe Medicine				$ 253	$ 203
Enforcement Enhancements				$ 667	$ 575
Totals, Disbursements	$ 50,242	$ 56,291	$ 57,115	$ 60,213	$ 60,058
FUND BALANCE					
Reserve for economic uncertainties	$ 24,613	$ 20,835	$ 16,243	$ 8,535	$ 1,009
Months in Reserve	5.2	4.4	3.2	1.7	0.2

NOTES:

A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED FOR 2011-12 AND BEYOND.

B. INTEREST ON FUND ESTIMATED AT .68% in FY 10/11 and beyond.

* This $9 million is part of the $15 million total loaned to the General Fund by the Board. $6 million was loaned to the General Fund in FY 08/09. These loans will be repaid when the fund is nearing its minimum mandated level.

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

4/8/2013

Medical Board of California
FY 12/13
Budget Expenditure Report
(As of FEBRUARY 28, 2013)
(67% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENSES/ ENCUMB	PERCENT OF BUDGET EXP/ENCUMB	UNENCUMB BALANCE
PERSONAL SERVICES				
Salary & Wages				
(Staff & Exec Director)	15,268,382	9,633,699	63.1	5,634,683
Board Members	31,500	36,384	115.5	(4,884)
Phy Fitness Incentive Pay	29,623	20,250	68.4	9,373
Temp Help	1,137,513	951,342	83.6	186,171
Overtime	12,143	31,488	259.3	(19,345)
Staff Benefits	7,775,513	4,621,315	59.4	3,154,198
Salary Savings	0			0
TOTALS, PERS SERVICES	24,254,674	15,294,479	63.1	8,960,196
OPERATING EXP & EQUIP				
General Expense	608,071	450,352	74.1	157,719
Fingerprint Reports	333,448	189,071	56.7	144,377
Minor Equipment	132,300	41,081	31.1	91,219
Printing	685,755	168,169	24.5	517,586
Communications	372,190	134,594	36.2	237,596
Postage	282,511	112,205	39.7	170,306
Insurance	41,053	17,295	42.1	23,758
Travel In-State	401,298	176,153	43.9	225,145
Travel Out-of-State	7,000	2,854	40.8	4,146
Training	78,895	65,734	83.3	13,161
Facilities Operation (Rent)	2,702,140	2,204,846	81.6	497,294
Consult/Prof Services	1,606,594	1,936,989	120.6	(330,395)
Departmental Prorata	4,540,957	3,409,982	75.1	1,130,975
Interagency Services	5,142	0	0.0	5,142
Consolidated Data Center	650,230	428,842	66.0	221,388
Data Processing	129,492	54,468	42.1	75,024
Central Admin Svcs (Statewide Prorata)	2,348,960	1,761,720	75.0	587,240
Attorney General Services	13,347,280	7,819,038	58.6	5,528,242
Office of Administrative Hearings	1,525,080	824,762	54.1	700,318
Evidence/Witness	1,893,439	1,185,994	62.6	707,445
Court Reporter Services	225,000	187,018	83.1	37,982
Major Equipment	652,000	44,401	6.8	607,599
Other Items of Expense	81	64,560	79,703.7	(64,479)
Vehicle Operations	261,925	186,587	71.2	75,338
Court-ordered Payments	0	10,927		(10,927)
Board of Control Claim	0	0		0
TOTALS, OE&E	32,830,841	21,477,642	65.4	11,353,199
TOTALS, EXPENDITURES	57,085,515	36,772,121	64.4	20,313,394
Scheduled Reimbursements	(384,000)	(236,858)	61.7	(147,142)
Distributed Costs	(780,000)	(402,746)	51.6	(377,254)
NET TOTAL, EXPENDITURES	55,921,516	36,132,517	64.6	19,788,998
Unscheduled Reimbursements		(1,114,592)		
		35,017,925		

Budget Expenditure Report.xls
Date: April 08, 2013

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
BUDGET REPORT
JULY 1, 2012 to FEBRUARY 28, 2013

	FY 12/13 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	2,476,739	1,602,667	current
Staff Benefits	1,216,790	756,818	current
TOTAL PERSONAL SERVICES	3,693,529	2,359,485	
OPERATING EXPENSES & EQUIPMENT			
General Expense	58,184	12,408	1-2
Fingerprint Reports*	333,448	187,849	1-2
Printing	61,000	25,741	1-2
Communications	52,246	12,413	1-2
Postage	125,000	68,661	1-2
Travel In-State	14,758	628	1-2
Training	8,500	1,478	1-2
Facilities Operation	226,000	204,056	current
Consult/Professional Services	1,225,873	1,710,180	1-2
Departmental Services	519,486	333,331	current
Interagency Services	587	0	current
Data Processing	4,000	4,672	1-2
Statewide Pro Rata	268,016	201,012	current
Attorney General	190,000	83,140	current
Evidence/Witness Fees	7,500	0	1-2
Court Reporter Services	250	0	1-2
Major Equipment	26,000	8,375	1-2
Minor Equipment	0	0	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	3,120,848	2,853,944	
SCHEDULED REIMBURSEMENTS	(384,000)	(236,858)	
DISTRIBUTED COSTS	(31,130)	(15,565)	
TOTAL BUDGET/EXPENDITURES	**6,399,247**	**4,961,006**	

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

4/8/2013

MEDICAL BOARD OF CALIFORNIA
ENFORCEMENT PROGRAM
BUDGET REPORT
JULY 1, 2012-FEBRUARY 28, 2013

	FY 12/13 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	9,884,363	6,340,821	current
Staff Benefits	4,545,798	2,707,052	current
TOTAL PERSONAL SERVICES	14,430,161	9,047,873	
OPERATING EXPENSE & EQUIPMENT			
General Expense/Fingerprint Reports	389,307	319,423	1-2
Printing	300,255	68,389	1-2
Communications	222,358	91,579	1-2
Postage	69,500	38,775	1-2
Insurance	38,235	14,890	current
Travel In-State	242,018	129,632	1-2
Travel Out-State	7,000	2,674	1-2
Training	31,000	51,168	1-2
Facililties Operations	2,064,940	1,636,001	current
Consultant/Professional Services	300,000	214,187	1-2
Departmental Services	3,191,838	2,542,145	current
Interagency Services	3,613	0	1-2
Data Processing	18,000	1,795	1-2
Statewide Pro Rata	1,650,379	1,237,784	current
Attorney General 1/	13,157,280	7,735,898	current
OAH	1,525,080	824,762	1
Evidence/Witness Fees	1,820,939	1,116,950	1-2
Court Reporter Services	224,750	187,018	1-2
Major Equipment	147,000	18,032	1-2
Other Items of Expense (Law Enf. Materials/Lab, etc.)	81	62,293	1-2
Vehicle Operations	210,925	156,234	1-2
Minor Equipment	0	9,561	1-2
Court-Ordered Payments	0	10,927	current
TOTAL OPERATING EXPENSES & EQUIPMENT	25,614,498	16,470,118	
DISTRIBUTED COSTS	(744,053)	(384,774)	
TOTAL BUDGET/EXPENDITURES	**39,300,606**	**25,133,217**	
Unscheduled Reimbursements		(54,020)	
		25,079,197	

1/See next page for monthly billing detail

4/08/2013

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

		Number of Hours	Rate	Amount
July	Attorney Services	5,386.75	170.00	915,747.50
	Paralegal Services	206.00	120.00	24,720.00
	Auditor/Analyst Services	110.00	99.00	10,890.00
	Cost of Suit			0.00
				951,357.50
August	Attorney Services	6,056.00	170.00	1,029,520.00
	Paralegal Services	215.00	120.00	25,800.00
	Auditor/Analyst Services	79.50	99.00	7,870.50
	Cost of Suit			264.00
				1,063,454.50
September	Attorney Services	5,132.25	170.00	872,482.50
	Paralegal Services	201.50	120.00	24,180.00
	Auditor/Analyst Services	76.00	99.00	7,524.00
	Cost of Suit			726.58
				904,913.08
October	Attorney Services	6,249.75	170.00	1,062,457.50
	Paralegal Services	242.00	120.00	29,040.00
	Auditor/Analyst Services	97.00	99.00	9,603.00
	Cost of Suit			315.00
				1,101,415.50
November	Attorney Services	5,098.25	170.00	866,702.50
	Paralegal Services	169.00	120.00	20,280.00
	Auditor/Analyst	121.50	99.00	12,028.50
	Cost of Suit			2,238.45
				901,249.45
December	Attorney Services	4,833.25	170.00	821,652.50
	Paralegal Services	230.50	120.00	27,660.00
	Auditor/Analyst	82.00	99.00	8,118.00
	Cost of Suit			1,853.20
				859,283.70
			Total July-Dec =	**5,781,673.73**
			FY 12/13 Budget =	**13,157,280.00**

MEDICAL BOARD OF CALIFORNIA

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

January				
	Attorney Services	5,992.75	170.00	1,018,767.50
	Paralegal Services	243.00	120.00	29,160.00
	Auditor/Analyst	122.00	99.00	12,078.00
	Cost of Suit			1,693.25
				1,061,698.75
February				
	Attorney Services	4,991.75	170.00	848,597.50
	Paralegal Services	273.00	120.00	32,760.00
	Auditor/Analyst	110.00	99.00	10,890.00
	Cost of Suit			278.50
				892,526.00
March				
	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst Services	0.00	99.00	0.00
	Cost of Suit			
				0.00
April				
	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst Services	0.00	99.00	0.00
	Cost of Suit			
				0.00
May				
	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst Services	0.00	99.00	0.00
	Cost of Suit			
				0.00
June				
	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst Services	0.00	99.00	0.00
	Cost of Suit			
				0.00

Revised 04/08/2013

FYTD Total =	**7,735,898.48**
FY 12/13 Budget =	**13,157,280.00**

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

	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	FYTD Total
Invest Cost Recovery	3,981	971	871	846	996	2,177	896	3,550	896	896	1,100	1,146	18,326
Criminal Cost Recovery	0	0	0	0	0	0	0	0	0	0	0	0	0
Probation Monitoring	43,697	74,202	31,474	35,029	120,104	157,971	332,595	170,590	72,520	94,712	71,738	47,283	1,251,913
Exam	2,475	3,730	1,750	9,456	4,031	1,158	1,237	2,621	1,400	4,235	2,500	627	35,219
Cite/Fine	5,500	9,000	10,075	4,000	2,600	5,700	5,000	2,896	1,950	5,650	950	200	53,521
MONTHLY TOTAL	55,653	87,903	44,170	49,331	127,731	167,006	339,728	179,656	76,766	105,493	76,288	49,255	1,358,980
FYTD TOTAL	55,653	143,557	187,727	237,058	364,788	531,794	871,522	1,051,178	1,127,944	1,233,436	1,309,725	1,358,980	

	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	FYTD Total
Invest Cost Recovery	300	350	300	100	50	3,932	40,589	50	10,281	205	0	0	56,157
Criminal Cost Recovery	0	0	150	0	50	250	605	504	1,055	754	14,147	2,558	20,073
Probation Monitoring	42,542	41,848	44,639	105,369	96,368	109,993	343,253	222,925	83,025	97,287	59,217	34,113	1,280,578
Exam	1,639	777	2,481	627	1,692	2,552	977	1,106	6,495	1,831	6,024	2,224	28,424
Cite/Fine	200	4,350	800	10,650	3,250	6,400	8,650	7,002	3,450	7,825	3,075	3,800	59,452
MONTHLY TOTAL	44,681	47,325	48,370	116,745	101,409	123,127	394,074	231,587	104,307	107,903	82,462	42,695	1,444,684
FYTD TOTAL	44,681	92,005	140,375	257,120	358,530	481,657	875,730	1,107,317	1,211,624	1,319,527	1,401,989	1,444,684	

