State of California

State and Consumer Services Agency

MEDICAL BOARD OF CALIFORNIA

Interim Full Board Meeting

Tuesday, June 4, 2013

10:00 am – 3:00 pm

MEDICAL BOARD OF CALIFORNIA

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.
Phil Tagami
Barbara Yaroslavsky, Past President
Felix Yip, M.D.

Hilton Sacramento Arden West
Folsom Room
2200 Harvard Street
Sacramento, California 95815

Tuesday, June 4, 2013
10:00 a.m. – 3:00 p.m.
(or until the conclusion of Business)

ORDER OF ITEMS IS SUBJECT TO CHANGE

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.

1. 10:00 a.m. Call to Order/Roll Call

2. Introduction and Swearing in of New Board Member – Mr. Phil Tagami

3. 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)}

4. Approval of Minutes from the April 25-26, 2013 Meeting

5. Closed Session
   Pursuant to Section 11126(a)(1) of the Government Code, the Board will meet in Closed Session, to discuss the continued employment of the Executive Director and the selection of an Acting Executive Director, if necessary; unless the Executive Officer exercises her right to have this agenda item heard in open session. If the matter is addressed in open session, the Board may still meet in closed session to conduct its deliberations pursuant to Government Code Section 1126(a)(4).

6. Announcement of Actions Taken in Closed Session (Government Code Section 11125.2) – Dr. Levine

7. Discussion of Procedures for the Selection of a New Executive Director, if necessary, depending on the action of Agenda Item 5 – Dr. Levine

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.

8. Status Update on Actions Taken at the April 25-26, 2013 Quarterly Board Meeting

   a. Enforcement Program:
      - Legislative Update: Senate Bill 62 (Price) – Ms. Simoes
      - Use of CURES Data – Ms. Threadgill and Ms. Cady
      - Cost/Ramifications of Senate Bill 304 (Price) - Proposal to Transfer all Investigative Staff from the Medical Board to the Department of Justice – Ms. Kirchmeyer and Ms. Threadgill

   b. Senate Bill 1441 (Ridley-Thomas) Chapter 548, Statutes of 2008 – Proposed Regulations to Incorporate Uniform Standards for Substance Abusing Licensees – Process and Timeline – Mr. Heppler

   c. Consumer Protection Enforcement Initiative (CPEI) Positions: Position Descriptions and Plan to fill Non-Sworn Investigator Positions and Timeline – Ms. Kirchmeyer and Ms. Threadgill

   d. Senate Bill 100 (Price) Chapter 645, Statutes of 2011: Task Force on Outpatient Surgery Settings – Dr. GnanaDev
      - Website – Mr. Worden and Ms. Ingram
      - Complaint Process – Ms. Threadgill and Ms. Cady
      - Accreditation Standards – Mr. Worden and Mr. Heppler

   e. Disciplinary Guidelines (Informational Item) – Dr. Levine

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

10. Adjournment

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.

Meetings of the Medical Board of California are open to the public except when specifically noticed otherwise in accordance with the Open Meetings Act. The audience will be given appropriate opportunities to comment on any issue presented in open session before the Board, but the President may apportion available time among those who wish to speak. For additional information call (916) 263-2389.

MEDICAL BOARD OF CALIFORNIA
QUARTERLY BOARD MEETING

Hilton LAX
Los Angeles Room
5711 W. Century Blvd
Los Angeles, CA 90045

Thursday, April 25, 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 April 25, 2013 at 4:10 pm. A quorum was present and due notice was provided to all interested parties.

Members Present:

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

Staff Present:

William Boyd, Investigator
Susan Cady, Enforcement Manager
Dianne Dobbs, Department of Consumer Affairs, Legal Counsel
Christopher Figueroa, Investigator
Jon Genens, Investigator
Dianna Gharibian, Inspector
Kurt Heppler, Staff Counsel
Kimberly Kirchmeyer, Deputy Director
Armando Melendez, Business Services Analyst
Regina Rao, Business Services Analyst
Verdeena Richardson, Inspector
Marie Russell, M.D., Medical Consultant
Teresa Schaeffer, Associate Analyst

Kevin Schunke, Licensing Outreach Manager
Jennifer Simoes, Chief of Legislation
Laura Sweet, Deputy Chief of Enforcement
Renee Threadgill, Chief of Enforcement
Lisa Toof, Administrative Assistant II
See Vang, Business Services Analyst
Rachel Wachholz-LaSota, Inspector III
Kerrie Webb, Staff Counsel
Linda Whitney, Executive Director
Curt Worden, Chief of Licensing

Members of the Audience:

Teresa Anderson, California Academy of Physician Assistants
Hilma Balain, Kaiser Permanente
Dr. James Bersot, The Joint Commission
Jessica Biscardi, Cancer Control Society
Jeff Bonenfant, Midwestern University (AZCOM)
Jorge Carreon, M.D., Former Board Member
Gloria Castro, Senior Assistant Attorney General, Attorney General's Office
Yvonne Choong, California Medical Association
Genevieve Clavreul, NRNPA
Alicia Cole, Consumers Union
Zennie Coughlin, Kaiser Permanente
Frank Cuny, California Citizens for Health Freedom
Karen Ehrlich, L.M., Midwifery Advisory Council
Julie D'Angelo Fellmeth, Center for Public Interest Law
Jack French, Consumers Union Safe Patient Project
Joseph Furman, Furman Healthcare Law
Louis Galiano, Department of Consumer Affairs
Lisa Girion, Los Angeles Times
Jennifer Hoppe, The Joint Commission
Dorothea Johnson, Deputy Director, Department of Consumer Affairs
Jeffrey Keys, M.D., American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF)
Carolyn Kurtz, J.D., General Council and Vice President of Government Affairs, Accreditation Association for Ambulatory Health Care, Inc. (AAAHC)
Christine McElyea, Midwestern University (AZCOM)
Leslie Perea
Deborah Rotenberg, PPAC
Victoria Samper, Institute for Medical Quality
Marni Shear, Midwestern University (AZCOM)
Douglas Shin, Cooperative of American Physicians
Jill Silverman, Institute for Medical Quality
Shannon Smith-Crowley, American Congress of Obstetricians and Gynecologists

Thomas Terranova, MA, Director of Accreditation, American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF)
Mary Wei, Assistant Director, Accreditation Association for Ambulatory Health Care, Inc. (AAAHC)

Agenda Item 2 Public Comments on Items not on the Agenda

No public comment was received for this agenda item.

Agenda Item 3 Approval of Meeting Minutes from the January 31-February 1, 2013

Dr. Levine noted that the Board had received an email from Carol Gottstein stating her name had been misspelled in the minutes and asking to have the spelling corrected from Godstein to Gottstein. Also, Ms. D'Angelo Fellmeth asked for a correction to the spelling of the Assembly Member's name on page 10.

Dr. GnanaDev made a motion to approve the meeting minutes with the corrections mentioned above; s/Mr. Serrano Sewell. Motion carried.

Agenda Item 4 Presentations by Approved Accreditation Agencies (pursuant to the relevant section of the Business and Profession Code and Health and Safety Code section 1248)

Mr. Heppler and Mr. Worden gave a detailed background description about how outpatient surgery settings (OSS) originated to supplement the upcoming Power Point presentations on OSS. This report included background history on each of the code sections regarding OSS. These codes include the following: California Business and Professions Code (B&P) sections 2215, 2216 and 2217; California Health and Safety Code (H&S) sections 1248-1248.85; and California Code of Regulations, Title 16, Division 1, (CCR) sections 1313.2 – 1313.6.

Dr. Levine announced there are four different Accreditation Agencies (AA) present that will be giving presentations on their particular agencies.

A. Accreditation Association for Ambulatory Health Care, Inc. (AAAHC)

Dr. Levine introduced Ms. Kurtz and Ms. Wei from the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC). Ms. Kurtz and Ms. Wei stated that they understand the concerns of the Board. They have been accrediting ambulatory health care organizations for almost 35 years and are the largest accreditor of ambulatory health care organizations in the country. They are deemed by CMS to do Medicare Certified ambulatory surgery centers (ASC). They are recognized in every state that mandates accreditation for both licensed ASCs as well as office based surgery centers. Ms. Kurtz gave a presentation on the agency's mission, objectives, how to apply to their agency, and the process taken when on site while conducting their survey. They discussed how the surveyor reports are submitted and reviewed and the steps they take to be certain that the organizations maintain compliance with their agency standards as they change from year to year.

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

Dr. Levine introduced Mr. Terranova, MA, Director of Accreditation & Dr. Keys, President of Board of Directors for the American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF). Mr. Terranova gave a presentation on their agency's mission, brief background history and goals. Mr. Terranova discussed their processes and procedures for accreditation approval, the ten areas of inspection, and their Inspector Training Program. Dr. Keys then discussed their peer review system, patient safety initiatives and statistics, and the ten most found common deficiencies. They accredit approximately 282 facilities.

C. Institute for Medical Quality (IMQ)

Dr. Levine introduced Ms. Samper and Ms. Silverman from the Institute for Medical Quality (IMQ). An overview presentation was given on their agency standards and types of facilities they accredit. They discussed their different types of surveys and the survey process as well as their surveyor training requirements and qualifications. Their accreditation decision process and facility notifications and reports were also discussed.

D. The Joint Commission

Dr. Levine introduced Dr. Bersot, Ambulatory Care Surveyor, and Ms. Hoppe, MPH, Senior Associate Director, State and External Relations. Ms. Hoppe gave a presentation in regards to the overview of the Joint Commission, their accreditation requirements, their mission and vision, their standards and onsite survey process, the post survey activities as well as the complaint process. They accredit approximately 160 facilities.

Public comment was received on this agenda item.

Alicia Cole expressed her concerns about accrediting agencies. She participated in several surveys during her two month hospital stay and her biggest concerns are patient protection and patient information. She feels that the data gathered from these surveys should be useful to the public. The rating of the hospital she was in never changed by their accrediting agency. During that time period and for two years, this hospital was sighted at the highest level of infection control problems with the Department of Public Health that the law can allow. For two years consistently, they were sighted for infection control and for not adhering to their own policies and procedures. This hospital almost lost their Medicare funding which is 40% of their income and during this same time, they still remained a stellar rated hospital with the accrediting agency. They had to hire an attorney to help them with a plan of correction. In addition to almost losing their Medicare funding, they had an "F" rating with the Better Business Bureau. She feels these accrediting agencies should keep tabs with other Governmental Agencies regularly and not just pay attention to the survey results.

Dr. Levine announced that she wanted to recognize a prior Board member that served from 2008 to 2012; Jorge Carreon, M.D.. He served on the Board's Access to Care Committee, the Wellness Committee, the Education Committee, and took a leading role in the Board's cultural/linguistic access standards. He was elected Board Secretary at the July 2012 meeting. She presented him with an award of recognition.

Dr. Carreon thanked the Board and expressed his appreciation for the dedicated people he worked with on the Board.

Agenda Item 5 Closed Session

Ms. Yaroslavsky made a motion to move into closed session and then recess until Friday morning at 9:00 a.m. Motion carried.

The open meeting ended at 6:25 pm and went into closed session.

Closed session adjourned at 6:45 pm.

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Friday, April 26, 2013

Members Present:

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

Staff Present:

Susan Cady, Enforcement Manager
Dianne Dobbs, Department of Consumer Affairs, Legal Counsel
Kurt Heppler, Staff Counsel
Robin Hollis, Investigator
Kimberly Kirchmeyer, Deputy Director
Albert Medina, Investigator
Armando Melendez, Business Services Analyst
Regina Rao, Business Services Analyst
Kevin Schunke, Licensing Outreach Manager
Jennifer Simoes, Chief of Legislation
Jack Sun, Investigator
Laura Sweet, Deputy Chief of Enforcement
Renee Threadgill, Chief of Enforcement
Lisa Toof, Administrative Assistant II
See Vang, Business Services Analyst

Kerrie Webb, Staff Council
Linda Whitney, Executive Director
Curt Worden, Chief of Licensing

Members of the Audience:

Teresa Anderson, California Academy of Physician Assistants
Hilma Balain, Kaiser Permanente
Robert McKim Bell, Deputy Attorney General, Attorney General's Office
Jessica Biscardi, Cancer Control Society
Gloria Castro, Senior Assistant Attorney General, Attorney General's Office
Yvonne Choong, California Medical Association
Genevieve Clavreul, NRNPA
Alicia Cole, Consumers Union
Zennie Coughlin, Kaiser Permanente
Frank Cuny, California Citizens for Health Freedom
Karen Ehrlich, L.M., Midwifery Advisory Council
Julie D'Angelo Fellmeth, Center for Public Interest Law
Jack French, Consumers Union Safe Patient Project
Joseph Furman, Furman Healthcare Law
Louis Galiano, Department of Consumer Affairs
Lisa Girion, Los Angeles Times
Steve Gray, California Society of Health System Pharmacists
Dorothea Johnson, Deputy Director, Department of Consumer Affairs
Leslie Perea
Deborah Rotenberg, PPAC
Michael Roth, Attorney
Douglas Shin, Cooperative of American Physicians
Shannon Smith-Crowley, American Congress of Obstetricians and Gynecologists
Carrie Sparrevohn, L.M., Midwifery Advisory Council
Brian Warren, California Pharmacists Association

Agenda Item 6 Call to Order /Roll Call

Dr. Levine, M.D. called the meeting of the Medical Board of California (Board) to order on April 26, 2013 at 9:10 am. A quorum was present and due notice was provided to all interested parties.

Agenda item 7 Public Comments on Items not on the Agenda

Michael Roth, introduced himself as an attorney on arbitration and mediation of health care matters. Mr. Roth asked the Board to consider adopting a policy of possibly encouraging mediation of peer review disputes before situations get too out of hand, to avoid physicians and surgeons going to hearing, which can take months or years to complete and at quite an expense.

Genevieve Clavreul suggested an item for a future agenda. With the shortage of physicians, it has been discussed to replace physicians with nurses. She feels that if nurse practitioners assume some functions,

then you need to define the way the two interact with each other, and designing something more precise so there is less misunderstanding between the two professionals.

Agenda Item 21 Update on Outpatient Surgery Centers Programs

Mr. Worden gave a brief update on several items:

- How the Board is making it easier to locate an OSS on its Web site.
- The Outpatient Surgery Accreditation Agencies' renewals have been sent out.
- The Accreditation Agencies have been sending in additional information. However, all Accreditation Agencies are missing some information.
- Board staff is working on providing each Accreditation Agency (AA) with a list of specific missing data.

Ms. Threadgill gave a brief update stating that the enforcement staff continue to track complaints that are received under a separate case number and tracking system to help identify these complaints. The Board has received three complaints to date.

Dr. Levine asked to have established a regular means of reporting to the Board the status of complaints to keep the Board updated for oversight of this process. Ms. Threadgill agreed to include a status report to the Board on a regular basis.

Dr. GnanaDev requested that the staff put together a detailed process report on how to proceed with discipline actions to complaints on OSSs.

Mr. Serrano Sewell would like the report to include the actions the Board has taken in the past on those surgery centers that have lost their accreditation.

Ms. Yaroslavsky recommended the Board President appoint a group of people to look at this issue in its entirety as to the barriers that have impacted information for the consumer and the physicians.

Dr. Levine asked for two Board Members to work together on this issue and create some clear direction to the staff on certain questions and concerns that need answers to help possibly create additional regulations and laws.

Dr. Salomonson and Dr. GnanaDev agreed to work together on this issue and bring some suggestions back to the next Board Meeting.