	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	FYTD Total
Invest Cost Recovery	250	300	650	2,349	750	700	4,527	600	2,595				12,721
Criminal Cost Recovery	1,409	705	619	5,136	964	10,914	2,411	1,198	676				24,032
Probation Monitoring	38,879	47,871	26,432	65,999	45,648	146,950	434,545	323,937	52,448				1,182,709
Exam	1,848	3,456	6,563	2,666	5,212	975	3,074	1,625	4,725				30,144
Cite/Fine	2,800	1,900	4,750	6,268	11,086	12,300	8,700	4,059	4,200				56,063
MONTHLY TOTAL	45,186	54,232	39,014	82,418	63,660	171,839	453,257	331,419	64,644	0	0	0	1,305,669
FYTD TOTAL	45,186	99,418	138,432	220,850	284,510	456,349	909,606	1,241,025	1,305,669	1,305,669	1,305,669	1,305,669	

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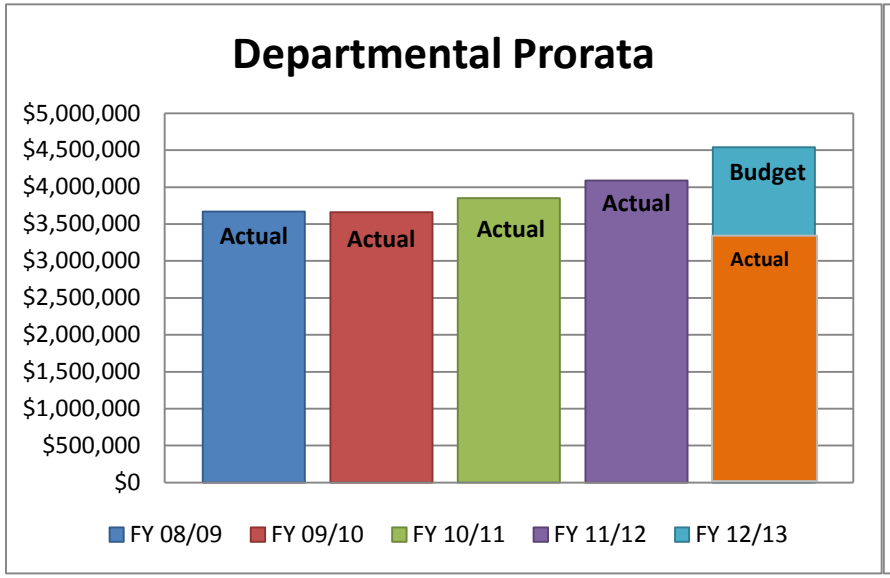
Departmental Prorata
$5,000,000
$4,500,000
$4,000,000
$3,500,000
$3,000,000
$2,500,000
$2,000,000
$1,500,000
$1,000,000
$500,000
$0
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Actual
Actual
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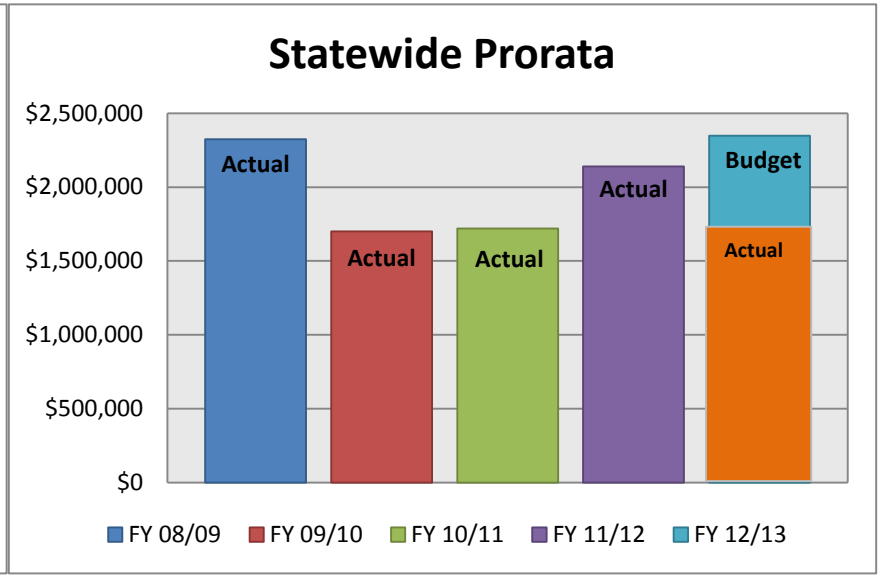
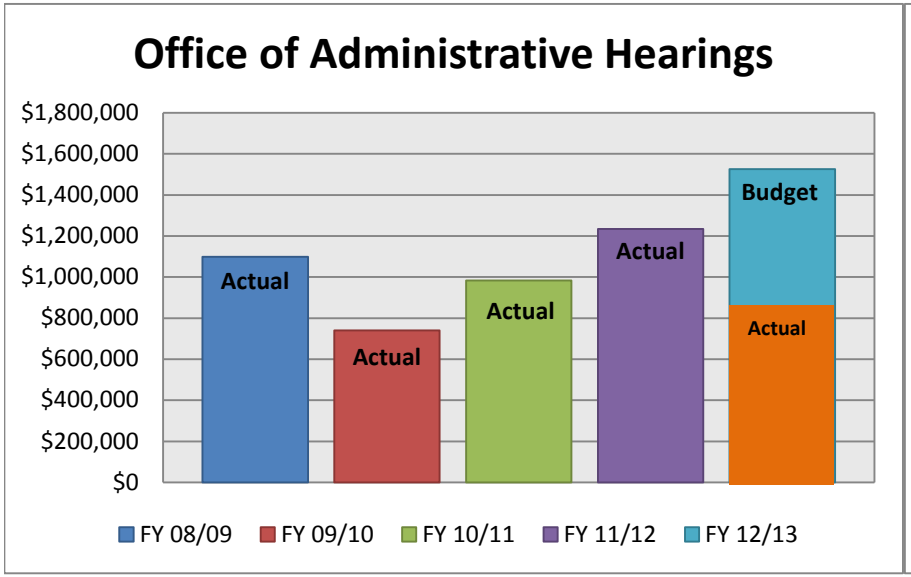
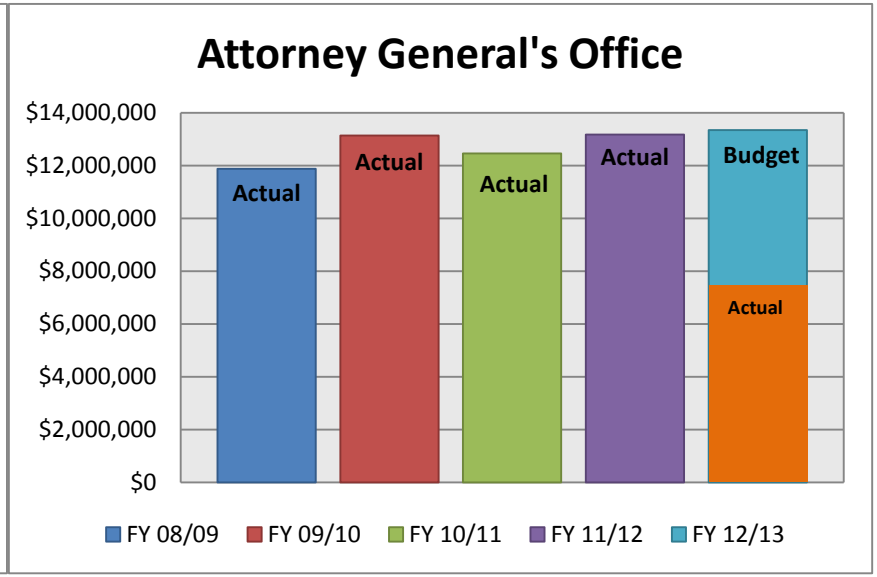
Budget
Actual
FY 08/09
FY 09/10
FY 10/11
FY 11/12
FY 12/13


Statewide Prorata
$2,500,000
$2,000,000
$1,500,000
$1,000,000
$500,000
$0
Actual
Actual
Actual
Actual
Budget
Actual
FY 08/09
FY 09/10
FY 10/11
FY 11/12
FY 12/13


Office of Administrative Hearings
$1,800,000
$1,600,000
$1,400,000
$1,200,000
$1,000,000
$800,000
$600,000
$400,000
$200,000
$0
Actual
Actual
Actual
Actual
Budget
Actual
FY 08/09
FY 09/10
FY 10/11
FY 11/12
FY 12/13


Attorney General's Office
$14,000,000
$12,000,000
$10,000,000
$8,000,000
$6,000,000
$4,000,000
$2,000,000
$0
Actual
Actual
Actual
Actual
Budget
Actual
FY 08/09
FY 09/10
FY 10/11
FY 11/12
FY 12/13

NAMES	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APRIL	MAY	JUNE	YTD
DR. BISHOP - Per diem	$1,100.00	$ 400.00	$ 600.00	$ 600.00	$ 600.00	$ 400.00							$ 3,700.00
Travel	$ 904.66		$ 517.90	$ 88.64									$ 1,511.20
	$2,004.66	$ 400.00	$1,117.90	$ 688.64	$ 600.00	$ 400.00	$ -	$ -	$ -	$ -	$ -	$ -	**$ 5,211.20**
DR. CARREON - Per diem	$1,700.00												$ 1,700.00
Travel													$ -
	$1,700.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 1,700.00**
DR. DIEGO - Per diem	$1,300.00	$ 800.00	$ 600.00	$ 1,800.00	$1,400.00	$1,100.00	$1,500.00	$ 800.00					$ 9,300.00
Travel	$ 244.80	$ 94.35		$ 619.76			$ 501.75	$ 320.35					$ 1,781.01
	$1,544.80	$ 894.35	$ 600.00	.	$1,400.00	$1,100.00	$2,001.75	$1,120.35	$ -	$ -	$ -	$ -	**$ 11,081.01**
DR. DURUISSEAU - Per diem	$1,100.00												$ 1,100.00
Travel	$ 126.56												$ 126.56
	$1,226.56	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 1,226.56**
DR GNANADEV - Per diem	$1,200.00	$ 900.00	$ 700.00		$ 700.00	$ 600.00							$ 4,100.00
Travel			$ -		$ -	$ -							$ -
	$1,200.00	$ 900.00	$ 700.00	$ -	$ 700.00	$ 600.00	$ -	$ -	$ -	$ -	$ -	$ -	**$ 4,100.00**
DR. LEVINE - Per diem	$ -												$ -
Travel	$ 413.90		$ 285.72	$ 359.62									$ 1,059.24
	$ 413.90	$ -	$ 285.72	$ 359.62	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 1,059.24**
DR. LOW - Per diem													$ -
Travel													$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
MS. PINES - Per diem			$1,100.00	$ 1,700.00	$1,600.00	$1,700.00	$1,800.00	$1,500.00					$ 9,400.00
Travel			$ 171.68	$ 365.64	$ 446.49		$ 552.46						$ 1,536.27
	$ -	$ -	$1,271.68	$ 2,065.64	$2,046.49	$1,700.00	$2,352.46	$1,500.00	$ -	$ -	$ -	$ -	**$ 10,936.27**
DR. SALOMONSON - Per diem	$ 400.00		$ 200.00	$ 500.00			$ 200.00	$ 500.00					$ 1,800.00
Travel	$ 742.92		$ 462.73	$ 515.94			$ 894.25	$ 687.68					$ 3,303.52
	$1,142.92	$ -	$ 662.73	$ 1,015.94	$ -	$ -	$1,094.25	$1,187.68	$ -	$ -	$ -	$ -	**$ 5,103.52**
MS.SCHIPSKE - Per diem	$1,200.00	$ 400.00	$ 600.00	$ 1,300.00	$ 700.00	$ 900.00	$ 700.00						$ 5,800.00
Travel	$ 523.85			$ 498.39									$ 1,022.24
	$1,723.85	$ 400.00	$ 600.00	$ 1,798.39	$ 700.00	$ 900.00	$ 700.00	$ -	$ -	$ -	$ -	$ -	**$ 6,822.24**
MR. SERRANO SWELL- Per diem			$ 600.00	$ 600.00		$ 600.00	$ 700.00	$ 800.00					$ 3,300.00
			$ 257.30	$ 774.36									$ 1,031.66
	$ -	$ -	$ 857.30	$ 1,374.36	$ -	$ 600.00	$ 700.00	$ 800.00	$ -	$ -	$ -	$ -	**$ 4,331.66**
MS. YAROSLAVSKY - Per diem	$1,600.00	$1,300.00	$ 900.00	$ 1,200.00	$1,000.00	$1,200.00	$ 300.00	$ 400.00					$ 7,900.00
Travel	$ 688.35	$ 883.88	$ 454.51	$ 581.44									$ 2,608.18
	$2,288.35	$2,183.88	$1,354.51	$ 1,781.44	$1,000.00	$1,200.00	$ 300.00	$ 400.00	$ -	$ -	$ -	$ -	**$ 10,508.18**
MS. YIP - Per diem													$ -
Travel													$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**

As of: 4/09/2013

TOTAL PER DIEM	$48,100.00
TOTAL TRAVEL	$13,979.88
TOTAL	**$62,079.88**

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED	April 17, 2013
ATTENTION:	Members, Medical Board of California
SUBJECT:	2014 Dates/Locations for Board Meetings
STAFF CONTACT:	Linda Whitney, Executive Director

RECOMMENDED ACTION:

Set dates for 2014 Board meetings.

BACKGROUND AND ANALYSIS:

A member has a conflict with the normally scheduled end of January, 2014 meeting. Staff has done the analysis of dates that are possible for the meetings that will still maintain the quarterly status of meetings and enough time for staff work and panel action.

PROPOSED DATES/LOCATIONS: (*Proposed by staff)	
January 16-17 or February 13-14*	Bay Area
April 17-18 or May 1-2* or May 8-9	LA Area (FSMB April 24-26)
July 17-18 or July 24-25*	Sacto Area
October 23-24* or October 30-31	SD Area

ANALYSIS OF DATES:

If the board were to select the January date, this is only 12 weeks after the October meeting. With holidays in November and December it if very difficult for staff to complete all of its work for the Board packet. In addition, the posting would be on January 2, which is still considered during a holiday period, and difficult for staff to complete the agenda and get materials on line.

If the board were to select the February date, this would put the meeting at 16 weeks. This could mean that interim panel meetings would have to be scheduled in early/mid-January. If this date is selected then the April 17-18 date is only 9 weeks, and the May 1-2 date would be 11 weeks, making it a better fit. If the board selects a later date, like May 8-9, this would make the dates of July 24-25 11 weeks from the prior meeting.

STAFF RECOMMENDATIONS:

February 13-14, 2014
May 1-2, 2014
July 24-25, 2014
October 23-24, 2014

AGENDA ITEM 17

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: April 11, 2013
ATTENTION: Board Members
SUBJECT: Teleconferencing of Board Meetings
STAFF CONTACT: Kimberly Kirchmeyer, Deputy Director

RECOMMENDED ACTION:

Review the information provided and determine the feasibility of providing teleconferencing for statewide public participation.

BACKGROUND AND ANALYSIS:

At previous Board meetings, and at the October Board meeting, the Board was asked to teleconference its future Board meetings to provide public participation from individuals not in attendance at the Board meetings. Specifically, the request was to allow individuals from any location to be able to call in, listen to the Board meeting, and provide public comment throughout the meeting. The Board Members requested staff research the feasibility of this request and provide the information back to the Members for their consideration.

Board staff has determined that there are several ways in which this request could be fulfilled. Although the options are discussed below, further research and paperwork would need to be completed to design, develop, and test the options as they are described below. Additionally, some of the options would require authorization and processing by the Department of Consumer Affairs (DCA).

Options for Teleconferencing:

1) Provide an 800 number for anyone to call in and listen to the Board meeting and provide comments. Individuals, no matter where they are calling from, would be able to call in on the 800 line and provide comment at the appropriate times. A moderator from the telephone company would assist callers in the process. Individuals on the line would remain in a "mute" mode until the Board President (or Chair at Committee Meetings) would ask for public comment. The individuals at the beginning of the call would be provided with a method of informing the moderator that they would like to make a comment (for example by pushing #1). The moderator would then notify the staff monitoring the call that a comment is pending. At the appropriate time, the callers would provide their comments. The callers would need to be limited to specified minutes per comment per agenda item (example two minutes).

   The cost for the moderator is $.287/minute and the cost for the callers is $.021/minute/person. The system can have up to 4,000 participants on the line at one time. The Board would also need to request a telephone line from the hotel and would need one additional staff at each meeting in order to coordinate the call with the moderator and notify the Board President if there is someone who wants to make a comment. If a Board meeting was approximately 6 hours long and there were 200 people on the call, the cost would be **$1,765.32** for the call at each meeting ($103.32 for the

moderator + $1,512.00 for the individuals on the phone call + $150.00 for the telephone line) plus one staff member's time and attendance at a Board meeting (and therefore not performing his/her normal duties in the office).

Note: In contacting the DCA to gather information on this option, the Board was notified that no other DCA board or bureau has made a request for such a system that would provide the public input as described. Additionally, if this option were chosen, the Board would need to complete paperwork to obtain a system and would need to test the system. It would be recommended that if this option were chosen, that this would be tested at the Sacramento Board meeting in July in order to have appropriate staff available.

There have been other State agencies who have offered this type of service, however, these entities are not regulatory agencies who have both licensing and disciplinary responsibilities. In most instances, these agencies would not have disgruntled licensees or consumers calling in to comment.

Pros:

- The public would not have to travel to the meeting location to make comments on items not on the agenda or items on the agenda.
- More information can be gathered by the Members when making decisions.

Cons:

- The loss of work from the additional staff needed to attend the meeting.
- The length of the meeting could be extensive. If there are 200 callers and if only half wanted to make a comment on items not on the agenda, the meeting time would increase by over three hours. In addition, depending on the number of individuals who wanted to comment on agenda items, the length of the meeting could increase just for the time comments are being made on agenda items, plus the administrative time for this function. If only 20 people made two minute comments throughout the meeting, this would add close to an hour per meeting.
- The Board President would be required to stop individuals at the end of their specified time (two minutes), which could be perceived as harsh if the comment was not completed.
- There is no method to stop individuals from using several phones to call in and identify themselves as someone else in order to make it appear as if there is more support or opposition on an item than there actually is.
- It would be difficult to ensure the callers do not discuss a specific case during their comment period. The attorneys would have to jump in quickly and this could appear harsh.

2) Provide an email Web account where an individual could listen to the meeting and provide written questions that would then be provided via staff for the Board's consideration. This type of communication is similar to a chat room. The cost for this service is $8.50 per month ($102/year) and it would require a staff member to attend the meeting for the sole purpose of monitoring and reading the comments or questions provided via the Web. There would not be a limit to the individuals who could provide comments. The comments could be long and over the specified time limit, requiring interpretation by the staffer if comments need to be abbreviated.

Pros:

- The public would not have to travel to the meeting location to make comments on items not on the agenda or items on the agenda.

- More information can be gathered by the Members when making decisions.
- These could be screened to ensure cases were not discussed.

Cons:
- The loss of work from the additional staff needed to attend the meeting.
- The length of the meeting could be extensive. If there are 100 individuals who wanted to make a comment on items not on the agenda, the meeting time would increase by over three hours. In addition, depending on the number of individuals who wanted to comment on agenda items, the length of the meeting could increase just for comments on agenda items.
- There is no method to stop an individual from using multiple email accounts to provide comments in order to make it appear as if there is more support or opposition on an item than there actually is.
- Staff would need to respond to those who did not have a comment read to explain it was due to a case.

3) Hold all meetings in Sacramento at the Evergreen Hearing Room and video conference to the three other locations throughout California where the Board has video conferencing equipment (San Jose, San Diego, and Cerritos). Although the main meeting would take place in Sacramento, individuals would be able to go to the three district offices and attend the meeting via video conferencing equipment. A staff member would have to be available at each of the off-site locations to monitor the meeting and equipment, as well as be the point of contact for moderating the public comment. There would be no additional cost to the Board other than the three staff who would not be performing their normal work duties, as long as the Board meets in the limited space of the Evergreen Hearing Room (seats 12 Members comfortably).

Note: Staff is also looking into the possibility of the main location being at a hotel and video conferencing from the hotel to the three district offices, but the ability to do so and the quality of such a system is unknown.

Pros:
- The public would not have to travel to the meeting location to make comments on items not on the agenda or items on the agenda, but would have to travel to one of three locations.
- More information can be gathered by the Members when making decisions.

Cons:
- The public would still need to travel to provide comments, though the travel would not be as extensive. (Although this is the same or similar travel requirements to attend <u>one</u> meeting in the regional location.)
- The loss of work from the additional staff needed to attend the meeting. Also, these individuals are in the field and if clerical staff is not available, it would require a supervising investigator or an investigator to moderate the video conference.
- The sites cannot hold a large number of people, therefore limiting those who could attend at these locations (most will hold 20 individuals).
- The Evergreen Hearing Room cannot hold the Board's full complement of Members and therefore could not be used when all members are on the Board.
- It will add some time to the Board meetings due to the additional comments

4) Teleconference the Board meeting to locations throughout California where the Board has the most space available (San Jose and Cerritos). The Board's main meeting would take place in its normal locations, and individuals would also be able to go to the two district offices and attend the meeting via teleconferencing equipment. A staff member would have to be available at each of the off-site locations to monitor the meeting and equipment as well as be the point of contact for moderating the public comment. The Board would have to request a telephone line from the hotel and would have to have a staff member there to run the telephone. There would be an additional cost of $150 for the phone line and the three staff who would not be performing their normal work duties.

   Pros:
   - The public would not have to travel to the meeting location to make comments on items not on the agenda or items on the agenda, but would have to travel to one of two locations.
   - More information can be gathered by the Members when making decisions.

   Cons:
   - The public would still need to travel to provide comments, though the travel would not be as extensive.
   - The loss of work from the additional staff needed to attend the meeting. Also, these individuals are in the field and if clerical staff is not available, it would require a supervising investigator or an investigator to moderate the video conference.
   - The sites cannot hold a large number of people, therefore limiting those who could attend at these locations.
   - It will add some time to the Board meetings due to the additional comments.

These are the options available at this time. Any of the options, as previously stated, would require implementation time, including development and testing. Additionally, there may be issues that may arise in any of the options above that are currently unknown to staff. It is important to note that State law provides the opportunity for written comments in the regulatory process. These comments must be considered as if a person is testifying in person before the Board. Please note that these options would not be applicable to closed session proceedings.