Public comment was heard on this agenda item.

Jack French, Consumers Union, spoke on his concerns about the Board's responsibilities for physician owned OSSs. After reviewing the OSS link, it was found that of the 747 centers, basic information is still missing after two years since the law went into effect, such as the name of the physician owner as well as evidence of current accreditation. Only 154 facilities of the 747 included the physician owner name and if the accreditation was current.

He stated a radio station in Southern California did its own analysis. They reviewed 100 surgery centers listed on the Board's Web site, and only 14 included the name of the physician owner and only five

provided the owner's medical license number, which he stated is required by law. They also found missing information from most of the records including whether a surgery center had their accreditation suspended or revoked.

Julie D'Angelo Fellmeth, Center for Public Interest Law, expressed her concerns about the Board's authority and jurisdiction over the OSSs. The Board's jurisdiction used to be limited, but now the Board has significant jurisdiction over the AAs as well as the OSSs. The Board needs to be able to detect if an AA is falling down on the job, as that might trigger the Board's duty to inspect the OSS and to seek a district attorney to get an injunction shutting it down. The issue for the Board is how the Board intends to monitor the AAs, so that the Board can meaningfully carry out this new responsibility. She also noted that the Board was not provided additional resources to do this work and inspect OSSs.

Genevieve Clavreul was recently involved with an outpatient physician who at the time of her appointment was so distraught from his prior patient that he could not remember her name or why she was there. When her test results came back, the information on them was wrong. She believes that OSSs should not be in business.

Agenda Item 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 stated that the current regulation for incarcerated physicians has no language regarding what type of notice a newly released person would receive during release procedures after being incarcerated. There are concerns that under the current regulation an incarcerated physician could say he/she had been released when he/she actually had not been and the Board would have no way of knowing for certain. Mr. Heppler stated that under the revised text the proper notice would be a signed statement under penalty of perjury submitted to the Board by the licensee stating that he/she had been released from incarceration. It would be provided to the Board by fax, regular mail or personal service, at the option of the licensee. He believes this is a workable solution to the problem where no records of the release currently exist. This language has been circulated for 15 days and there have been no adverse comments. He is asking that the Board approve the revised language shown in the documentation provided in the Board packet and instruct the Executive Director to complete the rulemaking file and transmit it to the Office of Administrative Law.

Ms. Schipske made a motion to accept the language change and instruct the Executive Director to complete the proper paperwork and submit it to the Office of Administrative Law: s/Dr. Levine. Motion carried.

Agenda Item 9 **Enforcement Process Overview: Role/Responsibilites of Physicians in the Enforcement Process**

Ms. Cady, Ms. Sweet, Mr. Heppler and Mr. Bell, gave an Enforcement Process Overview, which covered all the steps from the receipt of a complaint in the Central Complaint Unit to when a Decision is made by the Board.

The presentation included details on:

- The selection criteria for all Medical Reviewers

- The process from when a complaint comes in to when it gets to a reviewer
- The case management process with a Medical Consultant
- The steps for the field investigations
- The selection and approval of the Expert Reviewers
- The prosecution process with the Office of the Attorney General

Dr. Low recognized Laura Sweet and all her incredible efforts on organizing the expert reviewer program, since it is so crucial to the Enforcement Program. He encouraged the Board Members to attend the next session. He stated the course is impressive and interactive. He was impressed with the way the expert reviewers embraced the time spent learning about their true role in the process.

Public comment was heard on this agenda item.

Mr. Roth wanted to ask a couple of questions to staff, but was reminded that staff could not respond, so he made the comment that he believes there was a drafting error in one of the slides.

Joseph Furman, Health Care Attorney, who had worked in the Health Quality Enforcement Section for many years and now defends physicians in these types of cases, wanted to comment that as defense attorneys, they have to pay for their experts; however, there are many experts out there who are willing to work pro bono because they want the best outcome for their clients.

Agenda Item 10 Update of Board of Pharmacy Activities

Ms. Herold was unable to attend, so this item was postponed to the next meeting.

Ms. Schispke requested a report of activities since Ms. Herold was unable to attend rather than wait until our next Board meeting in July.

Dr. Levine said staff would request one, but also recommended reviewing the Board of Pharmacy's agenda on the Web site to get an idea of what they are working on currently.

Agenda Item 11 Update of Joint Forum to Promote Appropriate Prescribing and Dispensing

Ms. Whitney reported statistics on outcomes from the Joint Forum held in February, 2013. The Board has placed a link on the Web site with highlights related to the Forum, video clips from the speakers, and the speaker's presentations. The Board of Pharmacy has placed the same information on its Web site.

The Forum had approximately 400 attendees, most of them physicians and pharmacists. The evaluation forms have come in and two of the medical consultants that attended the forum are assisting the Board with the evaluation forms and will develop some materials for future Newsletters. One of the educational recommendations was to develop tip sheets. Board staff are working with the Board of Pharmacy on gathering tip sheets from other Departments, such as the U.S. Health and Human Services, the DEA, etc., and will be putting links to this information on the Web site as well as providing it to the Education and Wellness Committee.

Agenda Item 12 Update on Executive Committee Meeting – Consideration of Committee Recommendations

Dr. Levine reported that the Executive Committee has met twice since the last Board meeting. On April 5, 2013 the Committee reviewed legislation, took positions on some bills, and reviewed and approved revisions to the Board Member Administrative Procedure Manual that will be sent to Board Members next month. This item will be an ongoing process as the Board's work and accountabilities change. The Board will need to continue to look back at this to have a clear understanding of how the Board functions and what Board Members and staff's responsibilities are. An update of the Strategic Plan was provided. The Committee asked staff to come back to the next Board meeting with a ghant chart format to track where the Board is with progress.

The Committee also discussed the response to the 39 issues from the Sunset Review that were submitted on April 8, 2013. Prior to April 8, 2013, the Board received a letter from the Senate and Assembly Committee Chairs raising seven issues of concerns that they had in particular. The Board sent a response with detailed information of what the Board's action plans are and how the Board will deal with those issues, including providing a time line for addressing those seven issues.

The Executive Committee met again yesterday, April 25, 2013, to begin the process of the Executive Director's annual performance evaluation that will be completed at the Executive Committee meeting in July.

Mr. Serrano Sewell requested an agenda item for the next Executive Committee meeting be a closed session with all Board Members to discuss the evaluation findings and recommendations from the Executive Committee. Dr. Levine asked Ms. Dobbs to look into it and get back to her with details on how that can work.

Public comment was heard on this agenda item.

Jack French, Consumers Union stated that the Consumers Union supports SB304, which moves the Medical Board investigators into the Department of Justice's Health Quality Enforcement Section (HQES). This will allow investigators and prosecutors to work more closely together providing better communication and coordination. They believe it will create a more efficient and effective enforcement program, and provide more protection for patients.

Agenda Item 13 Legislation/Regulations

Ms. Simoes began her report on legislative outreach, pursuant to the Strategic Plan, Objective 4.1. She contacted 40 legislative district offices to let them know that the Board's quarterly Board meeting was being held in Los Angeles and extended an invitation. There are also 40 newly elected members of the Legislature (2 Senators and 38 Assemblymembers). She has met with almost all of the new Legislators, or in some cases met with their staff if the member was not available.

She referred the Members to their legislative packets. She stated that on the tracker list, the bills in green will be discussed at this meeting. The bills in blue are spot bills or 2-year bills and the bills in orange the Board has already taken a position on. However one of those bills, SB 62, has been amended, so the Board will be discussing that bill. The bills in yellow were discussed at the Executive Committee

Meeting and the Executive Committee has recommended positions. If all Members agree with those positions, it does not need to discuss the bills in yellow.

Dr. GnanaDev made a motion to approve all the positions of the bills in yellow as a consent calendar with the exception of SB 117 & AB 635; s/Mr. Serrano Sewell. Motion carried.

Public comment was heard on this agenda item.

Frank Cuny requested that SB 117 be discussed by the full Board. Dr. Levine noted that SB 117 & AB 635 had been pulled and would be discussed.

AB 127 (Medina) & SB 21 (Roth)
Both bills include similar language 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. SB 21 was recently amended to specify that the funds shall be available for planning and startup costs associated with academic programs to be offered at the UC Riverside School of Medicine. Both bills contain urgency clauses, which mean that the bills would take effect immediately once signed into law. 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 suggested that the Board support both AB 27 and SB 21.

Ms. Yaroslavsky made a motion to take a support position on both AB 27 and SB21; s/GnanaDev. Motion carried.

AB 186 (Mainschein)
This bill would require all boards under DCA, including the Medical Board, to issue a 12 month temporary license to applicants that qualify for an expedited license under existing law because they are a spouse of military personnel that have moved to California based upon active duty orders of the military spouse, and who have a license in another state. The temporary license shall expire 12 months after issuance, upon issuance of the expedited license, or upon denial of the application for expedited licensure, whichever occurs first. An applicant seeking a temporary license shall submit an application to the Board and include a signed affidavit attesting that he or she meets all of the requirements for the temporary license and that the information submitted in the application is accurate. The application shall also include a written verification from the applicants original licensing jurisdiction stating that the applicant's license is in good standing in that jurisdiction. This bill would specify that the applicant can only apply for expedited licensure and a temporary 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 a violation of this requirement could be grounds for the denial or revocation of a temporary license issued. This bill would also specify that the applicant cannot have been disciplined by a licensing entity in another jurisdiction and cannot be 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 furnish a full set of fingerprints for the purposes of conducting a criminal background check.

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 temporary license could be issued. Board staff suggested 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 temporary license to immediately cease practice, in order to ensure consumer protection.

GnanaDev made a motion to take a support if amended position; s/Dr. Levine. Motion carried.

AB 496 (Gordon)
This bill is sponsored by Equality California and would reauthorize the Task Force on Culturally and Linguistically Competent Physicians and Dentists

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, the Board's portion is estimated to be the same as before, $43,00.

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 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. 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. 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.

Public comment was heard on this agenda item.

Genevieve Clavreul stated that she supports this bill.

Ms. Schipske made a motion to take a support position; s/Ms. Yaroslavsky. Motion carried.

AB 512 (Rendon)

This bill is sponsored by Los Angeles County and 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. Although the Board has only issued one physician permit under the authorization program that was created by AB 2699 since regulations became effective on August 20, 2012, 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.

Ms. Yaroslavsky made a motion to take a support position; s/GnanaDev. Motion carried.

AB 565 (Salas)

This bill is sponsored by the California Medical Association and would amend the Steven M. Thompson Loan Repayment Program (STLRP) guidelines require applicants to have three years of experience providing health care services to medically underserved populations or in a medically underserved area, which is defined in existing law as an area that is a health professional shortage area pursuant to the Code of Federal Regulations or an area of the state where unmet priority needs for physicians exist as determined by the California Healthcare Workforce Policy Commission. 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 medically underserved area as defined in existing law, and who agree to serve a medically underserved population. This bill would also require that priority consideration be given to applicants from rural communities who agree to practice in a physician owned and operated medical practice setting, defined in existing law as a medical practice located in a medically underserved area and at least 50 percent of patients are from a medically underserved population. 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 medically underserved areas from existing law to the guidelines will help to ensure that STLRP applicants are serving in the areas with the most need.

Dr. GnanaDev made a motion to take a support position; s/Dr. Salomonson. Motion carried.

AB 635 (Ammiano)

Ms. Simoes removed this bill from the consent list per direction from the Executive Committee. She was asked to talk with the Author's office and come back.

This bill is sponsored by the Harm Reduction Coalition and the California Society of Addiction Medicine, and would 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. 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.

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.

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".

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.

Public comment was heard on this agenda item.

Genevieve Clavreul does not agree with the language in this bill and does not support it.

Karen Ehrlich, speaking as a member of the public has had a family member die from an overdose and would have much preferred the possible side effects of this drug rather than death.

Dr. GnanaDev made a motion to take a support position; s/Mr. Serrano Sewell. Ms. Schipske abstained. Motion carried.

AB 809 (Logue)
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. 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. This bill will allow the Telemedicine Advancement Act of 2011 to be better implemented, which will help to improve access to care via telehealth.

Ms. Yaroslavsky made a motion to take a support position; s/GnanaDev. Motion carried.

AB 860 (Perea)
This bill would provide that $600,000 from the Managed Care Administrative Fines and Penalties Fund (Fund) 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. 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 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.

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. This bill is consistent with the mission of the Medical Board of promoting access to care.

Dr. GnanaDev made a motion to take a support position; s/Dr. Low. Motion carried.

The Board recessed at 11:38 am and reconvened at 12:00 noon.

AB 1000 (Wieckowski)
This bill is sponsored by the California Physical Therapy Association, and would allow a physical therapist (PT) to make a "physical therapy diagnosis", 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 if 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.

Ms. Yaroslavsky made a motion to take an oppose position; s/GnanaDev. Motion carried. (7 ayes / 2 oppose)

AB 1003 (Maienschein)

This bill is sponsored by the California Medical Association and 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.

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. 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 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.

Dr. GnanaDev made a motion to take a support position; s/Mr. Serrano Sewell . Motion carried.

AB 1176 (Bocanegra & Bonta)
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. 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 establish the Graduate Medical Education Council (Council), which would consist of 11 members, and the Council would be required to establish standards and develop criteria for medical residency training programs grants in California; make recommendations to OSHPD concerning the funding of the medical residency training programs; and establish criteria for medical residency training program grant review. The Council would be required to submit an annual report to the Legislature that includes specified information until January 1, 2018.

This bill would require OSHPD, in consultation with the Council, to develop criteria for distribution of available moneys in the Fund.

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 Board of promoting access to care.

Dr. GnanaDev made a motion to take a support position; s/Mr. Serrano Sewell. Motion Carried. (8 ayes / 2 abstain - Levine/Yaroslavsky)

AB 1288 (M. Perez)
This bill would require the 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. An applicant would be able to demonstrate his or her intent to practice in a medically underserved area by providing proper documentation, including a letter from the employer.

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 factor that extends the time for licensure for the majority of applicants, as it takes only seven working days from receipt of all approved documentation to issue the license.

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. This bill may help to ensure that applicants planning on serving in underserved areas are licensed in a timely manner.

Public comment was heard on this agenda item.

Yvonne Choong, explained some of CMA's reasons for authoring this bill.

Ms. Yaroslavsky made a motion to take a neutral position; s/Dr. Levine. Motion carried.

ACR 40 (Perez)
This bill 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.

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.

Ms. Yaroslavsky made a motion to take a support position; s/Dr. Levine. Motion carried.

SB 20 (Hernandez)
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 STLRP. 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 will provide the STLRP a more robust funding source by shifting monies no longer needed for MRMIP.

Ms. Yaroslavsky made a motion to take a support position; s/GnanaDev. Motion carried.

SB 62 (Price)
This bill would require a coroner to report deaths to the Board when the contributing factor in the cause of death is related to toxicity from a Schedule II, III, or IV drug. 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. This bill was amended to allow the follow-up coroners' 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 coroner to report deaths to the Board when the contributing factor in the cause of death is related to toxicity from a Schedule II, III, or IV drug and 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.

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. These amendments have been made. The Board also requested an amendment to ensure that coroner's report these deaths to all boards responsible for licensing prescribers. This 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 DCA, as is currently done as part of the complaint process.

Public Comment was heard on this agenda item.

Genevieve Clavreul expressed her concerns about this bill as it is. She believes this bill is not the solution and should have more consideration before passing.