WORKLOAD REPORT
as of March 31, 2013

CONSUMER INFORMATION UNIT FY 12/13					
	FY 12/13	**Q1**	**Q2**	**Q3**	**Q4**
Total Calls Answered	**69,207**	26,022	20,578	22,607	
Calls Requesting Call Back	**8,859**	2,850	2,516	3,493	
Calls Abandoned	**8,070**	3,071	2,167	2,832	
Address Changes Completed	**4,254**	2,046	1,373	835	

CONSUMER INFORMATION UNIT FY 11/12					
	FY 11/12	**Q1**	**Q2**	**Q3**	**Q4**
Total Calls Answered	**89,497**	15,725	20,456	28,061	25,255
Calls Requesting Call Back	**14,923**	4,647	5,022	3,229	2,025
Calls Abandoned	**13,448**	4,356	4,616	2,657	1,819
Address Changes Completed	**8,894**	3,451	2,133	1,909	1,401

PHYSICIAN & SURGEON DATA FY 12/13					
	FY 11/12	**Q1**	**Q2**	**Q3**	**Q4**
Applications Received	**5,145**	1,722	1,715	1,708	
Initial Reviews Completed	**4,951**	1,556	1,791	1,604	
Total Pending	**N/A**	3,907	4,244	4,468	
Reviewed	**N/A**	3,365	3,770	3,900	
Not Reviewed	**N/A**	542	474	568	
(SR2s Pending)	**N/A**	93	88	38	
Licenses Issued	**4,002**	1,447	1,264	1,291	
Renewals Issued	**47,378**	16,282	14,830	16,266	

PHYSICIAN & SURGEON DATA FY 11/12					
	FY 11/12	**Q1**	**Q2**	**Q3**	**Q4**
Applications Received	**6,629**	1,711	1,666	1,862	1,390
Initial Reviews Completed	**6,729**	1,491	1,689	1,979	1,570
Total Pending	**N/A**	4,012	4,325	4,515	3,823
Reviewed	**N/A**	3,273	3,530	3,928	3,423
Not Reviewed	**N/A**	739	795	587	400
(SR2s Pending)	**N/A**	108	121	124	109
Licenses Issued	**5,351**	1,358	1,203	1,419	1,371
Renewals Issued	**64,351**	16,092	14,067	17,835	16,357

SPECIALTY BOARD APPLICATIONS FY 12/13					
	FY 12/13	**Q1**	**Q2**	**Q3**	**Q4**
Applications Received	**0**	0	0	0	
Applications Pending	**N/A**	1	1	1	

SPECIALTY BOARD APPLICATIONS FY 11/12					
	FY 11/12	**Q1**	**Q2**	**Q3**	**Q4**
Applications Received	**0**	0	0	0	0
Applications Pending	**N/A**	1	1	1	1

WORKLOAD REPORT
as of March 31, 2013

SR 2 - CATEGORIES FY 12/13					
	FY 12/13	**Q1**	**Q2**	**Q3**	**Q4**
Alcohol/Drugs	**17**	5	9	3	
PG/Medical Knowledge	**57**	25	19	13	
Convictions	**22**	15	5	2	
Other	**47**	11	19	17	

SR 2 - CATEGORIES FY 11/12					
	FY 11/12	**Q1**	**Q2**	**Q3**	**Q4**
Alcohol/Drugs	**86**	30	12	27	17
PG/Medical Knowledge	**188**	59	40	60	29
Convictions	**100**	43	18	16	23
Other	**179**	92	44	21	22

INTERNATIONAL MEDICAL SCHOOL APPLICATIONS FY 12/13					
	FY 12/13	**Q1**	**Q2**	**Q3**	**Q4**
Schools Pending Recognition at Beginning of Quarter	**N/A**	101	98	94	
Pending Self-Assessment Reports (included above)	**N/A**	7	9	8	
New Self-Assessment Reports Received	**2**	0	2	0	
New Unrecognized Schools Received	**68**	27	24	17	
School Recognized Pursuant to CCR 1314(a)(1)	**82**	30	33	19	
School Recognized Pursuant to CCR 1314(a)(2)	**1**	0	0	1	
TOTAL Schools Pending Recognition at End of Quarter	**N/A**	98	94	91	

INTERNATIONAL MEDICAL SCHOOL APPLICATIONS FY 11/12					
	FY 11/12	**Q1**	**Q2**	**Q3**	**Q4**
Schools Pending Recognition at Beginning of Quarter	**N/A**	43	62	75	90
Pending Self-Assessment Reports (included above)	**N/A**	3	5	6	7
New Self-Assessment Reports Received	**4**	2	0	1	1
New Unrecognized Schools Received	**102**	22	15	18	47
School Recognized Pursuant to CCR 1314(a)(1)	**47**	4	2	4	37
School Recognized Pursuant to CCR 1314(a)(2)	**1**	1	0	0	0
TOTAL Schools Pending Recognition at End of Quarter	**N/A**	62	75	90	101

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

RESEARCH PSYCHOANALYST FY 11/12					
	FY 11/12	**Q1**	**Q2**	**Q3**	**Q4**
RP Applications Received	**2**	1	0	1	0
RP Licenses Issued	**4**	3	0	0	1

WORKLOAD REPORT
as of March 31, 2013

LICENSED MIDWIVES FY 12/13					
	FY 12/13	**Q1**	**Q2**	**Q3**	**Q4**
Applications Received	**29**	8	12	9	
Applications Pending	**N/A**	5	6	8	
Licenses Issued	**22**	5	12	5	
Licenses Renewed	**91**	31	32	28	

LICENSED MIDWIVES FY 11/12					
	FY 11/12	**Q1**	**Q2**	**Q3**	**Q4**
Applications Received	**33**	9	5	13	6
Applications Pending	**N/A**	6	3	5	4
Licenses Issued	**31**	4	8	10	9
Licenses Renewed	**125**	24	31	33	37

FICTITIOUS NAME PERMITS FY 12/13					
	FY 12/13	**Q1**	**Q2**	**Q3**	**Q4**
P&S - FNP Received	**902**	363	230	309	
P&S - FNP Issued	**920**	284	343	293	
P&S - FNP Pending	**N/A**	55	116	98	
P&S - FNP Renewed	**3,724**	1,202	1,180	1,342	
P&S - FNP Due Diligence	**751**	544	101	106	
Podiatric FNP Received	**14**	6	4	4	
Podiatric FNP Issued	**15**	6	7	2	
Podiatric FNP Pending	**N/A**	18	8	2	
Podiatric FNP Renewed	**119**	38	37	44	
Podiatric FNP Due Diligence	**24**	14	8	2	

FICTITIOUS NAME PERMITS FY 11/12					
	FY 11/12	**Q1**	**Q2**	**Q3**	**Q4**
P&S - FNP Issued	**1,397**	384	380	315	318
P&S - FNP Pending	**N/A**	59	63	72	94
Podiatric FNP Issued	**23**	3	9	7	4
Podiatric FNP Pending	**N/A**	0	0	0	2

WORKLOAD REPORT
as of March 31, 2013

OPTICAL REGISTRATIONS FY 12/13					
	FY 12/13	**Q1**	**Q2**	**Q3**	**Q4**
RDO - Business Registrations Issued	**24**	0	9	15	
RDO - Pending Applications Business	**N/A**	1	20	28	
CLS - Out-of-State - Business Registrations Issued	**0**	0	0	0	
CLS - Pending Out of State Applications -Business	**N/A**	1	1	1	
Spectacle Lens Registrations Issued	**140**	66	32	42	
Spectacle Lens - Pending Applications	**N/A**	59	24		
Contact Lens Registrations Issued	**58**	33	14	11	
Contact Lens - Pending Applications	**N/A**	20	7	9	
Spectacle Lens Registrations Renewed	**668**	230	212	226	
Contact Lens Registrations Renewed	**310**	94	110	106	

OPTICAL REGISTRATIONS FY 11/12					
	FY 11/12	**Q1**	**Q2**	**Q3**	**Q4**
Business Registrations Issued	**48**	10	9	8	21
Pending Applications Business	**N/A**	30	30	18	23
Out-of-State Business Registrations Issued	**1**	0	0	0	1
Pending Applications Out of State Bus.	**N/A**	0	0	0	1
Spectacle Lens Registrations Issued	**192**	47	29	72	44
Pending Applications-Spectacle Lens	**N/A**	78	107	29	57
Contact Lens Registrations Issued	**85**	13	11	43	18
Pending Applications-Contact Lens	**N/A**	22	33	15	18
Spectacle Lens Registrations Renewed	**991**	216	217	276	282
Contact Lens Registrations Renewed	**420**	95	79	112	134

POLYSOM FY 12/13					
	FY 12/13	**Q1**	**Q2**	**Q3**	**Q4**
Polysomnographic Trainee Applications Received	**18**	2	9	7	
Polysomnographic Trainee Registrations Pending	**N/A**	2	9	16	
Polysomnographic Trainee Registrations Issued	**7**	0	6	1	
Polysomnographic Technician Applications Received	**95**	20	68	7	
Polysomnographic Technician Registrations Pending	**N/A**	21	33	37	
Polysomnographic Technician Registrations Issued	**32**	0	25	7	
Polysomnogrpahic Technologist Applications Received	**509**	168	327	14	
Polysomnogrpahic Technologist Applications Pending	**N/A**	208	130	142	
Polysomnogrpahic Technologist Registrations Issued	**253**	0	197	56	

POLYSOM FY 11/12 **					
	FY 11/12	**Q1**	**Q2**	**Q3**	**Q4**
Polysomnographic Trainee Applications Received	**0**	0	0	0	0
Polysomnographic Technician Applications Received	**1**	0	0	0	1
Polysomnogrpahic Technologist Applications Received	**29**	0	0	0	29

** Program began accepting applications April of 2012

REQUESTS FOR NEW SCHOOL CODES
IMG Applicants

COUNTRY	Medical School Name	Date Request Received	Letter Mailed to Medical School	Medical School Response	Status of Application	CCR 1314.1(a)(1)	Chief & Legal Approval (Per CCR 1314.1(a)(1)	Self Assessment Report Received	CCR 1314.1(a)(2)	Comments/Decision
Algeria	Universite Mouloud Mammeri de Tizi-Ouzou Faculty of Medicine	10/20/2011	3/14/2012		Pending	?			?	Letter sent on 3/14/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Argentina	Universidad Abierta Interamericana Facultad de Medicina y Ciencias de la Salud	2/18/2013	3/4/2013		Pending	?			?	Letter sent on 3/4/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Australia	Queensland University (QU) - Australia U.S. Branch Campus	10/29/2010	1/18/2013		Pending			1/17/2012	X	Medical Consultant completed initial review of SAR on 1/16/13. Additional information requested from school on 1/18/13.
Bangladesh	University of Dhaka, Medical College for Women & Hospital	10/21/2011	3/12/2012 6/19/2012	5/29/2012	Pending	?			?	Additional information requested from school on 6/19/12.
Bolivia	Universidad Privada del Valle Facultad de Ciencias de la Salud	5/2/2012	5/9/2012 5/29/2012	5/18/2012	Pending				X	School informed on 5/29/12 they will need to submit Self-Assessment Report since the school is a private, for profit university.
Brazil	Faculdade de Ciencias Medicas de Minas Gerais (FCMMG)	8/21/2012	8/27/2012		Pending	?			?	Letter sent on 8/27/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Brazil	Faculdade de Medicina de Itajuba (FMIT)	7/1/2011	9/21/2011 1/13/2012		Pending	?			?	Staff requested additional information from FMIT to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Brazil	Universidade Estacio de Sa (UNESA) Faculdade de Medicina	2/1/2012	3/27/2012 11/6/2012	10/29/2012 11/26/2012	Pending				X	School informed on 12/14/12 they will need to submit Self-Assessment Report since the school is a private, for profit university.
Brazil	Universidade Estadual de Ciências da Saúde de Alagoas (UNCISAL) Faculdade de Medicina	3/21/2013	3/21/2013		Pending	?			?	Letter sent on 3/21/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Brazil	Universidade Federal do Estado do Rio de Janeiro (UNIRIO) Escola de Medicina e Cirurgia	3/1/2013	3/20/2013		Pending	?			?	Letter sent on 3/20/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Brazil	Universidade Sao Francisco (USF) Faculdade de Ciencias Medicas	12/1/2011	4/13/2012		Pending	?			?	Letter sent on 4/13/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Bulgaria	Medical University Prof. Dr. Paraskev Stoyanov Varna	6/10/2011	3/22/2012		Pending	?			?	Letter sent on 3/22/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Bulgaria	Medical University, Sofia Faculty of Medicine		1/22/2013		Pending	?			?	Letter sent on 1/22/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).

REQUESTS FOR NEW SCHOOL CODES
IMG Applicants

COUNTRY	Medical School Name	Date Request Received	Letter Mailed to Medical School	Medical School Response	Status of Application	CCR 1314.1(a)(1)	Chief & Legal Approval (Per CCR 1314.1(a)(1)	Self Assessment Report Received	CCR 1314.1(a)(2)	Comments/Decision
China	Anhui Medical University Faculty of Medicine	10/12/2011	3/20/2012		Pending	?			?	Letter sent on 3/20/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
China	Fujian Medical University Faculty of Medicine	2/21/2013	3/4/2013		Pending	?			?	Letter sent on 3/4/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
China	HuBei University of Medicine	6/29/2012	6/19/2012		Pending	?			?	Letter sent on 6/19/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
China	Jilin University, Norman Bethune College of Medicine	7/19/2012	7/25/2012		Pending	?			?	Letter sent on 7/25/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
China	Liaoning Medical University College of Clinical Medicine	3/19/2013	3/20/2013		Pending	?			?	Letter sent on 3/20/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
China	Peking University Health Science Center	6/15/2011	3/22/2012		Pending	?			?	Letter sent on 3/22/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
China	Shanxi Medical University	11/27/2012	1/22/2013		Pending	?			?	Letter sent on 1/22/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
China	Xi'an Jiaotong University College of Medicine	6/21/2010	4/9/2012		Pending	?			?	Letter sent on 4/9/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Colombia	Universidad de Ciencias Aplicadas y Ambientales	2/14/2013	3/4/2013		Pending	?			?	Letter sent on 3/4/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Czech Republic	Charles University 2nd Faculty of Medicine	12/17/2012			Pending			12/17/2012	X	Staff needs to review Self-Assessment Report
Dominican Republic	Pontificia Universidad Catolica Madre y Maestra Facultad de Ciencias de la Salud	8/1/2012	8/1/2012		Pending	?			?	Letter sent on 8/1/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Dominican Republic	Universidad Iberoamericana (UNIBE)	08/22/2008	3/12/2012		Pending			8/22/2008	X	Additional information was requested from UNIBE on 3/12/12 based on medical consultant's review of self-assessment report.
Egypt	Benha Faculty of Medicine, Benha University	9/2/2011	3/22/2012	3/1/2013	Recognized	X	3/18/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).

REQUESTS FOR NEW SCHOOL CODES
IMG Applicants

COUNTRY	Medical School Name	Date Request Received	Letter Mailed to Medical School	Medical School Response	Status of Application	CCR 1314.1(a)(1)	Chief & Legal Approval (Per CCR 1314.1(a)(1)	Self Assessment Report Received	CCR 1314.1(a)(2)	Comments/Decision
Egypt	October 6 University, Faculty of Medicine	9/27/2011			Pending			9/26/2011	X	Staff needs to review Self-Assessment Report
Egypt	Tanta University Faculty of Medicine	6/8/2012	6/26/2012		Pending	?			?	Letter sent on 6/26/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
France	Université de Paul Sabatier, UFR des Sciences Médicales de Purpan	7/23/2012	7/25/2012	12/13/2012	Recognized	X	1/10/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Georgia	Tbilisi Medical Institute 'Vita'	6/22/2011	4/11/2012 10/10/2012	9/10/2012 11/15/2012	Pending				X	School informed on 11/15/12 they will need to submit Self-Assessment Report since the school is a private, for profit university.
Germany	Universität Duisburg-Essen Medizinische Fakultät (University of Duisburg-Essen Faculty of Medicine)	10/31/2012	11/8/2012	3/14/2013	Recognized	X	3/18/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Germany	Univeritaet Leipzig Faculty of Medicine	9/6/2012	9/12/2012		Pending	?			?	Letter sent on 9/12/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Ghana	Kwame Nkrumah University of Science & Technololgy	11/5/2012	11/8/2012		Pending	?			?	Letter sent on 11/8/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Haiti	Université Notre Dame d'Häiti Faculté de Médicine	9/06/2012	9/12/2012 10/10/2012	10/2/2012	Pending	?			?	Initial review completed by staff. Unofficial response received from school - Requested school to resubmit formal response on 10/10/12.
India	Dr. Babasaheb Ambedkar Marathwada University, Government Medical College Aurangabad	10/31/2012	11/8/2012		Pending	?			?	Letter sent on 11/8/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Gujarat University, Kerasal Medical College & Research Institute	10/11/2012	11/8/2012 1/18/2013	11/28/2012 2/8/2013	Recognized	X	3/18/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
India	Karnatak University, Karnataka Institute of Medical Sciences	10/7/2011	3/16/2012		Pending	?			?	Letter sent on 3/8/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Kerala University of Health and Applied Sciences, Dr. Somervell Memorial CSI Medical College & Hospital	2/6/2013	3/4/2013		Pending	?			?	Letter sent on 3/4/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Maharashtra University of Health Sciences, JMF's A.C.P.M. Medical College	8/28/2012	9/12/2012		Pending	?			?	Letter sent on 9/12/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Maharashtra University of Health Sciences, Rajarshi Chhatrapati Shau Maharaj Government Medical College Kolhapur	8/9/2012	8/9/2012		Pending	?			?	Letter sent on 8/9/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).

REQUESTS FOR NEW SCHOOL CODES
IMG Applicants

COUNTRY	Medical School Name	Date Request Received	Letter Mailed to Medical School	Medical School Response	Status of Application	CCR 1314.1(a)(1)	Chief & Legal Approval (Per CCR 1314.1(a)(1)	Self Assessment Report Received	CCR 1314.1(a)(2)	Comments/Decision
India	Maharashtra University of Health Sciences, Shri Bhausahab Hire Government Medical College	5/1/2012	5/1/2012		Pending	?			?	Letter sent on 5/1/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Mahatma Gandhi University, Malankara Orthodox Syrian Church Medical College	2/24/2011	3/16/2012		Pending	?			?	Letter sent on 3/16/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	NTR University of Health Sciences, Rangaraya Medical College, Kakinada	11/5/2012	11/8/2012		Pending	?			?	Letter sent on 11/8/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Padmashree Dr. D. Y. Patil University, Navi Mumbai, Dr. D. Y. Patil Medical College	01/15/2013	1/22/2013	1/30/2013	Recognized	X	2/5/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
India	Rajiv Gandhi University of Health Sciences, Al-Ameen Medical College	3/28/2012	4/30/2012		Pending	?			?	Letter sent on 4/30/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Rajiv Gandhi University of Health Sciences, Dr. B.R. Ambedkar Medical College	2/5/2013	3/4/2013 3/18/2013 (resent via email)		Pending	?			?	Letter sent on 3/4/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Rajiv Gandhi University of Health sciences, Father Muller's Institute of Medical Education and Research, Mangalore / Father Muller Medical College	6/17/2011	3/13/2012 6/4/2012 8/8/2012	11/19/2012	Recognized	X	1/10/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
India	Rani Durgavati Vishwavidyalaya University (formerly Jabalpur University), Netaji Chandra Bose Medical College	11/26/2012	11/27/2012 Resent 2/26/2013		Pending	?			?	Letter sent on 11/27/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Tamil Nadu Dr. M.G.R. Medical University, K.A.P. Vishwanathan Government Medical College	6/2/2011	3/15/2012 Resent on 1/22/2013		Pending	?			?	Letter sent on 3/15/12 and 1/22/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Tamil Nadu Dr. M.G.R. University, Stanley Medical College	8/28/2012	9/12/2012		Pending	?			?	Letter sent on 9/12/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	University of Kashmie, Jehlum Valley College of Medical Sciences	8/10/2011	3/20/2012		Pending	?			?	Letter sent on 3/20/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	West Bengal University of Health Sciences, Nilratan Sircar Medical College	7/19/2011	4/5/2012		Pending	?			?	Letter sent on 4/5/12 to the medical school requesting information to determine eligibility for recogntion pursuant to CCR 1314.1(a)(1).
Iran	Golestan University of Medical Education & Health Services	6/9/2011	3/26/2012		Pending	?			?	Letter sent on 3/26/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).

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COUNTRY	Medical School Name	Date Request Received	Letter Mailed to Medical School	Medical School Response	Status of Application	CCR 1314.1(a)(1)	Chief & Legal Approval (Per CCR 1314.1(a)(1)	Self Assessment Report Received	CCR 1314.1(a)(2)	Comments/Decision
Iran	Islamic Azad University, Ardabil Branch Faculty of Medicine	8/20/2012	8/27/2012		Pending	?			?	Letter sent on 8/27/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Iran	Khorasan University of Medical Sciences (Mashhad University of Medical Sciences)	11/27/2012	1/22/2013	2/22/2012	Recognized	X	3/4/2013			Chief verified the names Mashhad University of Health Sciences and Khorasan University of Health Sciences are used interchangeably by the school. New school code not needed; acceptable to use code IRA06.
Iraq	Al-Anbar University College of Medicine	10/19/2011	4/5/2012		Pending	?			?	Letter sent on 4/5/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Iraq	Kufa University College of Medicine	3/7/2013	3/21/2013		Pending	?			?	Letter sent on 3/21/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Iraq	University of Tikrit College of Medicine	3/20/2013	3/21/2013		Pending	?			?	Letter sent on 3/21/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Ireland	University of Dublin, Trinity College Dublin School of Medicine	9/17/2012	10/12/2012 2/26/2013		Pending	?			?	Letter sent on 10/12/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Italy	Universita degli Studi Insubria Varese-Como Facolta di Medicina e Chirurgia	11/21/2012	11/27/2012	2/7/2013	Recognized	X	3/18/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Japan	Ehime University School of Medicine	6/8/2012	6/19/2012		Pending	?			?	Letter sent on 6/19/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Japan	Faculty of Medicine, University of Miyazaki	10/6/2010	3/20/2012		Pending	?			?	Letter sent on 3/19/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Japan	Kansai Medical University	6/23/2010	3/22/2012 9/7/2012 1/18/2012 3/14/2013	8/23/2012 11/20/2012	Pending	?			?	Initial review completed by staff 9/6/12. Additional information requested from school on 9/7/12 and 1/18/12.
Japan	Kawasaki Medical School	8/9/2012	8/9/2012		Pending	?			?	Letter sent on 8/9/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Japan	Kyorin University School of Medicine	2/17/2012	3/13/2012 7/13/2012	7/6/2012	Pending	?			?	Additional information requested from school on 7/13/12.

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Kazakhstan	Karaganda State Medical Academy	8/25/2010	3/9/2012		Pending	?			?	Letter sent on 3/9/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Kenya	Moi University College of Health Sciences, School of Medicine	5/22/2012	6/6/2012 7/12/2012	6/28/2012 1/22/2013	Recognized	X	2/5/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Libya	Benghazi Medical University	6/20/2012	6/26/2012		Pending	?			?	Letter sent on 6/26/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Libya	University of Tripoli (formerly Al Fateh Faculty of Medicine)	2/1/2013	2/5/2013	3/11/2013	Pending	?			?	Staff needs to review information submitted by school.
Malaysia	Manipal University, Melaka-Manipal Medical College	6/10/2011	4/11/2012		Pending	?			?	Letter sent on 4/11/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Mexico	Benemerita Universidad Autonoma de Puebla Escuela de Medicina	10/1/2012	10/11/2012 3/5/2012	12/12/12	Pending	?			?	School's attorney has indicated that they are not able to release the requested information.
Morocco	Université Sidi Mohammed Ben Abdellah Fez, Faculty of Medicine and Pharmacy	9/10/2012	9/12/2012	1/21/2013	Recognized	X	2/21/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Nepal	Universal College of Medical Sciences, Paklihawa Campus	7/15/2011	10/29/2012		Pending			7/15/2011	X	Staff completed initial review of Self-Assessment Report. Additional information requested from school on 10/29/12.
Neves	Medical University of the Americas	3/19/2012			Pending			3/19/2012	X	Staff completed initial review of Self-Assessment Report. Additional information requested from school on 3/19/13.
Nigeria	Ambrose Alli University College of Medicine	8/28/2012	8/28/2012	2/4/2013	Recognized	X	3/18/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Pakistan	Foundation University Medical College	5/29/2012			Pending	?		5/29/2012	?	Legal Counsel will request additional information from school to determine if it can be categorized as a CCR 1314.1(a)(1) school.
Pakistan	Peoples University of Medical and Health Sciences for Women	10/24/2012	11/8/2012	2/13/2013	Recognized	X	3/18/2013		?	Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Pakistan	University of Health Sciences Lahore, Nishtar Medical College and Hospital (NMCH)	9/1/2010	5/17/2011 5/21/2012	7/19/2011	Pending	?			?	Letter sent on 5/21/12 requesting additional information from school.