Julie D'Angelo Fellmeth supports this bill as it is one bill of a multi-bill package. The requirements of this bill will guarantee the Board will receive important reports that are not currently being received. The Board is not getting reports or complaints right now about overdose deaths and the Board needs to know about these deaths. She urges the Board to support this bill as well as the many companion bills that will follow.

GnanaDev made a motion to take a support position; s/Ms. Yaroslavsky. Motion carried.

SB 117 (Hueso)
This bill is sponsored by California Citizens for Health Freedom and was formerly AB 1278 (Hueso), Assemblyman Hueso is now a Senator, so the bill has changed to a Senate Bill.

This bill would allow a physician to prescribe integrative cancer treatment, under specified circumstances. Current law (H&S Code 109300) restricts cancer therapy exclusively to conventional drugs, surgery, and radiation (those approved by the Food and Drug Administration).

This bill would define 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 specified written statements.
requirements:

- 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. The author believes this bill will provide cancer patients with more options to complement conventional therapy.

Public comment was heard on this agenda item.

Jessica Biscardi, Cancer Control Society, and a stage four cancer survivor of almost eight years urged the Board to support SB 117 and alternative cancer treatments such as those that saved her life.

Leslie Perea, second generation alternative cancer treatment survivor, also urged the Board to support SB 117 and give cancer patients a choice and allow the physicians to offer other options.

Frank Cuny also urged the Board to support SB 117.

Ms. Yaroslavsky made a motion to take a neutral position; s/Ms. Schipske. Motion Carried.

SB 304 (Price)

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. The Board's Sunset Review Hearing was held on March 11th and Ms. Simoes personally visited all 12 of the Assembly Committee members' offices, and all 9 of the Senate Committee members' offices. She spoke to Committee staff persons, or in some cases, met with the Member. This includes meeting with the staff of both Chairs' offices. No particular concerns were raised at any of these meetings. The Legislature prepared a background paper that raised 39 issues, many of the issues raised were related to the new issues included in the Board's Sunset Review Report. The Board responded to all issues and sent the responses to the Legislature and posted them on the Board's Web site on April 8th. On April 1st, the Chairs of the Committees wrote a letter to Dr. Levine regarding the importance of the Board being proactive and addressing the issues raised by the Committees, and called upon the Board to take a more proactive approach to its consumer protection mission and stated that until the Committees receive firm commitments from the Board that shows significant progress, the sunset extensions for the Board and for its Executive Director will be removed from the sunset legislation, SB 304. The sunset extension has in fact been removed from the language in this bill. Dr. Levine responded to that letter on April 25, 2013. Ms. Simoes stated that she and Ms. Whitney will be meeting with both Chairs on May 7th and will be having regular meetings with staff of both Committees as the sunset bill moves through the legislative process.

The following are the issues included in the bill that were also included as new issues in the Board's Sunset Review Report:

- 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.
- 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.
- 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**.**
- 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.
- 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).

- 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.
- 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.
- The Board recommended that the issue of midwife students/apprenticeships needs to be clarified in legislation, due to confusion in the midwifery community.
- The Board suggested that existing law be amended in to include certified nurse midwives (CNM) as being able to supervise midwifery students.
- 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.
- 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 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 ISO, which must be granted by an Administrative Law Judge. 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.

The Board also made the following recommendations that are not included in the bill:

- The Board recommended that the requirement in existing law for the Board to post a physician's approved postgraduate training be eliminated.
- 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.
- 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 recommended elimination of the ten year posting requirement in existing law in order to ensure transparency to the public.
- The Board in suggested that the transfer of the registered dispensing optician (RDO) Program to the Optometry Board or DCA should be examined.
- 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.

- 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 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 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.
- 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.

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 the changes are not included in this bill, e.g., removing the 10-year posting requirement in existing law, etc.. More importantly, this bill no longer extends the Board's sunset date, which must be extended in order for the Board to continue.

Ms. Simoes stated that the bill had just been amended to transfer the Board's Investigators to the Department of Justice. Ms. Simoes handed out a listing of the pros and cons for this transfer.

Dr. Levine requested that Ms. Simoes try and set up a meeting with the two Business and Professions Committee Chairs to meet and discuss the issue of moving the Board's investigators to Department of Justice in greater detail. It would be an in depth briefing.

Public comment was heard on this agenda item.

Julie D'Angelo Fellmeth, Center for Public Interest Law, discussed her experience with the Vertical Enforcement process when she worked for the Board back in 2003-2004 as an Enforcement Monitor. She and her team were required to examine the enforcement program and the diversion program . She believes that the transfer seems to be the last best hope for better informed and high quality investigations and prosecutions.

Ms. Yaroslavsky made a motion to take a support if amended position; s/ Ms. Schipske. Motion carried.

SB 305 (Price)
This bill would allow all boards under the DCA that require licensees to submit fingerprints, including 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.

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.

Public comment was heard on this agenda item.

Yvonne Choong, stated that CMA is taking an oppose position on this bill.

Dr. Bishop made a motion to take a support position; s/Ms. Schipske. Motion carried.

SB 491 (Hernandez)
This bill is part of a package of bills intended to expand the scope of nurse practitioners (NP), pharmacists, and optometrists. Currently, NPs operate under standardized procedures, that are overseen by a supervising physician. NPs are advanced practice registered nurses 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.

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An NP would be allowed 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 specified circumstances apply. 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. 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.

Public comment was heard on this agenda item.

Genevieve Clavreul expressed her concerns on this bill.

Dr. Low made a motion to take an oppose position; s/Dr. Bishop. Motion carried.
8 Ayes / 1 Oppose (Schipske) / 1 Abstain (Levine)

SB 492 (Hernandez)
Ms. Simoes explained that SB 492 relates to optometrists and is a part of the package of bills authored by Sen. Hernandez that would expand the scope of practice for nurse practitioners, optometrists and pharmacists. This bill was significantly amended yesterday. Before the recent amendments, the bill would have repealed the optometrist act and replaced it with new language. Now the amendments only make small changes to the optometrist act, so Ms. Simoes suggested that in its current form, that the Board should not oppose SB 492. Ms. Simoes went through the amendments, the bill would add habilitative therapy; instead of listing the pharmaceutical agents that optometrists can use, the bill would allow those approved by the FDA for treating eye conditions; and instead of listing what kind of laboratory and diagnostic tests optometrists can perform, the bill now says laboratory and diagnostics imaging tests. The bill would also allow optometrists to give immunizations for influenza and shingles and additional immunizations that may be necessary to protect public health during a declared disaster or public health emergency, and in addition to diagnosing and treating conditions of the visual system pursuant to existing law, this bill would allow diagnosis of diabetes, mellitus, hypertension and hyperlipidemia. Ms. Simoes suggested that the Board take a neutral position on the bill, as it is a work in

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progress, and it will be brought back to the Board in July. The Board Members discussed the recommendation and the meaning of a neutral position, and the allowances in the bill regarding use of pharmaceuticals and diagnosis of diabetes, mellitus, hypertension and hyperlipidemia.

Ms. Salomonson made a motion to take a neutral position; s/GnanaDev. Motion carried. 7 Ayes / 2 Oppose (Dr. Bishop, Dr. GnanaDev) / 1 Abstention (Dr. Levine)

SB 493 (Hernandez)

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 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 Advanced Practice Pharmacist (APP), which means a pharmacist who has 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.

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 ACA. 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 be reasonable.

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. 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.

Public comment was heard on this agenda item.

Brian Warren, California Pharmacists Association, and sponsor of this bill stated they have recently revised the bill to remove the concerns that were put into the analysis. They are working with the CMA and other organizations on resolving several pieces of the bill.

Steve Gray, President of the California Society of Health System Pharmacists stated this bill is not much of an expansion of the scope of practice in California. The section of law that this bill refers to has been law for collaborative drug therapy management pharmacist for over 25 years. In California, there are over 1000 pharmacists that meet those special qualifications of that Code section. The real essence of this bill is there is such a demand for those pharmacists in California that there needs to be another pathway in order to qualify pharmacists for that collaborative practice. Mr. Gray urged the Board to support this bill.

Yvonne Choong, CMA, thanked the pharmacists for working with them on amending this bill but still has some concerns about the smoking cessation part of the bill.

Dr. Low made a motion to take a support if amended position in regards to the smoking cessation drug amendment; s/Dr. Salomonson. Motion carried. 1 Abstention (Schipske)

SB 670 (Steinberg)

This bill would authorize 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.

Currently, in order for the Board to stop a physician from practicing while the physician is under investigation, the Board must request an ISO, which must be granted by an 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.

Public comment was heard on this agenda item.

Joseph Furman, Health Care Attorney, expressed his concerns about making it unprofessional conduct if a licensee fails to attend an interview with 30 days. He stated that the Attorney General's Office and the Medical Consultants are not available every day and the licensee may not be able to get everyone together who may need to attend this interview.

Mr. Roth suggested keeping the 30 days, but adjust it if there is "good cause" for not attending.

Dr. Low recommended 30 working days, which would give them two extra weeks.

Dr. GnanaDev made a motion to take a support if amended position; s/Dr. Low. Motion carried.

Dr. Levine stated that items on the agenda were going to be covered within the next 45 minutes due to time constraints and the Board will find another way to cover the agenda items that were not covered during this meeting. The agenda items that will be covered today are:14, 16d, 17, 19, 23, 24 and 25.

Agenda Item 14 Board Member Communication with Interested Parties

Dr. Levine asked if any of the members had any communication with interested parties to report. With nothing to report, Dr. Levine moved on to next necessary agenda item.

Agenda Item 16 Executive Director's Report

Ms. Whitney reported that staff will provide a written summary for items 16 A through 16 C, due to time restraints.

D. 2014 Board Meeting Dates

Ms. Whitney reported there is a Board Member with a conflict on the usual January 2014 Board Meeting date and offered proposed dates for early January or mid-February. These changes may cause the Board to have to have interim Panel Meetings in between normal quarterly meeting dates. The new proposed dates are: January 16-17, 2014 or February 13-14, 2014 in the Bay area; April 17-18, 2014, May 1-2, 2014, or May 8-9, 2014 in the Los Angeles area; July 17-18, 2014 or July 24-25, 2014 in the Sacramento area; and October 23-24, 2014 or October 30-31, 2014 in the San Diego area.

Staff recommendations are: February 13-14, 2014, May 1-2, 2014, July 24-25, 2014 and October 23-24, 2014.

Ms. Whitney asked for a motion to set the first meeting of 2014 as February 13-14 and the next meeting as May 1-2.

Dr. Levine made motion to approve the proposed dates for the first two 2014 meetings; s/Dr. GnanaDev. Motion carried.

Agenda Item 17 Discussion and Consideration of Teleconferencing of Medical Board Meetings

Ms. Kirchmeyer reported that at the October Board meeting, the Board was asked to teleconference its future 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 identified four options the Board could consider. Further research and paperwork would need to be completed to develop and test the options and some of the options would require authorization and processing by the DCA.

Ms. Kirchmeyer pointed out that for any option the Board must still comply with the Open Meeting Act. All teleconferencing locations would need to be posted on the Board's agenda and would need to be posted 10 days prior to the meeting. Board members would need to be at one of the public locations and could not phone in from some unknown location.

The first option would be to provide an 800 number for anyone to call in and listen to the Board meeting and provide comments. A moderator would assist callers in the process and 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. 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 (for example two minutes).

The cost for this type of function would be dependent upon the number of callers and the length of meeting, but would be $1000 to $1500 plus staff time. The system can have up to 4,000 participants on the line at one time.

She asked the Board Members to note that 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. If this option were chosen, it is recommended that this would be tested at the Sacramento Board meeting in July in order to have appropriate staff available.

She pointed out some of the pros and cons of this option. One important pro is that the public would not have to travel to the meeting, but a significant con is that the Board meeting structure may need to be reviewed due to the additional time that may be required as it could increase the meeting time by at least 4 hours. For example, the Board meeting may need to be three days rather than two.

The second option is to 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. 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 pros and cons for this option are that again the public would not need to travel to the meeting, but again the meeting structure may need to be reviewed due to the additional time that may be required.

The third option is to 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). 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.

The final option is to 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.

Ms. Kirchmeyer asked the Board Members for their thoughts and/or any recommendations on these options.

Dr. GnanaDev expressed concerns about having to take an additional day off in some cases and that would create possible problems with many of the Board Members' already busy schedules. His preferred option is the video conference to where everyone can see each other no matter what location they are scheduled.

Ms. Schipske suggested using U-Stream, where public comments can be sent in via email prior to the meeting where then staff puts a list of these emailed comments together to present to each Board Member the day of the meeting. She also suggested having a Facebook chat setup so that people can post comments the day of the meeting and have a staff person monitor it and/or read the comments as they come in during public comment time.

Dr. Levine recommended that Ms. Schipske and Ms. Kirchmeyer work together on a few other possible options that may be available and recommended not taking a vote until other options are brought to the Board at the next Board Meeting.

Public comment was heard on this agenda item.

Jack French, Consumers Union, stated he is pleased to have this be an agenda item as there are many Californians who cannot afford to travel to the Board meetings in different locations of the State to attend in person. Many of the people who would like to attend are survivors of medical harm and disabled as a result.

Genevieve Clavreul would like the Board to look into a capability that she has participated in where attendees and Board Members can communicate both ways.

Alicia Cole, Consumers Union, stated that she is a committee member of the Hospital Inquired Infection Advisory Committee through Department of Public Health. This committee holds all of their meetings in Sacramento and uses teleconferencing for their meetings and it works very well.

Agenda Item 19 Special Faculty Permit Committee Recommendation; Approval of Applicant

Dr. Low reported that the Committee held a teleconference meeting on March 14, 2013 and reviewed one application from the University of California, San Francisco, School of Medicine for a Dr. Damato . Dr. Low asked Mr. Worden to present to the Board Dr. Damato's area of expertise and qualifications. Mr. Worden stated that Dr. Damato's area of expertise is ocular oncology and proton beam therapy. He graduated from the University of Malta Faculty of Medicine and Surgery. He has a Ph.D. from the University of Glasco in Scotland and did his post graduate training in Scotland for Surgery, Internal Medicine, Pathology and Ophthalmology. He is a professor of radiation oncology, assuming that the Board approves him for that position at the University of San Francisco. He is currently a professor at the University of Glasco and is considered a world renowned expert in ocular oncology. He developed a specific procedure for treating cancer of the eye, which actually saves most of the eye and had never been done before. It was the direct proton beam treatment of iris melanomas. Dr. Damato receives patients from over 32 countries and receives 700 cases per year.

Dr. Low made a motion for the Board to approve Dr. Bertil Eric Damato for a Business and Professions Code section 2168.1 (a) (1) (A) at the University San Francisco School of Medicine; s/Dr. Levine. Motion carried.

Agenda Item 25 **Update on Enforcement Committee: Consideration of Committee Recommendations**

Dr. Low reported that the Enforcement Committee heard an update from Ms. Sweet regarding the February 9, 2013 Expert Reviewer Training in Irvine. The training was well-attended and well-received. As with the earlier training, feedback was quite positive. Ms. Sweet implemented the new process where in order to receive CME credit, the participants had to prepare a sample expert opinion. This is yielding interesting information that will be used to enhance the next training which will hopefully take place in October or November in San Diego.