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Pakistan	University of Karachi, Jinnah Medical and Dental College	2/13/2013	3/4/2013	3/11/2013	Pending	?			?	Staff needs to review information submitted by school.
Pakistan	University of the Punjab, Fatima Jinnah Medical College for Women	6/26/2012	6/26/2012		Pending	?			?	Letter sent on 6/26/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Peru	Universidad Nacional Mayor de San Marcos Facultad de Medicina	7/26/2012	8/2/2012		Pending	?			?	Letter sent on 8/2/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Peru	Universidad Peruana Cayetano Heredia Facultad de Medicina Alberto Hurtado	11/15/2012	11/27/2012	1/18/2013	Recognized	X	1/18/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Philippines	Silliman University Medical School	11/28/2012			Pending			11/28/2012	X	Staff needs to review Self-Assessment Report
Philippines	University of the Philippines Manila College of Medicine	3/4/2013	3/20/2013		Pending	?			?	Letter sent on 3/20/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Poland	Medical University of Warsaw English Language Program	3/12/2012	3/12/2012		Recognized			4/15/2010	X	Approved at the January 2013 Board Meeting. Approval is retroactive to the beginning of the English Language Program in 1996.
Russia	Ural State Medical Academy / Sverdlovsk State Medical Institute	10/2/2012	10/12/2012		Pending	?			?	Letter sent on 10/12/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Russia	Yaroslavl State Medical Academy	5/10/2011	4/11/2012	11/27/2012	Recognized	X	11/27/2012			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Saudi Arabia	University of Dammam College of Medicine	12/14/2012	1/22/2013	3/12/2013	Pending	?			?	Staff needs to review information submitted by school.
Senegal	Cheikh Anta Diop University, Faculty of Medicine, Pharmacy and Odontology	3/27/2012	5/18/2012		Pending	?			?	Letter sent on 5/18/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Serbia	University of Nis Faculty of Medicine	11/26/2012	11/27/2012		Pending	?			?	Letter sent on 11/27/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
South Korea	Dongguk University College of Medicine	4/28/2011	4/30/2011	5/16/2011	Recognized	X	5/17/2011			Dongguk University COM provided all of the necessary documents to verify eligibility for recognition pursuant to CCR 1314.1(a)(1).
South Korea	Inha University College of Medicine	2/29/2012	4/5/2012		Pending	?				Letter sent on 4/5/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).

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South Korea	Konkuk University College of Medicine	10/31/2011	4/5/2012 6/19/2012 3/14/2013	6/13/2012	Pending	?			?	Letter sent on 6/19/12 and resent on 3/14/2013 requesting additional information from school.
South Korea	Sungkyunkwan University School of Medicine	3/11/2013	4/20/2013		Pending	?			?	Letter sent on 3/20/13to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Spain	Universidad Miguel Hernández Facultad de Medicina	9/12/2012	9/12/2012 Resent on 12/7/2012		Pending	?			?	Letter sent on 4/5/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Sudan	International University of Africa Faculty of Medicine & Health Sciences	11/19/2012	11/27/2012		Pending	?			?	Letter sent on11/27/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Turkey	Istanbul University, Cerrahpasa School of Medicine (Turkish and English)	11/12/2010		4/21/2011	Recognized	X	4/28/2011			UICSM provided all of the necessary documents to verify eligibility for recognition pursuant to CCR 1314.1(a)(1).
Turkey	Gulhane Askeri Tip Akademisi (Gulhane Medical Military Academy)	4/12/2012	4/13/2012		Pending	?			?	Letter sent on 4/13/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Ukraine	Crimea State Medical University named after S.I. Georgievsky	11/8/2012	11/8/2012	1/29/2013	Recognized	X	2/5/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Ukraine	Lugansk State Medical University	8/6/2012	8/7/2012	12/27/2012	Recognized	X	2/5/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Ukraine	M. Gorky Donetsk National Medical University	7/8/2011	4/9/2012		Pending	?			?	Letter sent on 4/9/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Ukraine	Vinnica State Medical University	5/16/2012	5/18/2012	7/31/2012	Recognized	X	8/7/2012			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Ukraine	Zaporozhye State Medical University	2/25/2013	3/4/2012		Pending	?			?	Letter sent on 3/4/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
United Kingdom	University of London,King's College London School of Medicine	2/26/2013	3/4/2013		Pending	?			?	Letter sent on 3/4/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
United Kingdom	University of London, University College London School of Medicine	10/1/2012	10/10/2012	11/13/2012	Recognized	X	1/10/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Venezuela	Universidad Central de Venezuela Escuela de Medicina Jose Marie Vargas	3/22/2012	3/22/2012	5/7/2012	Recognized	X	5/16/2012			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).

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Venezuela	Universidad Central de Venezuela Escuela de Medicina Luis Razetti	3/22/2012	3/22/2012 1/22/2013 2/26/2013		Pending	?			?	Letter sent on 3/22/12 and resent on 1/22/13 and 2/26/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Vietnam	Can Tho University School of Medicine and Pharmacy	7/30/2010	4/16/2012		Pending	?			?	Letter sent on 4/16/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Vietnam	Hue University, Hue College of Medicine and Pharmacy	5/11/2011	4/16/2012	1/24/2013	Recognized	X	2/5/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Zimbabwe	University of Zimbabwe College of Health Sciences, Godfrey Huggins School of Medicine	8/28/2012	8/28/2012		Pending	?			?	Letter sent on 8/28/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).

Color Code:
Green: CCR 1314.1(a)(2)
Light Blue: Recognized

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	April 26, 2013
ATTENTION:	Medical Board of California
SUBJECT:	Special Faculty Permit Review Committee Recommendation
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing

RECOMMENDED ACTION:

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

BACKGROUND AND ANALYSIS:

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

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

The SFPRC is comprised of two Board members, one who is a physician and surgeon and one who is a public member, and of one representative from each of the medical schools in California. The SFPRC reviews and makes recommendations to the Board regarding the applicants applying pursuant to Section 2161.1 of the B&P.

At its March 14, 2013 meeting, the SFPRC reviewed the qualifications of one applicant from the University of California San Francisco, School of Medicine (UCSF-SOM,).

Bertil Eric Damato, M.D., Ph.D., UCSF-SOM - SFP APPLICANT:

Neal Cohen, M.D., M.P.H., M.S., UCSF, Vice Dean Academic Affairs, presented UCSF-SOM's request for Bertil Eric Damato, M.D., Ph.D., to receive a special faculty permit and the qualifications of Dr. Damato. Dr. Cohen indicated that Dr. Damato is an internationally recognized expert in the field of Ocular Oncology and is currently the President of the International Society of Ocular Oncology. He is also the Director and Clinical Lead of Liverpool Ocular Oncology Centre, which he established at the Royal Liverpool University Hospital in 1993. Dr. Damato is a highly sought after presenter at international scientific conferences and meetings. In addition, Dr. Damato has attracted trainees form around the world, who have gone back to leadership positions in their own right in their respective countries. Dr. Damato is an innovator in the field of Ocular Oncology, and his expertise in

proton beam therapy and the management of adult intraocular tumors, will provide a new level of patient care at UCSF.

Dr. Damato was the first to employ direct proton beam treatment of iris melanomas, which is an excellent approach to treating disseminated tumor in the anterior chamber angle, while preserving the eye. This innovation necessitated abandoning prevailing concepts of the time which held that proton beam was damaging to the anterior segment of the eye. The work done by Dr. Damato found that this damage did not occur when the treated volume was limited to the iris plane. His expertise in proton beam therapy will provide a new level of care to patients with intraocular tumors. In addition to proton therapy, Dr. Damato offers an exceptionally wide range of eye-conserving therapies, which include transpupillary thermotherapy, photodynamic therapy and endo- and exo-resection. As such, Dr Damato receives patients from over 32 countries and receives 700 cases per year.

Dr. Damato is the primary adult ocular oncology specialist for the entire British National Health Service and currently practices in the UK.

Dr. Damato will hold a full time faculty appointment as a Professor of Clinical Ophthalmology. Dr. Damato will be teaching medical students, residents, and fellows in the field of Ocular Oncology, along with performing surgeries at UCSF Parnassus Campus, Moffitt-Long Hospitals, and Mt. Zion Campus.

SPECIAL FACULTY PERMIT REVIEW COMMITTEE FINDINGS:

The SFPRC recommended approval of Dr. Damato for a SFP at UCSF pursuant to Business and Professions Code Section 2168 (a)(1)(A).

FISCAL CONSIDERATIONS:

None

April 11, 2013

Ms. Carrie Sparrevohn
[redacted]

Dear Ms. Sparrevohn,

At your request, we are providing the additional costs which the Midwives Alliance, Division of Research (MANA-DOR) would incur on behalf of the state of California to manage data collection from all Licensed Midwives active in the state through the MANA Statistics Project (MANA Stats), allowing those midwives to submit their individual Annual Summary Report to OSHPD on an annual basis.

Considerable discussion has already resulted in a good understanding of California's requirements, including the reporting period and the final submission date that would allow reporting using MANA Stats to be successful. The costs we are reporting here assume that legislation and/or rules and policies that are adopted are consistent with these discussions.

Experience in other states has shown that it is vital for there to be clear lines of communication early in the roll-out of this process among the parties responsible for implementation. In California those parties would include The MBC, OSHPD, the MANA-DOR, and CAM, the midwives' professional organization. Early in the implementation of the new regulations, these parties would work together to develop a clear understanding of how the process would work, and then provide information for the midwives that describes their requirements.

The MANA Stats Project requires that midwives, beginning a year before their first reporting deadline and continuing year-round as long as they maintain their licenses, enroll and remain active as contributors to the MANA Stats data registry. For this reason, it is imperative that the midwives be informed about these requirements well over a year before their first reporting deadline. This is why it is emphasized that early coordination among all parties is essential for success.

It is expected that a method will be determined by which midwives may submit their Annual Summary Reports from their MANA Stats accounts to OSHPD by electronic means, in the interest of efficiency. If this is desired, implementation of software on the MANA web system supporting a mutually agreed-upon method for electronic submittal will be the responsibility of the MANA-DOR, and implementation on the OSHPD end will the responsibility of OSHPD.

Given the above, the MANA-DOR is prepared to support data collection by licensed midwives using MANA Stats. Our costs quoted here are exclusively for the support of the midwives to promote their success in meeting the requirements, and work with OSHPD and CAM as described above. Specifically, costs quoted here include:

- Consulting with state agencies on: the role of MANA Stats, roll-out of requirement, report timing, instructions for state's midwives, etc.
- Enrolling or updating enrollment of all licensed midwives in the state, ensuring that all midwives will be able to report accurately; contacting each midwife to provide orientation, instructions, and strategies for success.
- Individual support of midwives being required to submit data: technical support as required, proactive support in following reporting protocols, reminders sent or individual contact initiated if not current in data submittal.

Other ongoing costs of maintaining the MANA Stats registry will be borne by the MANA-DOR as part of our mission to operate the national research registry. These include maintenance of our existing software, maintenance and ongoing validation of the data collection instrument, ongoing data review and sentinel event review, and database maintenance.

The cost structure is attached, which varies by number of licensed midwives in the state. Based on the current number in California of 241[1], the cost for the above California-specific services would be:

$19,000 for the first year
$9,500 per year thereafter

Thank you for your work on this potential improvement to data collection by California Licensed Midwives. We trust that if enacted it will benefit consumers and professionals within the state, streamline operations to ultimately save taxpayer money, provide accurate reporting, and by mandating participation in the MANA Stats research registry, benefit public health nationwide.