The Enforcement Committee then heard from Ms. Sweet regarding a proposal to increase the expert reviewer hourly rate upon completion of the Expert Reviewer Training Program. She stated that when experts are surveyed, they regularly comment on the low rate of pay, particularly how incomparable the pay is to the private rate. The Board knows it cannot compete with those rates, and many experts are not doing the work for the money, but instead for the satisfaction in upholding the standard of care and helping public protection. The Board might be able to be more demanding of our experts if they were not compensated at a volunteer rate of pay. Ms. Sweet reported that the Board has a particularly difficult time procuring neurosurgery experts. One neurosurgery expert told her that he was usually paid between $500-800 per hour, and although he knew the Board could not pay that rate, he believed there would be more of a willingness to participate if the rate were higher.

Currently, all experts are compensated at a rate of $150.00 per hour to review records and prepare a report, and at $200 per hour to testify. Staff recommended that a budget augmentation be prepared that would call for experts who have successfully completed the 8 hours of training and have provided a satisfactory sample expert opinion, be compensated at a rate of $200.00 per hour for record review and report writing and $250.00 per hour for testifying for all specialties except for neurosurgery. In neurosurgery cases, staff would like to recommend compensation be increased to $300.00 per hour for record review and report writing and $400.00 per hour for testimony. The committee made a motion to bring this item to the full Board. Dr. Low asked for a motion to direct staff to prepare a budget augmentation to increase expert reviewer pay according to that schedule.

Dr. GnanaDev made a motion to direct staff to prepare a budget augmentation to increase expert reviewer pay according to that schedule; s/Dr. Diego. Motion carried.

Dr. Low reported that Ms. Threadgill gave the Enforcement Committee a presentation regarding the historical efforts the Board has made to improve retention of investigators. He stated that it is remarkable how long the Board has been trying to get higher pay for investigators (commensurate with other state agencies) and how unsuccessful these attempts have been.

The most recent effort the Board made was from Chief Threadgill requesting that the DCA submit a request to DPA to pursue pay differentials for Field Training Officers, Rangemasters, Defensive Tactics Instructor and other formal training assignments. As of this date, this request remains unheeded.

Being mindful of the economic times, staff is making a modest recommendation to at least level the playing field with other State agencies. The recommendation would be to request a differential be established for Field Training Officers, Rangemasters, Defensive Tactic Instructors, and other formal training assignments; and that investigators receive pay differentials for living in Los Angeles or other

high-cost areas where investigators in other agencies receive differentials. The Committee made a motion to recommend to the full Board that staff work with the DCA to amend the specifications for the investigator classification series to expand the subject areas of the degrees accepted for admission to the examination. Dr. Low asked for a motion for staff to pursue the differentials described above.

Dr. GnanaDev made a motion for staff to pursue the pay differentials for investigators; s/Ms. Schipske. Motion carried.

Dr. Low then reported that Ms. Cady provided the Enforcement Committee a review of the priorities established in Business and Professions Code Section 2220.05. The law was established in 2003 and identifies priorities for the Board's investigative and prosecutorial resources.

Ms. Cady and Mr. Heppler provided a briefing on the Utilization Review Process in response to public comment during the last meeting. The Board has stated that utilization review decisions do constitute the "practice of medicine" and that a physician who reviews and makes medical necessity determinations is considered to be "practicing medicine." The Board receives a very small percentage of complaints regarding physicians who perform utilization review and this function is used in a variety of settings.

The complaint handling protocol entails staff looking at the role performed by the physician named in the complaint. If the physician is acting as a treating physician providing care to the patient, regardless of whether the care is paid for by a worker's compensation carrier or the patient's health benefits, the complaint would be handled as a "quality of care" complaint. However, if the physician had no direct involvement in the patient's care and treatment and was making a decision about whether the procedure or treatment would be covered as medically indicated or necessary, the Board would consider those complaints to be "non-jurisdictional."

Staff suggested that the Board continue its established policy of performing a preliminary analysis of each new complaint. If the complaint involves a utilization review issue, Board staff should inform the complainant to pursue their appeal options. Much discussion then ensued about legal matters. The outcome of that discussion was that the Committee made a motion to recommend to the full Board that it re-affirm that utilization review is the practice of medicine and direct staff to come up with guidelines and identify any legislative amendments that may be required in order for the Board to take action on cases when utilization review results in the practice of substandard medical care. Dr. Low asked for a motion.

Dr. GnanaDev made a motion that the Board re-affirm that utilization review is the practice of medicine and direct staff to come up with guidelines and identify any legislative amendments that may be required in order for the Board to take action on cases when utilization review results in the practice of substandard medical care; s/Dr. Salomonson. Motion carried.

Dr. Low gave a brief presentation at the Enforcement Committee meeting regarding the growing problem with controlled substance prescription abuse. Historically, the pendulum has swung back and forth on this issue. In the 1990's, it was thought that drug laws were too restrictive and therefore patients were being under-medicated and their pain was not being relieved. The Legislature answered this concern with numerous pieces of law, one of which was Business and Professions Code Section 2241.5, which states that no physician and surgeon shall be subject to disciplinary action for prescribing, dispensing or administering dangerous or prescription controlled substances when they meet certain criteria. That

criteria is generally encompassed in the Board's pain management guidelines. There has been an "epidemic" of prescription drug overdoses in the United States. The Committee has been looking at ways to address this issue, and some legislation is in process that will assist in addressing these cases, but the Committee thinks this would be a good time to convene a task force to further define the best practices as it relates to prescribing controlled substances and to revisit the pain management guidelines to see if there are additional guidelines that can be added (or removed) to address this very serious problem. The Committee made a motion to support the recommendation to establish a task force to include interested parties. Volunteers to staff this task force include Barbara Yaroslavsky, who will act as the Chair, Dr. Bishop, and Dr. Levine. Yvonne Choong also offered CMA's resources to assist with this issue.

Public comment was heard on this agenda item.

Genevieve Clavreul stated that in yesterday's Committee meeting, she had asked if members of the public could be included in the requested task force and if so, she would like to participate.

Dr. GnanaDev made a motion to support Dr. Low's recommendation to establish a task force and include interested parties; s/Dr. Yip. Motion carried

Dr. Low stated that Ms. Cady had presented to the Enforcement Committee a very thorough historical review of the Model Disciplinary Guidelines and rulemaking process as it related to the implementation of the Uniform Standards set forth in Senate Bill 1441. Much discussion ensued and in the final analysis, the Committee made a motion to recommend that the full Board commence rule making procedures to be discussed at the next Board meeting in order to adopt the uniform standards set forth in SB 1441, and to direct legal counsel to draft a response to the Attorney General's Office regarding action taken by the Board. Dr. Low asked the Board for a motion for staff to initiate the rule making procedures in order to adopt the uniform standards as set forth in SB 1441 and to direct legal counsel to draft a response regarding action taken by the Board.

Public comment was heard on this agenda item.

Alicia Cole, Consumers Union just wanted to thank the Enforcement Committee and the Board for the recommendation of the adoption of rulemaking to adopt the full uniform standards.

Dr. Salomonson made a motion for staff to initiate the rule making process in order to adopt the uniform standards as set forth in SB 1441 and to direct legal counsel to draft a response regarding action taken by the Board; s/Dr. GnanaDev. Motion carried.

Agenda Item 23 Vertical Enforcement Program (VEP) Report

Ms. Gloria Castro introduced herself as the newly appointed Senior Assistant Attorney General of the HQES. She stated she is honored to work for the Board and supervise the over 56 very talented attorneys statewide operating out of five offices and working out of 12 district offices with the Board's investigative and enforcement staff. Their attorneys are public interest attorneys at heart, but prosecutors by training and take every hit that the Board takes very personally and try to address them as quickly as possible. The HQES was created in 1990 as a specialized unit in the Attorney General's Office, which is charged with representing all State Agencies, but specifically the HQES was identified as trying to

provide the best and most efficient legal services to address the Board's biggest mandate of public protection. The HQES is interested in providing excellent, high quality legal services as efficiently as possible, to do it in a professional manner and always with public protection in mind.

Ms. Castro gave a brief update on the VEP noting that they continue to meet on a quarterly basis with the Board's enforcement supervisors to iron out any deficiencies identified. The staff have met a lot of goals that include being able to focus on subpoena enforcement, and develop some thoughtful ways to address the deficiencies in being able to obtain medical records in a quick manner. She will continue to work closely with enforcement staff to pursue and identify interim relief orders quickly, including Penal Code section 23 bail restrictions and interim suspension orders. They will also work closely to identify mentally and physical impaired physicians very early on so they are not posing a danger to patients.

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

Ms. Schipske recommended placing a summary of our Board meeting and the presentations that were given at the meeting on our Web site after the Meeting and perhaps placing some of the presentations in our Newsletter to assist the public with a step by step of how the enforcement processes work.

Agenda Item 32 Adjournment

Dr. Levine adjourned the meeting at 4:19 pm.

<u>Agenda Item 8a - Enforcement Program</u>

Bullet 1 – Legislative Update: Senate Bill 62 (Price)

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MEDICAL BOARD OF CALIFORNIA
Executive Office

May 7, 2013

The Honorable Curren D. Price, Jr.
California State Senate
State Capitol, Room 2057
Sacramento, CA 95814

Re.: **SB 62 (Price) – Support Position**

Dear Senator Price:

The Medical Board of California (Board) considered your SB 62 at its meeting on April 26, 2013. The Board has changed its position from support if amended to support. This bill would require coroners to report deaths to Board when the contributing factor in the cause of death is related to toxicity from a Schedule II, III, or IV drug. This bill would specify that 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. This bill would require the initial report to 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.

The Board included a proposal for required coroner reporting prescription drug related deaths in its Sunset Review Report, and believes that 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. I would like to thank you and your staff for working with the Board and taking our suggested amendment related to narrowing the types of reports the Board will receive, and I look forward to working with you and your staff to ensure passage of this important consumer protection measure.

Please contact my Chief of Legislation, Jennifer Simoes, or me at (916) 263-2389 if you need additional information regarding our position on this bill.

Sincerely,

Linda K. Whitney
Executive Director

cc: Senator De Leon, Chair, Senate Appropriations Committee

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-2389 (916) 263-2389 Fax (916) 263-2387 www.mbc.ca.gov

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 62
Author: Price
Bill Date: April 22, 2013, Amended
Subject: Coroners: Reporting Requirements: Prescription Drug Use
Sponsor: Author
Position: Support

STATUS OF BILL:

This bill is in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require a coroner to report deaths to the Medical Board of California (Board) when the contributing factor in the cause of death is related to toxicity from a Schedule II, III, or IV drug. This bill was amended to only require the reports to be filed with the Board and to narrow the deaths reported to those deaths related to toxicity from a Schedule II, III, or IV drug.. 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. The bill has been recently amended to narrow the deaths reported to the Board to those in which a contributing factor in the cause of death is related to toxicity from a Schedule II, III, or IV drug.

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
Medical Board of California

OPPOSITION: California Medical Association

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.

AMENDED IN SENATE APRIL 22, 2013

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 *that a contributing factor in* a *cause of* death ~~may be the result of prescription drug use~~ *is related to the toxicity from a Schedule II, III, or IV drug,* and to require the coroner to additionally file the report with the 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~~ *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, 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:

SECTION 1. Section 802.5 of the Business and Professions Code is amended to read:

802.5. (a) When a coroner receives information that is based on findings that were reached by, or documented and approved by, a board-certified or California licensed pathologist indicating that a death may be the result of a physician and surgeon's, podiatrist's, or physician assistant's gross negligence or incompetence, 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. The initial report shall 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 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.

(b) 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 California licensed 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 (c).

(c) When a coroner receives information that is based on findings that were reached by, or documented and approved by, a board-certified or California licensed pathologist indicating that

a contributing factor in the cause of death is ~~determined to be the result of prescription drug use~~ *related to toxicity from a Schedule II, III, or IV drug*, a report shall be filed with the Medical Board of California. 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, 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.

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.

O

<u>Agenda Item 8a - Enforcement Program</u>

Bullet 2 - Use of CURES Data

Pages 9-40

Prescription Drug Monitoring Program (PDMP) Utilization by State

State	Is the PDMP Proactively Queried?	How is the PDMP information utilized?
Arizona	No	The PDMP is only queried as part of an investigation (by physician prescriber or patient).
Arizona – Osteo	No	The PDMP is only queried as part of an investigation.
Colorado	No	The PDMP can only be subpoenaed as part of an open investigation.
Delaware	Yes	The pharmacist on staff monitors the PDMP. The pharmacist runs reports periodically to pull out any heavy prescribers based on patient's controlled substance prescription history.
Idaho	Yes, the Board of Pharmacy does.	The Board of Pharmacy monitors the PDMP and identifies outliers and provides information to the Board of Medicine for review/investigation.
Indiana	No	The PDMP is only queried for physicians on probation that are prohibited from prescribing controlled substance.
Iowa	No	State licensing agencies (including the Board of Medicine) must subpoena the Iowa PDMP to gain access to very specific information, as detailed in the subpoena.
Kansas	No	The Board cannot proactively query the PDMP, it is prohibited by statute.
Maine	No	The Board is not allowed to query proactively.
Maryland	No	Similar to Kansas, the Board cannot proactively query the PDMP. The PDMP will not become operational until this Fall.
Mississippi	Yes	The Board can actively query the PDMP.
N. Carolina	No	By statute, the Board is only allowed to access the PDMP when/if there is an active investigation.
N. Dakota	No	Statute allows the pharmacy board to give PDMP information if the request is "relevant to an investigation of" a licensee.
Oklahoma	Yes	The information is provided by the Oklahoma Bureau of Narcotics, investigators and medical advisors query the data.
Oregon	No	The PDMP is only queried as part of an investigation.
S. Dakota	No	The PDMP is queried as needed, upon request from an investigator.
Texas	Yes	The Board once ran a report that identified the top prescribers of specific drugs and investigations were opened on the top 20 prescribers. The PDMP is also utilized when investigating complaints.
W. Virginia	No	The PDMP can only be queried as part of an investigation.
W. Virigina – (Board of Osteopathic Medicine)	No	The Board only has authority to query the PDMP if there is an open investigation. An authorized representative of the Board must register with each state PDMP as an authorized user.
Wyoming	No	Statute requires that the Board has an investigation or complaint pending before the PDMP can be queried.

The Medical Board queried all 50 states through the Administrator's in Medicine Exec Net on 5/15/13, only 20 responses were received.

The Medical Board and CURES

- How does CURES work?
- How does CCU and MBC investigators use CURES
- Case study

What is CURES?

Controlled Substance Utilization Review and Evaluation System

Administered by the Department of Justice

CURES History

Originally evolved from the California Triplicate Prescription Program created in 1940.

The California Triplicate Prescription Program was the oldest running multiple copy prescription program in the nation.

How does CURES work?

Collects Schedule II, III, and IV prescription information from pharmacies on a weekly basis via an electronic data transfer system that allows for analysis and retrieval of data.

Allows pre-registered practitioners, pharmacists, law enforcement and regulatory boards instantaneous web-based access to controlled substance history information 24-hours a day.

Accessibility to Licensing Boards

- **Board of Pharmacy**
- **Medical Board**
- **Dental Board**
- **Nursing Board**
- **Osteopathic Medical Board**
- **Veterinary Board**

Two Primary Functions of the CURES Program

1. Prevention & Intervention

2. Investigation & Enforcement

Patient Activity Report

- Printout which contains the prescribing and dispensing history contained in the CURES data system for Schedule II, III, & IV controlled substances to patients under the requesting medical provider's care.
- Only available to prescribers and pharmacists

CURES

California Department of Justice
P.O. Box 160447, Sacramento, CA 95816
Telephone: (916) 319-9062
Fax: (916) 319-9448

Patient Activity Report (PAR)

Please complete the following information by typing or printing in the required fields.

PHYSICIAN INFORMATION			
Physician DEA No.:		License No.:	
Physician Name (As it Appears on your DEA Certificate)			
Physician Address			
	City:	State:	Zip Code:
Telephone No.:		Fax No.:	

PATIENT INFORMATION				
Last Name			First Name	
AKA (Also Known As)			Maiden Name	
Patient Address				
	City:		State:	Zip Code:
Telephone No.:				
Social Security No.:			Date of Birth	

ADDITIONAL COMMENTS OR INFORMATION

AUTHORIZATION

By signing below, I certify that I am a licensed health care practitioner eligible to obtain controlled substance history dispensed to the patient in my care identified above, based on data contained in the Controlled Substance Utilization Review and Evaluation System (CURES). I understand that any request for, or release of a controlled substance history shall be made in accordance with Department of Justice guidelines, that the history shall be considered medical information subject to the provisions of the Confidentiality of Medical Information Act (Civil Code §§ 56 et seq.)

Please FAX your request to (916) 319-9448

Or mail to: California Department of Justice, P.O. Box 160447, Sacramento, CA 95816

Physician Signature _____ Date _____

For Department of Justice Use Only	Date Received	Date Completed	Initials
	Comments		

BNE 1176 (06/2003)

CURES Patient Activity Report

Department of Justice - Bureau of Narcotic Enforcement

Controlled Substance Utilization Review & Evaluation System

Patient Prescription History

Date: 05/19/2004

Time: 12:19PM

CONFIDENTIAL DOCUMENT

Patient Last Name: [redacted] **Number of Hits:** 34

Date Filled	First Name	Birth Date	Sex	Serial #	Drug Name	Form	Strength	QTY	Pharmacy Name	PHY #	Dr. Name	Dr.'s DEA #	RX #
09/05/2000	[redacted]	10/19/1940	M	[redacted]	OXYCONTIN	TER	10 MG	180	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
09/28/2000	[redacted]		M	[redacted]	OXYCONTIN	TER	40 MG	30	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
09/28/2000	[redacted]		M	[redacted]	OXYCONTIN	TER	20 MG	30	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
10/19/2000	[redacted]		M	[redacted]	OXYCONTIN	TER	20 MG	40	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
10/19/2000	[redacted]		M	[redacted]	OXYCONTIN	TER	40 MG	35	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
11/16/2000	[redacted]		M	[redacted]	OXYCONTIN	TER	20 MG	45	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
11/16/2000	[redacted]		M	[redacted]	OXYCONTIN	TER	40 MG	40	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
06/14/2001	[redacted]		M	[redacted]	ROXICODONE	TAB	5 MG	720	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
06/28/2001	[redacted]		M	[redacted]	ROXICODONE	TAB	5 MG	720	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
07/05/2001	[redacted]		M	[redacted]	ROXICET	TAB	325 MG-5 MG	1440	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
07/10/2001	[redacted]		M	[redacted]	ROXICODONE	TAB	5 MG	500	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
07/16/2001	[redacted]		M	[redacted]	ROXICODONE	TAB	5 MG	940	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
08/30/2001	[redacted]		M	[redacted]	METHADONE HCL	TAB	10 MG	540	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
09/27/2001	[redacted]		M	[redacted]	METHADONE HCL	TAB	10 MG	540	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
10/25/2001	[redacted]		M	[redacted]	METHADONE HCL	TAB	10 MG	540	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
11/21/2001	[redacted]		M	[redacted]	METHADONE HCL	TAB	10 MG	540	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
12/20/2001	[redacted]		M	[redacted]	METHADONE HCL	TAB	10 MG	600	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
01/17/2002	[redacted]		M	[redacted]	METHADONE HCL	TAB	10 MG	600	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
02/14/2002	[redacted]		M	[redacted]	METHADONE HCL	TAB	10 MG	600	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
03/14/2002	[redacted]		M	[redacted]	METHADONE HCL	TAB	10 MG	600	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
04/11/2002	[redacted]		M	[redacted]	METHADONE HCL	TAB	10 MG	600	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
05/10/2002	[redacted]		M	[redacted]	METHADONE HCL	TAB	10 MG	600	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
06/06/2002	[redacted]		M	[redacted]	METHADONE HCL	TAB	10 MG	600	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
08/01/2002	[redacted]		M	[redacted]	METHADOSE	TAB	10 MG	600	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Disclaimer: **The Patient Activity Report is compiled from information maintained in the Department of Justice's Controlled Substance Utilization Review & Evaluation System. The CURES maintains Schedule II, III, IV prescription information that is received from California pharmacies and is therefore only as accurate as the information provided by the pharmacies.**

CURES Patient Activity Report

Benefits for the prescribers:

- Prescribers become aware of patients who may be drug-seeking
- Able to make more informed decisions on prescribing

Benefits for the patients:

- Patients who are drug-seeking will benefit from prescribers' intervention
- Patients who are not drug-seeking will benefit from prescribers' ability to feel more comfortable in prescribing medicines they need

CURES PDMP System

- Effective September 15, 2009 the CURES Prescription Drug Monitoring Program (PDMP) database became available online. Access is available to prescribers, pharmacists, law enforcement personnel.

- Once an application is received and approved, the requestor has real-time access to the database.

- To gain access to the PDMP database, register at https://pmp.doj.ca.gov/pmpreg/.

Case study (CCU):

- CCU receives a complainant from a Medical Doctor whose patient, M.C., revealed to him the subject physician prescribes whatever pt. wants with no examination or medical indication.
- Review of complaint history reveals previous disciplinary action for drug violations.
- CCU analyst orders CURES report which reveals 1,281 pages in a 3-year time period.

Case study (CCU):

- CCU analyst may submit CURES report and complaint documents to a medical expert for review or more likely, in this case, will send the case directly to the field for investigation.

- In less obvious cases (no priors, CURES report not as voluminous), the CCU reviewer would review the CURES to determine if there are any appearances of inappropriate prescribing.

Case study (field investigation)

Step 1: Investigator orders CURES for patient M.C.

- Patient M.C. has 16-pages of hydrocodone bitartrate prescriptions in 3-year period.
- In January of 2005, patient received 780 apap/hydrocodone pills
- In May of 2007, patient received 960 apap/hydrocodone pills
- Some pharmacy shopping
- Some doctor shopping

Case study (field investigation):

Step 2: Review entire CURES for physician for patterns

- Numerous other physicians prescribing same or similar medication
- Geographic location of pharmacy (pharmacy is far away from doctor's practice)
- Combination of medications (Vicodin and Soma)
- Quantity
- Family members receiving same medications

Case study (field investigation):

Step 3. Additional patient revealed

- Patient A.B. stands out on CURES report
- 52 pages of drugs prescribed by single physician to this patient
- Variations of hydrocodone filled on the same day (or within 1-2 days) at different pharmacies
- Pattern continues for three years (until subject is arrested/convicted/incarcerated)

Controlled Substance Utilization Review and Evaluation System

Prescriber Prescription History

AH1156795

[redacted]

Date Range: Between Nov 1, 2004 and Nov 30, 2007

Number of Prescriptions: 9,022

Patient Last Name	Patient First Name	Patient DOB	Date Filled	Drug Name	Drug Form	Strength	Quantity	PHY #	Pharmacy Name	RX Number
B[redacted]	ANGELA			BITARTRATE		MG				
		12/16/1965	11/12/2005	HYDROMET	SYR	1.5 MG/5 ML-5 MG/5 ML	360	PHY43040	PAVILIONS PHARMACY 2214	4066878
		12/16/1965	11/15/2005	APAP/ HYDROCODONE BITARTRATE	TAB	325 MG-10 MG	90	PHY46307	OLIVE AVENUE MEDICAL PHARMACY	0030307
		12/16/1965	11/17/2005	HOMATROPINE/ HYDROCODONE	SYR	1.5 MG/5 ML-5 MG/5 ML	360	PHY33068	CAL MED PHARMACY WEST	0499772
		12/16/1965	11/21/2005	APAP/ HYDROCODONE BITARTRATE	TAB	325 MG-10 MG	60	PHY19709	SAV MART DRUGS	0103779
		12/16/1965	11/22/2005	APAP/ HYDROCODONE BITARTRATE	TAB	325 MG-10 MG	90	PHY43382	SAV ON DRUGS NO 6547	0651379
		12/16/1965	11/22/2005	TUSSIONEX PENNKINETIC	SER	8 MG/5 ML-10 MG/5 ML	240	PHY43382	SAV ON DRUGS NO 6547	0651380

*** Confidential ***

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Controlled Substance Utilization Review and Evaluation System

Prescriber Prescription History

AH1156795

[redacted]VE

D[redacted]

Date Range: Between Nov 1, 2004 and Nov 30, 2007

Number of Prescriptions: 9,022

Patient Last Name	Patient First Name	Patient DOB	Date Filled	Drug Name	Drug Form	Strength	Quantity	PHY #	Pharmacy Name	RX Number
B[redacted]	ANGELA	12/16/1965	11/26/2005	HOMATROPINE/ HYDROCODONE	SYR	1.5 MG/5 ML-5 MG/5 ML	300	PHY39331	PX DRUG STORE	4533575
		12/16/1965	11/29/2005	APAP/ HYDROCODONE BITARTRATE	TAB	325 MG-10 MG	90	PHY46783	CVS PHARMACY NO 4789	0144137
		12/16/1965	12/01/2005	HOMATROPINE/ HYDROCODONE	SYR	1.5 MG/5 ML-5 MG/5 ML	240	PHY39331	PX DRUG STORE	4533643
		12/16/1965	12/13/2005	APAP/ HYDROCODONE BITARTRATE	TAB	325 MG-10 MG	90	PHY19709	SAV MART DRUGS	0105830
		12/16/1965	12/20/2005	APAP/ HYDROCODONE BITARTRATE	TAB	325 MG-10 MG	90	PHY46307	OLIVE AVENUE MEDICAL PHARMACY	0031051
		12/16/1965	12/20/2005	HYDROMET	SYR	1.5 MG/5 ML-5 MG/5 ML	240	PHY46307	OLIVE AVENUE MEDICAL PHARMACY	0031049
		12/16/1965	12/27/2005	APAP/	TAB	325	120	PHY43382	SAV ON DRUGS NO	0654901

*** Confidential ***

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Last Update: 10/14/2010

Run Date: Oct 18, 2010 04:04

Controlled Substance Utilization Review and Evaluation System

Prescriber Prescription History

AH1156795

[redacted]

Date Range: Between Nov 1, 2004 and Nov 30, 2007

Number of Prescriptions: 9,022

Patient Last Name	Patient First Name	Patient DOB	Date Filled	Drug Name	Drug Form	Strength	Quantity	PHY #	Pharmacy Name	RX Number
B[redacted]	ANGELA			HYDROCODONE BITARTRATE		MG-10 MG			6547	
		12/16/1965	12/27/2005	HOMATROPINE/ HYDROCODONE	SYR	1.5 MG/5 ML-5 MG/5 ML	180	PHY43382	SAV ON DRUGS NO 6547	0654907
		12/16/1965	01/06/2006	HOMATROPINE/ HYDROCODONE	SYR	1.5 MG/5 ML-5 MG/5 ML	240	PHY39331	PX DRUG STORE	4534131
		12/16/1965	01/09/2006	HYDROMET	SYR	1.5 MG/5 ML-5 MG/5 ML	240	PHY19709	SAV MART DRUGS	0108097
		12/16/1965	01/16/2006	HOMATROPINE/ HYDROCODONE	SYR	1.5 MG/5 ML-5 MG/5 ML	240	PHY46783	CVS PHARMACY NO 4789	0151115
		12/16/1965	01/19/2006	HYDROMET	SYR	1.5 MG/5 ML-5 MG/5 ML	180	PHY46307	OLIVE AVENUE MEDICAL PHARMACY	0031711
		12/16/1965	01/23/2006	HYDROMET	SYR	1.5 MG/5 ML-5	240	PHY43512	WALGREENS PHARMACY NO	0378355

*** Confidential ***

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Controlled Substance Utilization Review and Evaluation System

Prescriber Prescription History

AH1156795

[redacted]

Date Range: Between Nov 1, 2004 and Nov 30, 2007

Number of Prescriptions: 9,022

Patient Last Name	Patient First Name	Patient DOB	Date Filled	Drug Name	Drug Form	Strength	Quantity	PHY #	Pharmacy Name	RX Number
B[redacted]	ANGELA					MG/5 ML			04474	
		12/16/1965	01/24/2006	APAP/ HYDROCODONE BITARTRATE	TAB	325 MG-10 MG	90	PHY19709	SAV MART DRUGS	0109531
		12/16/1965	01/27/2006	APAP/ HYDROCODONE BITARTRATE	TAB	325 MG-10 MG	30	PHY46307	OLIVE AVENUE MEDICAL PHARMACY	0031051
		12/16/1965	01/27/2006	HYDROMET	SYR	1.5 MG/5 ML-5 MG/5 ML	240	PHY40912	JAY SCOTT DRUGS	0159201
		12/16/1965	02/03/2006	HOMATROPINE/ HYDROCODONE	SYR	1.5 MG/5 ML-5 MG/5 ML	240	PHY39331	PX DRUG STORE	4534539
		12/16/1965	02/06/2006	HYDROMET	SYR	1.5 MG/5 ML-5 MG/5 ML	300	PHY43040	PAVILIONS PHARMACY 2214	4067974
		12/16/1965	02/09/2006	HYDROMET	SYR	1.5 MG/5 ML-5 MG/5 ML	240	PHY19709	SAV MART DRUGS	0111056

*** Confidential ***

Disclaimer:
The Prescriber Prescription History Report is compiled from information maintained in the Department of Justice's Controlled Substance Utilization Review and Evaluation System (CURES). The CURES maintains Schedule II, Schedule III, and Schedule IV prescription information that is received from California Pharmacies and is therefore only as accurate as the information provided by the Pharmacies.