Bruce Ackerman
Data Collection Director
Midwives Alliance of North America
17 Valley Road
Fairfax, CA 94930-1914
Phone 415-721-7692

[1] 2011 Annual Reports Submitted, as reported to MAC at August 30, 2012 meeting, agenda item 5A

MANA STATISTICS PROJECT
COSTS OF MANAGING MANDATORY DATA-COLLECTION FOR STATES

Start-up					
Base cost of $2,500	Covers consulting with state agency on: role of MANA Stats, roll-out of requirement, report timing, instructions for state's midwives, etc.				
Variable start-up cost	Based on number of midwives being required to submit data. Covers enrolling or updating enrollment of all licensed midwives in the state, ensuring that all midwives will be able to report accurately; contacting each midwife to provide orientation, instructions, and strategies for success.				
Annual cost	Based on number of midwives being required to submit data. Covers tech support on demand, proactive support in following reporting protocols, reminders sent or individual contact initiated if not current in data submission.				
	Number of Midwives	**Start-up Cost, first year only**	**Annual Cost**	**= FIrst-year cost**	
	1-20 LMs	$3,000	$1,150	$4,150	
	21-40 LMs	$3,500	$2,300	$5,800	
	41-60 LMs	$4,000	$3,400	$7,400	
	61-80 LMs	$5,000	$4,500	$9,500	
	81-100 LMs	$5,500	$5,700	$11,200	
					Pricing for over 100 LMs reflects the following assumed volume savings on annual costs:
	101-120 LMs	$5,500	$6,250	$11,750	9%
	121-140 LMs	$6,500	$6,700	$13,200	16%
	141-160 LMs	$7,000	$7,200	$14,200	21%
	161-180 LMs	$7,500	$7,600	$15,100	26%
	181-200 LMs	$8,000	$8,100	$16,100	29%
	201-220 LMs	$8,500	$8,650	$17,150	31%
	221-240 LMs	$9,000	$9,050	$18,050	34%
	241-260 LMs	$9,500	$9,500	$19,000	36%
	261-280 LMs	$10,000	$10,050	$20,050	37%
	281-300 LMs	$10,500	$10,500	$21,000	39%

Medical Board of California
Expert Reviewer Program Report
CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY

April 2, 2013

SPECIALTY	Number of cases reviewed/ sent to Experts (Jan-Mar, 2013)	Number of Experts Utilized (Jan-Mar, 2013)	Active List Experts 950↓
ADDICTION	3	**3 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE	16
ALLERGY & IMMUNOLOGY (A&I)			4
ANESTHESIOLOGY (Anes)	4	**5 EXPERTS** 5 LIST EXPERTS REVIEWED 1 CASE	63 ↓
COLON & RECTAL SURGERY (CRS)	2	**2 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE	3
COMPLEMENTARY/ALTERNATIVE MEDICINE	9	**4 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES	21 ↑
CORRECTIONAL MEDICINE			29
DERMATOLOGY (D)	1	**1 EXPERT** 1 LIST EXPERT	10
EMERGENCY (EM)	6	**4 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES	49 ↓
FAMILY (FM)	30	**23 EXPERTS** 16 LIST EXPERTS REVIEWED 1 CASE 4 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES	82 ↓
INTERNAL (General Internal Med)	21	**15 EXPERTS** 11 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 5 CASES	189 ↓
Cardiovascular Disease (Cv)	5	**4 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	33
Gastroenterology (Ge)	1	**1 EXPERT** 1 LIST EXPERT	18 ↑
Medical Oncology (Onc)	3	**3 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE	11

Medical Board of California
Expert Reviewer Program Report
CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
April 2, 2013

SPECIALTY	Number of cases reviewed/ sent to Experts (Jan-Mar, 2013)	Number of Experts Utilized (Jan-Mar, 2013)	Active List Experts 950↓
Nephrology (Nep)	1	**1 EXPERT** 1 LIST EXPERT	9
Rheumatology (Rhu)	1	**1 EXPERT** 1 LIST EXPERT	8
MIDWIFE REVIEWER	1	**1 EXPERT** 1 LIST EXPERT	6
NEUROLOGICAL SURGERY (NS)	4	**2 EXPERTS** 2 LIST EXPERTS REVIEWED 2 CASES	10
NEUROLOGY (N)	3	**3 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE	26 ↓
NEUROLOGY with Special Qualifications in Child Neurology (N/ChiN)			2
NUCLEAR MEDICINE (NuM)			5
OBSTETRICS & GYNECOLOGY (ObG)	12	**12 EXPERTS** 10 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES	81 ↑
OPHTHALMOLOGY (Oph)	7	**4 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	31
ORAL & MAXILLOFACIAL SURGERY	1	**1 EXPERT** LIST EXPERT	1
ORTHOPAEDIC SURGERY (OrS)	4	**3 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	27
OTOLARYNGOLOGY (Oto)			22 ↑
PAIN MEDICINE (PM)	15	**9 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE 4 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	18 ↓

Medical Board of California
Expert Reviewer Program Report
CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY

April 2, 2013

SPECIALTY	Number of cases reviewed/ sent to Experts (Jan-Mar, 2013)	Number of Experts Utilized (Jan-Mar, 2013)	Active List Experts 950↓
PATHOLOGY (Path)			10
PEDIATRICS (Ped)	2	**3 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE	43 ↓
PHYSICAL MEDICINE & REHABILITATION (PMR)	1	**2 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE	10
PLASTIC SURGERY (PIS)	18	**9 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 2 LIST EXPERTS REVIEWED 4 CASES	49 ↓
PSYCHIATRY (Psyc)	26	**19 EXPERTS** 13 LIST EXPERTS REVIEWED 1 CASE 5 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	81
RADIOLOGY (Rad)	1	**1 EXPERT** LIST EXPERT	33
SLEEP MEDICINE (S)			8
SURGERY (S)	9	**7 EXPERTS** 5 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES	47 ↑
Vascular Surgery (VascS)			8
THORACIC SURGERY (TS)			17 ↑
(MEDICAL) TOXICOLOGY			3
UROLOGY (U)	6	**4 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES	14 ↓

TOTAL CASES SENT (1ST QUARTER)	**185**
TOTAL LIST EXPERTS UTILIZED (1ST QUARTER)	**140**
TOTAL ACTIVE LIST EXPERTS	**950**

Medical Board of California
Expert Reviewer Program Report
CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY

April 2, 2013

SPECIALTY	Number of cases reviewed/ sent to Experts (Jan-Mar, 2013)	Number of Experts Utilized (Jan-Mar, 2013)	Active List Experts 950↓

/susan (4/2/13)

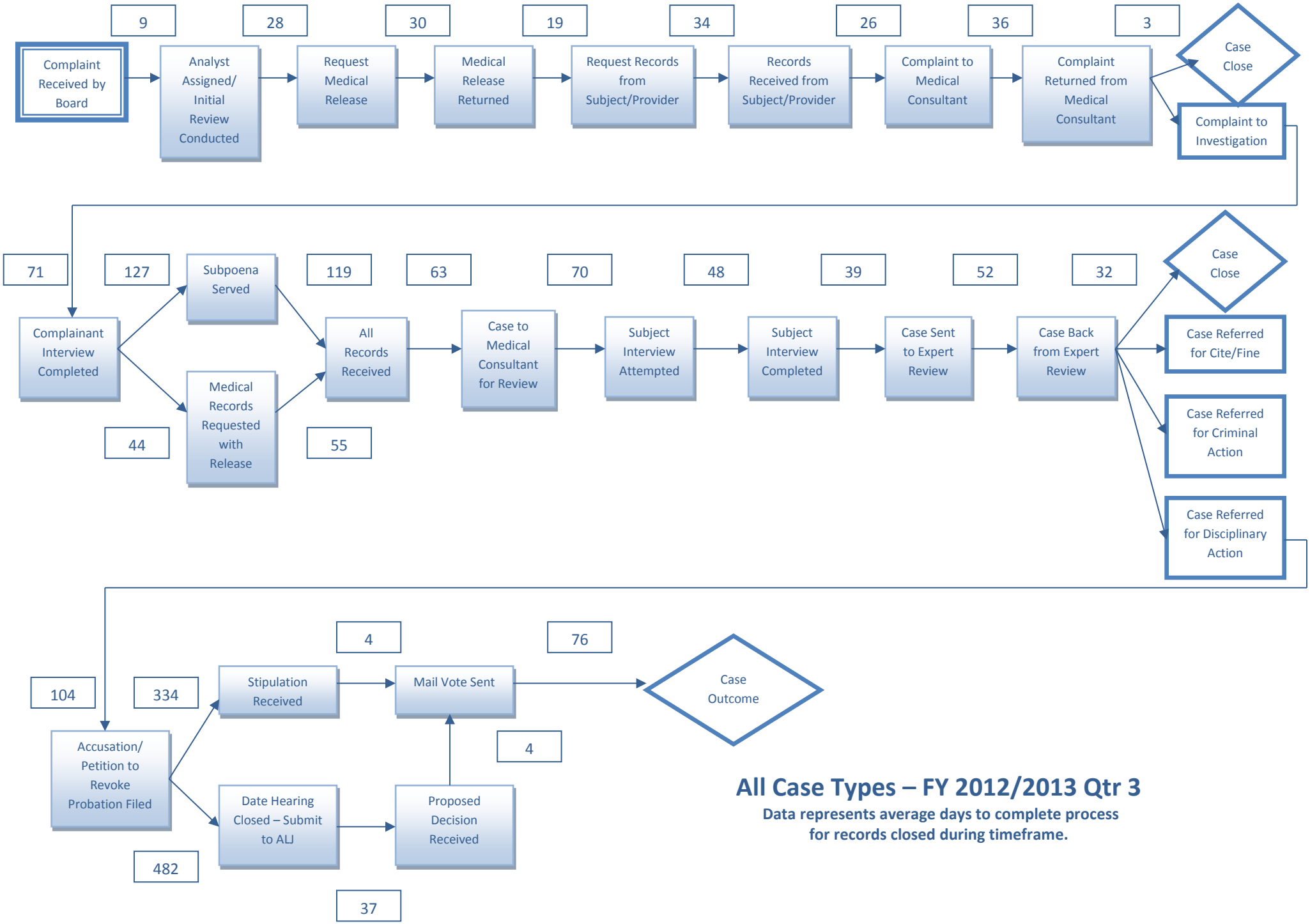
Enforcement Data Markers
All Case Types

Data represents average days to complete Complaint and Investigation processes for records closed during reported time frames.	FY 2008/2009		FY 2009/2010		FY 2010/2011		FY 2011/2012		FY 2012/2013 1st Qtr		FY 2012/2013 2nd Qtr		FY 2012/2013 3rd Qtr	
	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records
Complaint Processes														
Complaint Received by Board → Analyst Assigned/Initial Review Conducted	10	6761	11	6869	9	7513	12	7699	9	2141	8	1974	9	1918
Analyst Assigned/Initial Review Conducted → Request Medical Release	25	1216	24	1360	28	1567	42	1557	29	395	28	354	28	330
Request Medical Release → Medical Release Returned	29	1044	26	1166	25	1321	27	1281	29	327	29	310	30	291
Medical Release Returned → Request Records from Subject/Provider	7	687	7	802	11	888	17	865	14	222	15	192	19	180
Request Records from Subject/Provider → Records Received from Subject/Provider	39	1759	38	1879	35	1906	35	2015	34	548	32	469	34	447
Records Received from Subject/Provider → Complaint to Medical Consultant	15	1617	16	1865	17	1768	21	1798	23	456	20	377	26	411
Complaint to Medical Consultant → Complaint Returned from Medical Consultant	54	1934	54	2120	52	2129	45	2164	39	535	31	467	36	473
Complaint Returned from Medical Consultant → Case Closed/Complaint to Investigation	7	1932	4	2114	5	2126	4	2151	5	534	7	464	3	472
Investigative Processes														
Complaint to Investigation → Complainant Interview Completed	103	349	102	424	110	490	89	531	95	132	71	132	71	130
Complainant Interview Completed → Subpoena Served	173	42	237	43	172	44	202	45	155	18	161	18	127	16
Complainant Interview Completed → Medical Records Requested with Release	76	141	88	170	59	194	87	203	69	49	75	60	44	56
Subpoena Served → All Records Received	124	120	100	178	88	166	82	146	90	40	60	27	119	36
Medical Records Requested with Release → All Records Received	95	372	92	406	85	420	64	416	67	114	43	109	55	96
All Records Received → Case to Medical Consultant for Review	78	227	84	318	70	369	59	322	50	79	52	75	63	70
Case to Medical Consultant for Review → Subject Interview Attempted	110	374	109	488	77	558	76	532	87	109	73	111	70	116
Subject Interview Attempted → Subject Interview Completed	66	712	53	880	53	961	51	1046	57	255	46	244	48	247
Subject Interview Completed → Case Sent to Expert Review	97	412	81	511	72	580	57	626	60	147	48	147	39	148
Case Sent to Expert Review → Case Back from Expert Review	79	510	72	601	63	658	61	701	78	171	55	172	52	178
Case Back from Expert Review → Case Closed or Referred for Action	39	495	31	585	30	656	29	705	35	169	32	174	32	175