Last Update: 10/14/2010

Run Date: Oct 18, 2010 04:04

Controlled Substance Utilization Review and Evaluation System

Prescriber Prescription History

AH1156795

[redacted]

Date Range: Between Nov 1, 2004 and Nov 30, 2007

Number of Prescriptions: 9,022

Patient Last Name	Patient First Name	Patient DOB	Date Filled	Drug Name	Drug Form	Strength	Quantity	PHY #	Pharmacy Name	RX Number
B[redacted]	ANGELA	12/16/1965	02/13/2006	HYDROMET	SYR	1.5 MG/5 ML-5 MG/5 ML	240	PHY40912	JAY SCOTT DRUGS	0159923
		12/16/1965	02/20/2006	HYDROMET	SYR	1.5 MG/5 ML-5 MG/5 ML	240	PHY43512	WALGREENS PHARMACY NO 04474	0382389
		12/16/1965	02/23/2006	HOMATROPINE/ HYDROCODONE	SYR	1.5 MG/5 ML-5 MG/5 ML	240	PHY39331	PX DRUG STORE	4534781
		12/16/1965	03/02/2006	HYDROMET	SYR	1.5 MG/5 ML-5 MG/5 ML	240	PHY19709	SAV MART DRUGS	0112943
		12/16/1965	03/04/2006	APAP/ HYDROCODONE BITARTRATE	TAB	325 MG-10 MG	90	PHY43382	SAV ON DRUGS NO 6547	0661841
		12/16/1965	03/13/2006	APAP/ HYDROCODONE BITARTRATE	TAB	325 MG-10 MG	60	PHY19709	SAV MART DRUGS	0113922
		12/16/1965	03/13/2006	HYDROMET	SYR	1.5 MG/5	240	PHY19709	SAV MART DRUGS	0113923

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Controlled Substance Utilization Review and Evaluation System

Prescriber Prescription History

AH1156795

[redacted]

Date Range: Between Nov 1, 2004 and Nov 30, 2007

Number of Prescriptions: 9,022

Patient Last Name	Patient First Name	Patient DOB	Date Filled	Drug Name	Drug Form	Strength	Quantity	PHY #	Pharmacy Name	RX Number
[redacted]	ANGELA					ML-5 MG/5 ML				
		12/16/1965	03/18/2006	HOMATROPINE/ HYDROCODONE	SYR	1.5 MG/5 ML-5 MG/5 ML	240	PHY46783	CVS PHARMACY NO 4789	0161496
		12/16/1965	03/27/2006	HYDROMET	SYR	1.5 MG/5 ML-5 MG/5 ML	240	PHY46307	OLIVE AVENUE MEDICAL PHARMACY	0033158
		12/16/1965	03/29/2006	HOMATROPINE/ HYDROCODONE	SYR	1.5 MG/5 ML-5 MG/5 ML	240	PHY39331	PX DRUG STORE	4535228
		12/16/1965	03/30/2006	APAP/ HYDROCODONE BITARTRATE	TAB	325 MG-10 MG	60	PHY43382	SAV ON DRUGS NO 6547	0664388
		12/16/1965	03/30/2006	HOMATROPINE/ HYDROCODONE	SYR	1.5 MG/5 ML-5 MG/5 ML	180	PHY43382	SAV ON DRUGS NO 6547	0664385
		12/16/1965	04/06/2006	HYDROMET	SYR	1.5 MG/5 ML-5	240	PHY44963	LA CRESCENTA PHARMACY INC	4118327

*** Confidential ***

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Controlled Substance Utilization Review and Evaluation System

Prescriber Prescription History

AH1156795

[redacted]

Date Range: Between Nov 1, 2004 and Nov 30, 2007

Number of Prescriptions: 9,022

Patient Last Name	Patient First Name	Patient DOB	Date Filled	Drug Name	Drug Form	Strength	Quantity	PHY #	Pharmacy Name	RX Number
B[redacted]	ANGELA					MG/5 ML				
		12/16/1965	04/08/2006	HOMATROPINE/ HYDROCODONE	SYR	1.5 MG/5 ML-5 MG/5 ML	240	PHY36376	SAV ON DRUGS NO 9717	1608327
		12/16/1965	04/11/2006	HOMATROPINE/ HYDROCODONE	SYR	1.5 MG/5 ML-5 MG/5 ML	240	PHY33068	CAL MED PHARMACY WEST	0507333
		12/16/1965	04/18/2006	APAP/ HYDROCODONE BITARTRATE	TAB	325 MG-10 MG	30	PHY43512	WALGREENS PHARMACY NO 04474	0390136
		12/16/1965	04/18/2006	HYDROMET	SYR	1.5 MG/5 ML-5 MG/5 ML	240	PHY43512	WALGREENS PHARMACY NO 04474	0390135
		12/16/1965	04/21/2006	HYDROMET	SYR	1.5 MG/5 ML-5 MG/5 ML	360	PHY19709	SAV MART DRUGS	0117746
		12/16/1965	04/24/2006	APAP/ HYDROCODONE BITARTRATE	TAB	325 MG-10 MG	90	PHY43382	SAV ON DRUGS NO 6547	0666623

*** Confidential ***

Disclaimer:
The Prescriber Prescription History Report is compiled from information maintained in the Department of Justice's Controlled Substance Utilization Review and Evaluation System (CURES). The CURES maintains Schedule II, Schedule III, and Schedule IV prescription information that is received from California Pharmacies and is therefore only as accurate as the information provided by the Pharmacies.

Potential investigative options:

- Surveillance
- Undercover Operation
- Search Warrant
- Subpoena duces tecum

DANGER

- In preparing a declaration for a subpoena duces tecum, the CURES report cannot be relied upon on its own as the basis for demonstrating the state's burden of "good cause."

- Investigator must procure all of the individual prescriptions to ensure the CURES report is accurate and that we have the "best" evidence, which is the original script.

- Hugely time consuming process.

Record Review

- Medical records typically tell the story between the legitimate pain patient and the indiscriminate prescriber

- Basic question: have the pain management guidelines been met?

Pain Management Guidelines

- MBC investigators always mindful of distinguishing between physicians treating legitimate pain patients and physicians who are peddling drugs.

- Pain management guidelines and sensitivity toward legitimate pain management practices

Subject Interview

Expert Review

- No Departure
- Simple Departure
- Extreme Departure
- Excessive Prescribing
- Inadequate record keeping
- Prescribing without legitimate medical purpose
- Prescribing without appropriate prior exam
- Violating drug statutes

Staff Recommendation: ***The MBC should advise the Committee whether CURES is currently working for its investigatory and regulatory purposes. Does MBC query CURES as a tool in its investigations? Should it do so? MBC should provide an update on its usage by the Board, and how it can be improved. Does the MBC recommend that consideration should be given to using licensing fees of various health related boards to adequately funding CURES in the future and the these licensing boards have primary responsibility for any actions to be taken against its licensees?***

MBC Response (April 2013):

The CURES Program is currently housed in the Department of Justice (DOJ) and is a state database of dispensed prescription drugs, some of which 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 MBC, to access patient controlled substance history information through a secure Web site.

Since the inception of CURES, the MBC has utilized the reports available through the CURES data base as a valuable tool throughout the investigative process. As part of the intake or triage review of new complaints received in the MBC's Central Complaint Unit, when allegations of excessive or inappropriate prescribing are made, the prescriber history report is generated from CURES. The report provides the MBC with information on the quantity of prescriptions written by the physician, which can then be referred to a medical expert for review. The medical expert reviews the report to determine whether the quantity of medication being prescribed to a patient or patients is either appropriate or excessive and a field investigation can be initiated as a result. The medical expert also helps focus on specific patients who may be receiving a concerning amount or combination of controlled substances, as these patients generally do not complain to the MBC about the physician who is prescribing to them. The MBC's Central Complaint Unit also utilizes the CURES data base to evaluate complaints related to care being provided to specific patients; particularly when the complaint is made by a patient's family and if the patient refuses to provide an authorization for release of medical records. A patient activity report would be generated to identify whether the patient is receiving controlled substances from more than one prescriber or is receiving an excessive amount of controlled substances from a single provider. If deemed to be an issue, the MBC would then need to subpoena the medical records since an authorization for release could not be obtained from the patient.

When a case alleging inappropriate prescribing is sent from the MBC's Central Complaint Unit to the field, investigators will utilize the CURES reports for a variety of reasons. The investigator typically will initially run a CURES report that lists all patients to whom a physician is prescribing. The investigator will look for patients who reside far away from the physician's office or the pharmacy where prescriptions are being filled; patients who are using a variety of pharmacies to "cash" the prescriptions (this is done to avoid detection by pharmacy personnel); numerous people with the same surname receiving scheduled drugs from the same physician; and the combination of drugs being prescribed and the age of the patient. Once a sampling of patients who fit an aberrant prescribing pattern is identified, the

investigator will then run the individual patient CURES report to learn of all the prescribers who are writing scheduled drugs to the patient. Investigators will then begin acquiring the information upon which a determination will be made whether or not the prescribing is within the standard of care.

Investigators also use CURES reports for cases alleging self-prescribing or physician impairment. In these instances, a CURES report is run for the individual physician to determine if he or she is receiving a concerning amount of prescriptions.

It is important to note that the CURES report does not stand alone as an investigative tool. It is a critical "roadmap" that leads the investigator to the evidence that ultimately will be utilized for prosecution, should that become necessary.

The MBC uses the CURES database to monitor physicians who have been placed on probation following disciplinary action for excessive or inappropriate prescribing. A common condition of probation ordered for inappropriate prescribing violations is to limit or restrict the controlled substances that a physician can prescribe. For example, a physician may be ordered to not prescribe Schedule II controlled substances during the period of probation. The MBC's Probation Unit will generate a report from CURES showing the physician's prescribing history in order to ensure that the doctor is complying with their probation condition. The Probation Unit can also order a patient activity report to ensure that physicians who are required to abstain from the use of controlled substances are not receiving or writing prescriptions in violation of this condition.

The MBC believes CURES is a very important enforcement tool, however the system needs to be fully funded and upgraded to be more real time and able to handle inquiries from all prescribers in California. The MBC has been very supportive in the past of any effort to get CURES more fully funded in order for the PDMP to be at optimum operating capacity.

As stated above, the MBC has supported in the past and recommends that legislation be considered to provide an adequate funding source for CURES. The funding should come from prescribers/dispensers (including physicians, dentists, pharmacists, veterinarians, nurse practitioners, physician assistants, osteopathic physicians, optometrists, and podiatrists), pharmaceutical companies, and the public.

ISSUE #23: Exclude medical malpractice reports from requirements of a medical expert review by the MBC.

Background: The MBC has raised the following as a new issue in its Sunset Report. BPC § 2220.08 requires that before a quality of care complaint is referred for investigation it must be reviewed by a medical expert with the expertise necessary to evaluate the specific standard of care issue raised in the complaint. While, the rationale for the up-front specialty review makes sense, it may not make sense in the case of Medical Malpractice cases that have been reported to the Board.

The Board believes that medical malpractice cases reported pursuant to section 801.01 after the civil action has been concluded would be appropriate to exclude from the upfront specialty review as well. Unlike complaints filed by the public, medical malpractice cases

<u>Agenda Item 8a - Enforcement Program</u>

Bullet 3 - Cost/Ramifications of Senate Bill 304 (Price)
Proposal to Transfer all Investigative Staff to DOJ

Pages 41-51

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: May 23, 2013
ATTENTION: Board Members
SUBJECT: Cost/Ramifications of Senate Bill 304, Specifically the Proposal to Transfer all Investigative Staff to the Department of Justice
STAFF CONTACT: Kimberly Kirchmeyer, Deputy Director

RECOMMENDED ACTION:
This information is provided to the Members for information and discussion.

BACKGROUND AND ANALYSIS:
Senate Bill 304 (Price) proposes the transfer of all investigative staff within the Medical Board of California (Board) to the Department of Justice (DOJ). The language states,

> ”(b) On January 1, 2014, all persons employed by the Medical Board of California who are performing investigations and those person’s staff shall be transferred to, and shall become employees of, the Department of Justice. The status, position, and rights of those persons shall, upon transfer, be the same as employees of the Department of Justice holding similar positions, and for those persons transferred who are performing investigations shall include the status of peace officer provided for in Section 830.1 of the Penal Code. Nothing in this section affects or diminishes the duty of the Medical Board of California to preserve the confidentiality of records as otherwise required by law. On and after January 1, 2014, any reference in this code to an investigation conducted by the Medical Board of California shall be deemed to refer to an investigation conducted by employees of the Department of Justice.”

Costs
The Board has completed a fiscal analysis on this portion of the bill. In reviewing the bill, the fiscal portion of the transfer of these positions includes the fact that the Investigators at the DOJ are classified as Special Agents and have a higher salary. As such, once the Investigators are transferred, they should be moved into the same classifications as DOJ personnel. This results in an increase of $1.294 million per year (this only includes the increase in salaries, it does not include the increase in benefits). Please see the attached fiscal sheet for specifics **(Attachment 1)**. Additionally, please see the attached fund condition indicating the impact of these positions moving to DOJ **(Attachment 2)**. This fund condition also includes anticipated future costs for the Board. A second fund condition is also provided with a potential fiscal year 12/13 $2 million reversion, which is anticipated for the Board **(Attachment 3)**.

Ramifications
Certain:

- The Investigators, Supervising Investigators I/II, Medical Consultants, Office Staff (including the Expert Reviewer Program staff), Deputy Chief, and Chief from the Board would all be transferred to the DOJ. The attached organization chart indicates the staff that would be moving to DOJ **(Attachment 4)**.
    - The funding for these positions would be removed from the Board’s salary and wages and moved to the Attorney General line item on the Board’s budget as an operating expense.

    - The operating expenses in the Board's budget associated with the current investigator positions would be reduced for all overhead costs, including equipment, vehicle maintenance, rent, travel, training, etc., and would be moved to the Attorney General line item in the Board's budget.
    - The Attorney General would determine billing methodology and bill the Board an hourly rate for the investigative services – currently the Board charges/reimbursed $149/hour for investigative services for physician and surgeon cases.
- The Investigative staff in the Operation of Safe Medicine (OSM) will not be transferred to the DOJ due to the fact they do criminal investigations.
- All other staff in the enforcement unit would remain at the Board (Central Complaint Unit, Discipline Coordination Unit, Probation Unit, Non-Sworn Special Investigative Unit, Central File Unit).
- The Board would need to have an individual designated to review investigation reports to ensure the appropriate action was taken, i.e. closure or filing.
- The Investigators would be provided increased authority under their status in Penal Code section 830.1, which will allow them to work more efficiently in their cases, specifically prescribing practices and sexual misconduct cases.

Uncertain:

- The Office of Standards and Training Unit (OST) staff would be needed at the DOJ; however, a few of the staff may also need to remain at the Board in order to assist with hiring and training the OSM staff and the non-sworn special Investigators.
- It is uncertain whether the boards who utilize the Medical Board's Investigators to perform investigations (i.e. Board of Podiatric Medicine, Osteopathic Medical Board of California, Physician Assistant Board, and Board of Psychology) would continue to use the transferred investigators or would use the Department of Consumer Affairs' Division of Investigation (DOI). Note: Board of Podiatric Medicine utilizes the vertical enforcement model.
- It is uncertain whether the DOJ would pay for the expert opinion reviews and the Board reimburse the DOJ or whether the experts would be paid by the Board.
- Once the Board hits the financial threshold for the hours that could be paid to the Attorney General's office from that line item, the Board would have to <u>halt</u> investigations until July 1 of the next fiscal year. (This sometimes happens with boards who have investigations performed by the Board or DOI.)
- What other positions the DOJ may determine are required to implement this new responsibility.
- If this could actually happen by January 1, 2014 as that is only three months after the bill is signed.

<u>Additional Information</u>

The Board polled other states, via the Administrators in Medicine, to determine who employs Investigators at other state boards. The attached matrix **(Attachment 5)** indicates the findings from the

other boards that responded. As identified in the matrix, nine of the twelve boards that responded use their own in-house Investigators to conduct investigations. One of the boards that responded uses Investigators from the Attorney General's Office.

In addition, the Federation of State Medical Boards provided a matrix of state board activities and authority (**Attachment 6**). Under the heading "Disciplinary Investigations" it shows 32 states with authority over investigations (note that some states did not respond).

At the April 26, 2013 Board Meeting, a list of initial pros and cons was provided to the Board Members. A copy of that document is also attached **(Attachment 7)**.

Fiscal Impact of Moving MBC Investigators to DOJ
On an Annual Basis

MBC	DOJ
Investigators - $74,328	Special Agent – $88,092
Difference - $13,764	
72 investigators = $991,008	
Sup. I Investigator – $81,624	Special Agent Sup - $96,828
Difference – $15,204	
14 Sup. I Investigators - $212,856	
Sup. II Investigator - $92,148	Special Agent In Charge - $107,268
Difference - $15,120	
4 Sup. II Investigators - $60,480	

TOTAL - $1,264,334 + $30,000 for Chief/Deputy Chief = $1,294,344

NOTE: This analysis does not include the Operation Safe Medicine Unit and its staff (4 Investigators and 1 Supervising Investigator I). This analysis does not include the increase in benefits.

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	$ 22,113	$ 16,845	$ 6,134
Prior Year Adjustment	$ 752	$ -	$ -	$ -	$ -
Adjusted Beginning Balance	$ 30,998	$ 24,613	$ 22,113	$ 16,845	$ 6,134
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	$ 74,636	$ 69,350	$ 58,666
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	$ 54,644 **	$ 55,673	$ 57,993	$ 57,980
2013-2014 Proposed BCP					
BreEZe Costs			$ 1,183		
Anticipated Future Costs					
CURES funding			$ 676	$ 790	
Increase in Expert pay				$ 476	$ 476
Antcipated BreEZe Cost				$ 1,300	$ 1,300
Movement of Investigators to DOJ				$ 1,294	$ 1,294
Northern OSM				$ 697	$ 568
Enforcement Enhancements - to DOJ***				$ 454	$ 388
Enforcement Enhancements - at MBC				$ 212	$ 187
Totals, Disbursements	$ 50,242	$ 55,013	$ 57,791	$ 63,216	$ 62,193
FUND BALANCE					
Reserve for economic uncertainties	$ 24,613	$ 22,113	$ 16,845	$ 6,134	$ (3,527)
Months in Reserve	5.4	4.6	3.2	1.2	-0.7

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 excludes the $1.278 million authorized for the BreEZe system as the BreEZe system was not implemented as projected in this fiscal year.

*** The Board will be putting forward a proposal for 2 additional investigators and 2 additional AGPAs to assist with the expert program. All of these individuals would transfer to DOJ.

5/22/2013

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

with proposed $2 million reversion

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	$ 24,113	$ 18,845	$ 8,134
Prior Year Adjustment	$ 752	$ -	$ -	$ -	$ -
Adjusted Beginning Balance	$ 30,998	$ 24,613	$ 24,113	$ 18,845	$ 8,134
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	$ 76,636	$ 71,350	$ 60,666
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	$ 54,644 **	$ 55,673	$ 57,993	$ 57,980
		$ (2,000)			
2013-2014 Proposed BCP					
BreEZe Costs			$ 1,183		
Anticipated Future Costs					
CURES funding			$ 676	$ 790	
Increase in Expert pay				$ 476	$ 476
Antcipated BreEZe Cost				$ 1,300	$ 1,300
Movement of Investigators to DOJ (SB 304)				$ 1,294	$ 1,294
Northern OSM				$ 697	$ 568
Enforcement Enhancements - to DOJ***				$ 454	$ 388
Enforcement Enhancements - at MBC				$ 212	$ 187
Totals, Disbursements	$ 50,242	$ 53,013	$ 57,791	$ 63,216	$ 62,193
FUND BALANCE					
Reserve for economic uncertainties	$ 24,613	$ 24,113	$ 18,845	$ 8,134	$ (1,527)
Months in Reserve	5.6	5.0	3.6	1.6	-0.3

NOTES:

A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED FOR 2011-12 AND BEYOND.

B. INTEREST ON FUND ESTIMATED AT .68% in FY 10/11 and beyond.

* This $9 million is part of the $15 million total loaned to the General Fund by the Board. $6 million was loaned to the General Fund in FY 08/09. These loans will be repaid when the fund is nearing its minimum mandated level.

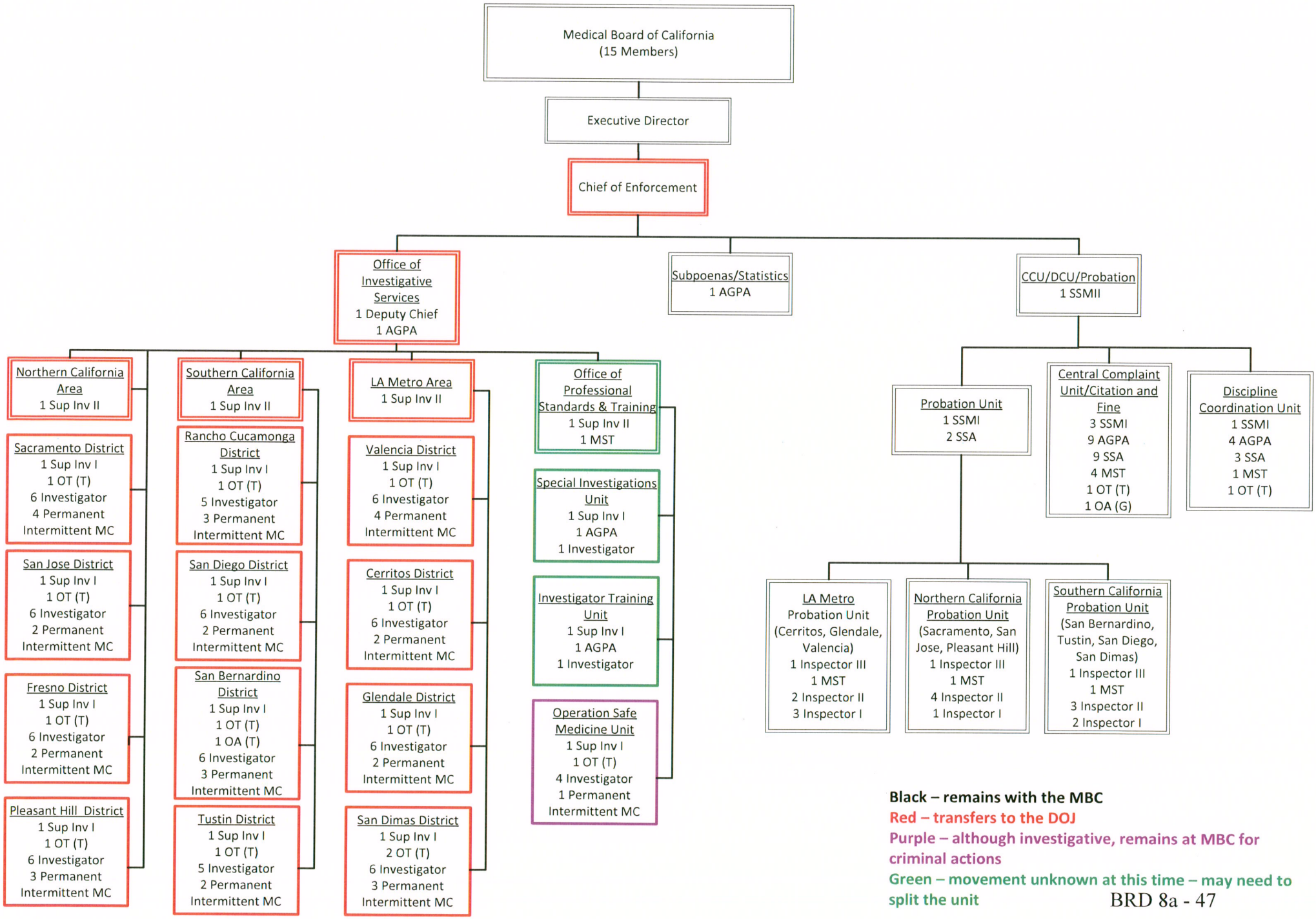
** This excludes the $1.278 million authorized for the BreEZe system as the BreEZe system was not implemented as projected in this fiscal year.

*** The Board will be putting forward a proposal for 2 additional investigators and 2 additional AGPAs to assist with the expert program. All of these individuals would transfer to DOJ should SB 304 pass.

5/22/2013

Medical Board of California
Enforcement Program
FY 2012/2013

Attachment 4



Black – remains with the MBC

Red – transfers to the DOJ

Purple – although investigative, remains at MBC for criminal actions

Green – movement unknown at this time – may need to split the unit

Investigator Information by State

State	Are Investigators Employed by the Board?	If Not, What Agency Handles Investigations?
Arizona	Yes	The Board has 7 full time investigators who gather medical records for the clinical consultants and conduct the professional conduct investigations. The Board conducts approximately 1200 investigations per year.
Delaware	No	The Division has 12 investigators for all 53 regulated professions. The Medical Board has access to all investigators, but there are usually 3-4 dedicated investigators to Medical Board cases only.
Idaho	Yes	The Board employs 3 investigators - 1 physician assistant and 2 registered nurses.
Indiana	No	All investigators are housed at the Office of the Attorney General.
Kansas	Yes	The Board has its own investigators in-house. The Board believes it is critical to have in-house investigators so that they are dedicated to the priorities of the Medical Board and so that they have subject matter knowledge, training, experience, and expertise. The investigators know the statutes enforced and what to look for in an investigation.
Maryland	Yes	The Board has 10 in-house investigators.
Mississippi	Yes	The Board has 9 in-house investigative staff.
N. Carolina	Yes	The Board has its own investigators, most of whom are retired State Bureau of Investigations agents.
N. Dakota	No	The Board utilizes investigators who are independent contractors, not affiliated with any state agency.
Oklahoma	Yes	The Board has a total of 5.5 investigator positions.
Oregon	Yes	All investigators are in-house.
S. Dakota	Yes	The Board has 1 in-house investigator and 2 additional investigator staff able to work cases. Also 1 staff legal counsel from the AG's office (part-time) and 1 Board Member is used on each case to make a recommendation to the Board for a final action (that Board Member does not vote or deliberate on their own case).
Texas	Yes	All investigators are in-house.
W. Virginia	Yes	There is 1 Board investigator on staff and the Board very infrequently contracts with a third party investigator.
Wyoming	Yes	The Board has an in-house investigator who is a paralegal and provides support to the prosecuting attorney.

The Medical Board queried all 50 states through the Administrator's in Medicine Exec Net on 5/15/13, only 15 responses were received.

	Activities within the Authority or Responsibility of the Board									
	Adoption of rules, regulations	Administration or selection of Licensing Examination	Issuance of licenses, permits, certificates	Approval for other authority's issuance of licenses, permits, certificates	Evaluation of applicant's education	Setting of fees	Disciplinary investigations	Disciplinary decision-making	Functions performed in an advisory capacity only	Authority to develop or adopt model policies, guidelines
AL										
AK	X	X	X	X	X	X	X	X	--	X
AZ-M	X	--	X	--	X	X	X	X	--	X
AZ-O										
AR										
CA-M	X	--	X	X	X	X	X	X	--	X
CA-O										
CO	X	X	X	X	X	--	X	X	--	X
CT	--	--	-	--	X	--	--	X	X	--
DE	X	--	X	X	X	--	--	X	X	X
DC										
FL-M	X	--	X	X	X	X	--	X	--	X
FL-O	X	--	X	X	X	X	--	X	--	X
GA	X	--	X	--	X	X	X	X	--	X
GU										
HI	X	--	X	--	--	--	--	X	--	--
ID	X	--	X	X	X	X	X	X	--	X
IL	--	--	-	--	X	--	--	--	X	--
IN	X	--	X	X	X	X	--	X	--	X
IA	X	--	X	--	X	X	X	X	--	X
KS	X	X	X	X	X	X	X	X	--	X
KY	X	X	X	X	X	X	X	X	--	X
LA	X	X	X	--	X	--	X	X	--	X
ME-M	X	X	X	X	X	X	X	X	--	X
ME-O										
MD	X	--	X	--	X	X	X	X	--	X
MA	X	--	X	--	X	X	X	X	X	X
MI-M	X	--	X	--	--	--	--	X	X	--
MI-O	X	--	X	--	--	--	--	X	X	--
MN										
MS	X	X	X	X	X	X	X	X	--	X
MO	X	X	X	--	X	X	X	X	--	X
MP	X	X	X	X	X	X	X	X	--	X
MT	X	--	X	--	X	X	X	X	--	X
NE	X	--	--	--	X	X	--	--	X	X

	Activities within the Authority or Responsibility of the Board									
	Adoption of rules, regulations	Administration or selection of Licensing Examination	Issuance of licenses, permits, certificates	Approval for other authority's issuance of licenses, permits, certificates	Evaluation of applicant's education	Setting of fees	Disciplinary investigations	Disciplinary decision-making	Functions performed in an advisory capacity only	Authority to develop or adopt model policies, guidelines
NV-M	X	--	X	--	X	--	X	X	--	X
NV-O	X	X	X	X	X	X	X	X	X	X
NH	X	--	X	--	X	X	X	X	--	X
NJ										
NM-M										
NM-O										
NY										
NC	X	--	X	X	X	X --	X	X	--	X
ND	X	--	X	--	X	X	X	X	--	X
OH	X	--	X	--	X	--	X	X	--	X
OK-M	X	--	X	X	X	X	--	X	--	X
OK-O	X	--	X	--	X	X	--	X	--	X
OR	X	X	X	--	X	X	X	X	--	X
PA-M	X	--	X	--	X	X	--	X	--	X
PA-O	X	--	X	--	X	X	--	X	--	X
PR	X	X	X	X	X	X	X	X	--	X
RI										
SC										
SD										
TN-M	X	X	X	X	X	X	X	X	X	X
TN-O	X	X	X	X	X	X	X	X	X	X
TX	X	X	X	--	X	X	X	X	--	X
UT-M	X	--	--	--	X	--	--	--	X	X
UT-O	X	--	--	--	X	--	--	--	X	X
VT-M	--	X	X	--	X	--	X	X	--	X
VT-O										
VI										
VA	X	X	X	--	X	X	X	X	--	X
WA-M	X	--	X	--	X	X	X	X	--	X
WA-O	X	X	X	--	X	--	X	X	X	X
WV-M	X	--	X	--	X	X	X	X	--	X
WV-O	X	--	X	X	X	X	X	X	--	X
WI	X	X	X	X	X	--	X	X	X	X
WY	X	X	X	--	X	X	X	X	--	X

SB 304 - Proposal To Move Medical Board Investigators to the Department of Justice

PROS:

- Investigators will receive a higher salary, which will address retention issues.
- Concept should streamline the enforcement process by placing investigations and prosecution under the jurisdiction of one agency.
- Medical Board investigators and Deputy Attorneys General could more easily be co-located, which will enhance communication.

CONS:

- The Medical Board will have no control or authority over investigations or timelines.
- The Medical Board will have no input on the decisions made regarding the outcome of a case (e.g. whether a case is referred for discipline, whether a case is closed, whether a public letter of reprimand is offered, settlement proposals, etc.), thus this could conflict with disciplinary guidelines.
- The Medical Board will be held accountable for the activities of another agency.
- Implementation issues will need to be addressed - enforcement staff will undergo a reorganization and contracts will need to be redone for existing field offices.
- Will increase what the Medical Board will pay for investigations, with higher salaries and associated costs; however, the full fiscal impact has not yet been determined.
- Board will be required to ask for the return of the loan to the Administration much sooner than currently projected.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	May 28, 2013
ATTENTION:	Board Members
SUBJECT:	Consumer Protection Enforcement Initiative (CPEI) Non-Sworn Investigator Positions
STAFF CONTACT:	Renee Threadgill, Chief of Enforcement, and Kimberly Kirchmeyer, Deputy Director

RECOMMENDED ACTION:
This information is provided to the Members for information and discussion.

PROPOSAL:
The Board has proposed to establish a Complaint Investigation Unit staffed with six (6) Special Investigator, non-sworn positions and one Supervising Special Investigator I position within the Enforcement Program. The Board has identified a number of case types that can be investigated and referred for prosecution without the use of a "peace officer" investigator. The Board is proposing to redirect the following cases types to non-sworn personnel to investigate:

- Physicians who have been charged with or convicted of a criminal offense or reported an arrest on their renewal application;
- Quality of care investigations following a medical malpractice settlement or judgment;
- Violations of a term or condition required of a physician on probation following a disciplinary action;
- Reports of disciplinary actions taken by another jurisdiction or state;
- Physicians petitioning the Board for reinstatement of a license following revocation or surrender;
- Physicians petitioning for modification or early termination of probation; and
- Outpatient settings based upon information from the accreditation agencies.