Enforcement Data Markers
All Case Types

Data represents average days to complete Disciplinary processes for records closed during reported time frames.	FY 2008/2009		FY 2009/2010		FY 2010/2011		FY 2011/2012		FY 2012/2013 1st Qtr		FY 2012/2013 2nd Qtr		FY 2012/2013 3rd Qtr	
	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records
Case Referred for Action → Accusation/Petition to Revoke Probation Filed	121	239	113	237	103	219	129	284	146	70	95	84	104	72
Accusation/Petition to Revoke Probation Filed → Stipulation Received	330	159	291	173	318	142	329	202	294	46	301	53	334	51
Stipulation Received → Mail Vote Sent	6	136	6	132	4	124	5	153	5	35	3	39	4	35
Accusation/Petition to Revoke Probation Filed → Date Hearing Closed - Submit to ALJ	416	25	370	30	393	44	318	45	484	15	400	15	482	10
Date Hearing Closed - Submit to ALJ → Proposed Decision Received	28	35	98	43	39	58	40	63	67	27	58	22	37	18
Proposed Decision Received → Mail Vote Sent	5	54	5	53	6	60	6	72	6	27	4	22	4	19
Mail Vote Sent → Case Outcome	131	206	87	208	111	205	82	262	109	72	74	75	76	57

Data represents overall average days from Receipt to Closure for records closed during reported time frames.	FY 2008/2009		FY 2009/2010		FY 2010/2011		FY 2011/2012		FY 2012/2013 1st Qtr		FY 2012/2013 2nd Qtr		FY 2012/2013 3rd Qtr	
	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records
Complaint Received → Closure in Complaint Unit	84	5278	84	5247	80	5755	91	5687	73	1583	74	1440	77	1452
Complaint Received → Closure at Field/Referred for Administrative or Criminal Action/Citation Issued	467	1585	464	1747	453	1861	419	2101	396	585	396	558	411	497



All Case Types – FY 2012/2013 Qtr 3

Data represents average days to complete process for records closed during timeframe.

Enforcement Process	2008/2009		2009/2010		2010/2011		2011/2012		2012/2013 Qtr 1		2012/2013 Qtr 2		2012/2013 Qtr 3	
	Cases[1]	AVG[2]	Cases	AVG	Cases	AVG	Cases	AVG	Cases	AVG	Cases	AVG	Cases	AVG
Complaint	6426	75	6563	76	7008	74	7217	83	1980	67	1844	63	1808	70
% of Complaints Below 50 days (Goal: 50-60%)	**43%**		**41%**		**35%**		**42%**		**48%**		**50%**		**44%**	
Investigation	1100	349	1290	328	1411	312	1545	264	406	267	394	269	373	277
Discipline														
AG Processing to Preparation of an Accusation	240	103	304	106	294	107	333	103	73	83	79	70	65	100
Other Stages of the Legal Process (e.g., after charges filed)	228	381	232	368	216	417	280	396	67	440	80	412	71	408

[1] Some cases closed were opened in a prior fiscal year. **(Footnote applies to all years provided on report)**

[2] Average time (calendar days) in processing complaints during the fiscal year, for all cases, from date of original receipt of the complaint, for each stage of discipline, through completion of judicial review. **(Footnote applies to all years provided on report)**

ENFORCEMENT TIMEFRAMES

FISCAL YEARS	2006 - 2007		2007 - 2008		2008- 2009		2009 - 2010		2010 - 2011		2011 - 2012		2012 - 2013 *	
	AVERAGE	MEDIAN	AVERAGE	MEDIAN	AVERAGE	MEDIAN	AVERAGE	MEDIAN	AVERAGE	MEDIAN	AVERAGE	MEDIAN	AVERAGE	MEDIAN
COMPLAINT PROCESSING	54	49	61	49	75	63	76	63	74	77	83	64	67	54
INVESTIGATION	307	289	324	272	349	309	328	292	312	283	264	225	271	246
TOTAL MBC														
DAYS	361	338	385	321	424	372	404	355	386	360	347	289	338	300
YEARS	0.99	0.93	1.05	0.88	1.16	1.02	1.11	0.97	1.06	0.99	0.95	0.79	0.93	0.82
AG PREP FOR ACC	127	76	121	58	103	63	106	66	107	72	104	78	84	71
OTHER LEGAL	446	350	471	324	381	311	368	312	417	324	396	351	421	344
TOTAL AG														
DAYS	573	426	592	382	484	374	474	378	524	396	500	429	505	415
YEARS	1.57	1.17	1.62	1.05	1.33	1.02	1.30	1.04	1.44	1.08	1.37	1.18	1.38	1.14
TOTAL MBC & AG														
DAYS	934	764	977	703	908	746	878	733	910	756	847	718	843	715
YEARS	2.56	2.09	2.68	1.93	2.49	2.04	2.41	2.01	2.49	2.07	2.32	1.97	2.31	1.96

Years calculated using 365 days per year
Data source: MBC Annual Reports, except 2012-2013

* Data through 3/31/2013

Suspension Order Type	FY 04/05	FY 05/06	FY 06/07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13 *
Automatic Suspension Order	5	1	5	0	3	7	4	6	3
PC 23 Order	8	4	8	6	15	7	12	12	18
Out of State Suspension Order	15	14	8	11	18	18	21	17	6
Agreement - No Practice/Restriction	2	6	5	2	3	3	2	0	3
Suspension/Cease Practice Issued by Chief	5	5	3	1	2	1	3	4	3
Interim Suspension Order	31	32	22	18	22	22	28	35	24
Temporary Suspension Order	1	0	0	1	0	0	1	0	0
Totals	**67**	**62**	**51**	**39**	**63**	**58**	**71**	**74**	**57**

*** Suspensions Issued through 3/31/2013**

	2005	2006		2007		2008		2009		2010		2011	2012	2013 Qtr 1
	Prior to VE	All	VE	All	VE	All	VE	All	VE	All	VE	All	All	All
Calendar Day Age from Case Assigned to Case Closed Not Resulting in Prosecution														
Average	271	299	138	330	268	374	358	383	381	333	333	296	263	266
Median	252	285	134	304	269	335	324	346	346	298	297	273	230	246
Record Count	827	703	192	648	539	609	588	673	672	664	663	857	794	222
Calendar Day Age from Request to Suspension Order Granted														
Average	51	44	4	34	38	19	19	52	39	40	40	43	73	33
Median	17	3	2	22	23	10	10	23	23	1	1	17	24	29
Record Count	24	21	11	17	13	21	17	17	16	27	27	31	51	9
Calendar Day Age from Request to Receipt of Medical Records														
Average	58	53	37	59	57	63	58	73	73	64	64	67	46	69
Median	32	31	26	31	31	28	28	32	32	29	29	30	28	34
Record Count	475	376	228	264	259	256	252	243	243	257	257	246	236	46
Calendar Day Age from Request to Physician Interview Completed														
Average	48	51	43	52	50	63	63	52	52	46	46	52	47	48
Median	36	42	38	37	36	41	42	37	37	34	34	38	35	37
Record Count	597	453	172	406	371	473	466	696	696	582	582	729	664	145
Calendar Day Age from Request to Receipt of Expert Opinion														
Average	51	47	35	51	43	50	50	48	48	47	47	58	57	47
Median	41	35	31	36	35	39	38	36	35	37	37	39	38	36
Record Count	519	424	82	344	270	374	359	426	424	415	415	599	447	142
Calendar Day Age from Case Assigned to Completed Investigation and Accusation Filed														
Average	556	554	140	543	340	565	493	584	578	589	588	552	495	558
Median	525	504	120	523	339	541	486	575	569	616	616	533	457	530
Record Count	187	149	17	198	95	157	131	189	186	200	199	239	231	54
Calendar Day Age from Accusation Filed to Disciplinary Outcome**														
Average	608	602	85	576	188	561	243	473	339	426	340	425	449	459
Median	526	466	99	426	182	384	238	351	309	326	304	391	367	422
Record Count	212	195	3	226	29	203	80	198	145	171	156	190	237	51

*Excludes Out of State and Headquarters Cases
**Excludes Outcomes where no Accusation Filed

Agenda Item 23

New Senior Assistant Attorney General, Gloria Castro,
Health Quality Enforcement Section

Ms. Castro has over 15 years of experience as an attorney – the majority of which have been with the Department of Justice. Before joining the Attorney General's Office, she was awarded a fellowship by Equal Justice Works, where she combated immigration benefit fraud by creating and directing the Notario Fraud Project.

Upon joining the Attorney General's office in 1999, Ms. Castro began her tenure as a deputy in the Civil Rights Enforcement Section. She helped lead a year-long investigation of two immigration consulting firms, which resulted in the filing of two lawsuits against fourteen defendants. Ms. Castro received the Attorney General's Award for Excellence for her work on these two cases. She joined HQE in 2005, where she has developed her knowledge of administrative law and established herself as a skilled civil litigator. In 2010, she became a Supervising Deputy.

Ms. Castro holds Bachelor of Arts degrees in History and Latin American Studies from U.C. Santa Barbara and a J.D. from the University of Southern California.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	April 17, 2013
ATTENTION:	Members, Medical Board
SUBJECT:	Summary of the Gag Clause for Physicians
STAFF CONTACT:	Linda Whitney, Executive Director and Renee Threadgill, Chief of Enforcement

History of Gag Clause Legislation:

2003/04 – Assembly Member Correa introduced AB 320. This bill would prohibit a licensee, or an entity acting on behalf of a licensee, which licensee is regulated by the Department of Consumer Affairs or various boards, bureaus, or programs from including, or permitting to be included, a provision in an agreement to settle a civil dispute that prohibits the other party in that dispute from contacting, filing a complaint with, or cooperating with the department, board, bureau, or program or that requires the other party to withdraw a complaint from the department, board, bureau, or program. A licensee in violation of these provisions would be subject to disciplinary action by the board, bureau, or program. This bill passed out of the legislature but was vetoed by the Governor.

2005 - Assembly Member Negrete McLeod introduced AB 446. This bill would prohibit a licensee who is regulated by the Department of Consumer Affairs or various boards, bureaus, or programs, or an entity or person acting as an authorized agent of a licensee, from including or permitting to be included a provision in an agreement to settle a civil dispute that prohibits the other party in that dispute from contacting, filing a complaint with, or cooperating with the department, board, bureau, or program, or that requires the other party to withdraw a complaint from the department, board, bureau, or program. A licensee in violation of these provisions would be subject to disciplinary action by the board, bureau, or program. The bill would also prohibit a board, bureau, or program from requiring its licensees in a disciplinary action that is based on a complaint or report that has been settled in a civil action to pay additional moneys to the benefit of any plaintiff in the civil action. This bill passed out of the legislature but was vetoed by the Governor.

2006 – Assembly Member Negrete McLeod introduced AB 2260, sponsored by the Medical Board of California. This bill addressed revisions to the special programs (B&P 2111, 2113, 2168) and the gag clause, as follows. This bill would prohibit a physician and surgeon from including certain provisions in an agreement to settle a civil dispute arising from his or her practice that interferes with communications, as specified, between the board and another party to the dispute. The bill would make the violation of this requirement subject to disciplinary action by the board. This bill was signed into law on 9/28/06, effective on 1/1/07.

Business and Professions Code section 2220.7 provides (commonly referred to as prohibition against gag clause or confidentiality agreement):

> "(a) A physician and surgeon shall not include or permit to be included any of the following provision in an agreement to settle a civil dispute arising from his or her practice, whether the agreement is made before or after filing the action:
> (1) A provision that prohibits another party to the dispute from contacting or cooperating with the board.
> (2) A provision that prohibits another party to the dispute from filing a complaint with the board.
> (3) A provision that requires another party to the dispute to withdraw a complaint he or she has filed with the board.
> (b) A provision described in subdivision (a) is void as against public policy.
> (c) A physician and surgeon who violates this section is subject to disciplinary action by the board."

The board has taken several actions against licensees since this law was enacted.