Not all enforcement activities or investigative duties require the use of sworn peace officer investigators. Many tasks associated with investigations can be performed by non-sworn investigators such as detecting and verifying violations, interviewing witnesses, gathering information, analyzing testimony, serving legal papers, or serving as an expert witness amongst other non-sworn duties. Having non-sworn investigators allows sworn investigators to perform investigative tasks requiring peace officer status such as the use of firearms, making arrests, or search and seizure, etc. A simple change such as this will help shorten the timeframes on core investigative tasks and reduce the number of cases currently assigned to the Board's peace officer investigators. A reduced caseload will allow the investigators to complete their investigation in a more timely manner, which is consistent with the Board's strategic goals, objectives, and mission.

BACKGROUND AND ANALYSIS:
The attached memo **(Attachment 1)** was presented to the Executive Committee on January 31, 2013. It identifies how the CPEI positions received in fiscal year (FY) 2010/2011 ultimately ended in 15.5 CPEI positions, which were eliminated from the Governor's Budget due to the 5% salary savings drill (Budget Letter 12-03). At the January 31, 2013 meeting, the Board's plan was to reclassify these positions; however, after the January meeting, the Board was notified that the

positions would need to remain as non-sworn special investigator positions. Therefore, Board staff revived, reviewed, and amended the original plan that was developed when the positions were originally established in FY 2010/2011 and proposes the positions be used as identified under the "Proposal" section.

Please be aware, these positions are not counted in the Board's vacancy rate as they are not authorized positions in the Governor's budget. Attached is the Salaries and Wages section of the Governor's budget FY 2013/2014 (**Attachment 2**). According to the Governor's budget the Board has 281.4 authorized positions. Of those positions 10.3 are for temporary help (the Board's permanent intermittent positions [including medical consultants], or retired annuitants). These positions are also not included in the vacancy rate because these positions are "temporary". The temporary help positions have their own line item and a set amount of money is allocated to these positions. In order to track this budget line item, the Board looks at the amount of money budgeted rather than the number of positions.

The Board's total **full-time, permanent** authorized positions is **271.1** (281.4 – 10.3 = 271.1). The Board currently has 16.8 vacant positions, which equates to a 6% vacancy rate. The Board currently has an individual in background for every investigator vacancy (not Supervising Investigator I), and therefore the vacancy rate is 4% taking into consideration individuals in background.

The CPEI positions cannot be included in the official vacancy rate as the positions were eliminated from the Governor's budget as part of the salary savings position elimination. The Board previously had 289.4 positions (excluding the temporary help positions) with CPEI. However, when the 5% salary savings drill requested 18.1 positions and eliminated the salary savings line item ($940,585), the Board gave up 2.6 positions from other units and 15.5 CPEI positions, thus leaving 271.1 positions. The Governor's budget reflects this reduction. It is important to note that the Board must ensure at least a salary savings of $941,000, which means that approximately a 5% vacancy rate would need to be maintained.

The CPEI positions were removed from the Board's authority, but if the Board maintains an overall vacancy rate of 5% (equivalent to $941,000) it can fill these positions. Whether the Board fills 15.5 positions or not, is dependent upon which positions are vacant at the Board. Therefore, the Board will need to remain cognizant of this fact and ensure the Board's budget is not over expended.

At this time, the Board staff recommends that it fill 7 of the 15.5 positions, since this is a new unit with new duties and workload. This will allow staff to determine the impact of these positions in regards to the budget, to ensure the duties are appropriate for this level of staff, to ensure there is sufficient workload, and to provide adequate training. Should the workload justify additional positions, this can be established in the future.

PROCESS AND TIMELINE:

- Complete the appropriate paperwork (Request for Personnel Action, justifications, organization chart, duty statements, etc.) and submit to the Department of Consumer Affairs (DCA) for processing – June 3, 2013
- DCA reviews the documents and submits the package to CalHR (required because these are new non-sworn positions – July 8, 2013
- CalHR reviews the documents and provides approval to move forward – August 16, 2013
- The Board advertises the positions and applications are received – September 6, 2013

- The Board interviews applicants, identifies top candidates, and submits information to DCA for eligibility – October 7, 2013
- The DCA approves eligibility and the Board tentatively offers the candidate the position pending fingerprints – October 11, 2013
- New staff are hired and training begins – October 28, 2013 – November 18, 2013

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: January 11, 2013
ATTENTION: Members, Executive Committee
SUBJECT: Consumer Protection Enforcement Initiative (CPEI) Positions
STAFF CONTACT: Kimberly Kirchmeyer, Deputy Director

RECOMMENDED ACTION:

Staff will provide background information and an update on the CPEI positions.

BACKGROUND AND ANALYSIS:

In July 2009 there were several negative articles written regarding the length of time it was taking the Board of Registered Nursing to discipline a registered nurse who was in violation of the law. The articles also looked at the length of time it was taking other healing arts boards under the Department of Consumer Affairs (DCA) to complete investigations. It was determined by DCA that the enforcement processes of these boards was lengthy and needed to be improved to provide better consumer protection. In response to these articles, the DCA developed the CPEI. This initiative's main goal was to reduce the enforcement completion timelines by addressing three specific areas. These areas included administrative improvements, staffing and information technology resources, and legislative changes. For the staffing resources, the DCA developed a Budget Change Proposal (BCP) requesting resources for all healing arts boards. This BCP went through the budget process and was approved in 2010. Due to this BCP, the Medical Board of California (Board) received **22.5** positions effective fiscal year (FY) 2010/2011.

The Board began to fill these positions by hiring an additional manager and one Staff Services Analyst in the Central Complaint Unit. The manager would provide the review of the complaints, and the analyst's duties included seeking experts to perform the upfront review, preparing the complaint for mailing to the expert, and conducting the follow-up to ensure timely response by the expert. The Board management knew that the timeframe for the upfront expert review was increasing and these two resources would assist in this area. This left the Board with **20.5** CPEI positions.

Because the Board conducted investigations for the Osteopathic Medical Board of California (OMBC) and the Board of Psychology (BOP), 2.5 of the CPEI positions authorized for the Board were to assist in those boards' investigations. However, these boards determined that they would rather have the positions under their specific authority. Therefore, in FY 2011/2012, those 2.5 positions were taken from the Board and provided to the OMBC and the BOP. This left the Board with **18** CPEI positions.

During FY 2010/2011, the Board was required to decrease its positions due to a requested workforce cap drill. The Board had not moved to fill any of its positions due to the uncertainty of the number of positions it would lose. The final direction on how many positions the Board would lose due to the workforce cap (2.5 positions) was not provided to the Board until June 2011. With the loss of these 2.5 positions, the Board had **15.5** remaining CPEI positions.

Although the Board began to identify where to establish these 15.5 positions and into which classification, the Board was also under a hiring freeze, which required the Board to request hiring freeze exemptions for any position the Board wanted to fill. The Board had several investigator and

medical consultant positions that required exemptions, as well as several licensing positions that were vacant, and determined that those exemptions were higher priority than the establishment of new positions.

The hiring freeze was lifted in November of 2011 and the Board again began discussion to fill these positions. However, in early 2012, the Board was notified that it would be required to eliminate 18.1 positions due to the 5% salary savings reduction. Rather than eliminate existing staff, the Board used the 15.5 CPEI positions (and 2.6 vacant positions) to meet the reduction.

The Board was notified in September 2012 that it could reestablish these positions in the temporary help blanket as long as the Board always maintains a 5% vacancy rate to meet the required salary reduction level. The Board has determined that it will request the re-establishment of **14.5** positions in the following areas in order to improve the enforcement timeframes as originally planned in the CPEI.

- Six (6) positions will be used to establish a Northern Operation Safe Medicine Unit (OSM), identical to the OSM in the South. The Northern OSM will consist of 1 Supervising Investigator, 4 Investigators, and 1 Office Technician. The establishment of this office will take the unlicensed activity cases from the workload of the investigators in the northern district offices. This will reduce the investigators caseloads in the field offices and will assist in decreasing the investigation time for physicians who violate the law. This basically adds four (4) investigators for general workload.
- Two (2) positions will be used to provide the Tustin and Rancho Cucamonga district offices with the full complement of investigators. All other district offices have six investigators. Due to budget reductions several years ago, these two offices were reduced to five investigators. This increase in investigators will assist in the reduction of the number of cases assigned to each investigator thus reducing the investigation timeframe.
- Two (2) positions will be added to the Board's Expert Reviewer Program. These analyst positions will assist in the recruitment and training of the Board's expert reviewers. The Board needs additional experts and has determined that training experts not only improves the time to provide an opinion, but also improves the quality of the opinion.
- Three (3) positions will be added to the Central Complaint Unit (CCU) and the Discipline Coordination Unit (DCU) to assist in the ever increasing workload in these areas. One analyst will be assigned to the Quality of Care section and will assist with the processing of those complaints, reducing the analysts workload in this section. One analyst will be assigned to the DCU and will process the administrative cases in an effort to reduce the time it takes to prepare the disciplinary documents. Lastly, one position will be used to establish a clerical position to assist with these duties in both the CCU and the DCU. All three of the positions will assist in improving the enforcement timeframes.
- One and a half (1.5) positions will be used to conduct malpractice investigations. It is believed that this workload could be processed beginning with a desk investigation thereby reducing the number of cases referred to the field investigative staff. This will reduce the investigators workload and reduce the time it takes to investigate a complaint.

Board staff is working on preparing the paperwork for the establishment of these positions, which also requires the review and approval by DCA. All of these positions will help the Board in reducing the enforcement timeframe and meeting the original goal of the CPEI. Thus far the following positions have been sent to DCA for approval: the Northern OSM positions; the additional two investigator positions; and the three CCU/DCU positions.

ORGANIZATIONAL UNIT	NUMBER OF POSITIONS			EXPENDITURES		
	Filled	Authorized	Proposed	Actual	Estimated	Proposed
Classification	2011-12	2012-13	2013-14	2011-12 (Salary Range)	2012-13	2013-14
Ofc Asst-Typing	1.0	1.0	1.0	2,143-2,826	33,912	33,912
Ofc Asst-Gen	0.3	1.0	1.0	2,074-2,770	33,240	33,240
Exam Proctor	-	0.1	0.1	(196)	158	158
Overtime	-	-	-	(37,524)	-	-
Totals, State Dental Assistants	6.2	9.1	9.1	$325,389	$392,148	$398,620
Totals, Dental Board of California	65.7	74.5	74.1	$3,943,473	$4,614,686	$4,673,927
Dental Hygiene Committee of California						
Committee Member (9)	-	-	-	100/day	24,400	24,400
Exec Ofcr	1.0	1.0	1.0	6,297-6,811	81,732	81,732
Assoc Govtl Prog Analyst	2.2	3.0	3.0	4,440-5,348	189,480	192,528
Special Investigator	-	1.2	1.2	3,902-5,899	56,189	58,997
Staff Svcs Analyst-Gen	1.0	2.0	2.0	2,817-4,446	95,266	100,033
Exam Proctor	0.1	-	-	(3,036)	1,881	1,881
Temporary Help	0.9	-	-	(51,648)	65	65
Overtime	-	-	-	(9,198)	-	-
Totals, State Dental Hygiene Committee of California	5.2	7.2	7.2	$327,774	$449,013	$459,636
State Board of Guide Dogs for the Blind						
Board Member (7)	-	-	-	100/day	2,844	2,844
Exec Ofcr	1.0	1.0	1.0	4,424-5,339	64,068	64,068
Ofc Techn-Typing	0.3	0.5	0.5	2,686-3,264	16,384	17,202
Limited Exam/Appt Prog Candidate	-	-	-	2,074-2,770	-	-
Overtime	-	-	-	(65)	-	-
Totals, State Board of Guide Dogs for the Blind	1.3	1.5	1.5	$75,181	$83,296	$84,114
Medical Board of California						
Medical Board:						
Executive:						
Board Member (21)	-	-	-	100/day	31,500	31,500
Committee Members (5)	-	-	-	100/day	-	-
Exec Director	1.0	1.0	1.0	9,215-9,968	119,616	119,616
C.E.A. II	1.0	1.0	1.0	7,815-8,616	103,608	103,608
Attorney III	1.0	1.0	1.0	7,682-9,478	113,736	113,736
C.E.A. I	1.0	1.0	1.0	6,173-7,838	90,312	90,312
Info Ofcr II	0.6	1.0	1.0	5,312-6,409	65,606	68,889
Staff Svcs Mgr I	1.0	0.8	0.8	5,079-6,127	53,390	53,390
Adm Asst I	0.7	1.0	1.0	3.658-4,652	53,352	53,352
Exec Asst	0.5	1.0	1.0	3,288-3,996	41,808	43,896
Ofc Techn-Typing	0.4	1.0	1.0	2,686-3,264	37,737	39,141
Ofc Asst-Typing	0.3	-	-	2,143-2,826	-	-
Temporary Help	-	-	-	-	5,000	5,000
Overtime	-	-	-	(3,055)	924	924
Totals, Executive	7.5	8.8	8.8	$655,641	$716,589	$723,364
Administrative Services:						
Research Prog Spec II	0.8	1.0	1.0	5,309-6,451	77,304	77,412
Assoc Govtl Prog Analyst	4.2	4.0	4.0	4,440-5,348	241,308	246,952
Assoc Budget Analyst	1.0	1.0	1.0	4,440-5,348	60,642	63,668
Staff Svcs Analyst-Gen	1.0	1.0	1.0	2,817-4,446	53,352	53,352
Totals, Administrative Services	7.0	7.0	7.0	$374,628	$432,606	$441,384

ORGANIZATIONAL UNIT	NUMBER OF POSITIONS			EXPENDITURES		
	Filled	Authorized	Proposed	Actual	Estimated	Proposed
Classification	2011-12	2012-13	2013-14	2011-12 (Salary Range)	2012-13	2013-14
Business Services Office/Cashiering:						
Staff Svcs Mgr I	1.0	1.0	1.0	5,079-6,127	73,524	73,524
Assoc Govtl Prog Analyst	1.0	1.0	1.0	4,440-5,348	62,358	64,176
Staff Svcs Analyst-Gen	0.4	1.0	1.0	2,817-4,446	33,804	35,496
Bus Svcs Asst-Spec	2.8	4.0	4.0	2,495-3,708	168,192	172,061
Temporary Help	0.8	0.1	0.1	(65,838)	15,000	15,000
Overtime	-	-	-	(12,697)	959	959
Totals, Business Services Office/Cashiering	6.0	7.1	7.1	$397,381	$353,837	$361,216
Information Systems:						
DP Mgr II	1.0	1.0	1.0	5,849-7,464	89,568	89,568
Sr Info Systems Analyst-Spec	1.0	1.0	1.0	5,571-7,109	85,308	85,308
Systems Software Spec II-Tech	2.0	2.0	2.0	5,561-7,097	165,740	169,232
Staff Programmer Analyst-Spec	1.6	2.0	2.0	5,065-6,466	147,793	150,974
Staff Info Systems Analyst-Spec	3.0	3.0	3.0	5,065-6,466	232,776	232,776
Assoc Info Systems Analyst-Spec	4.4	5.0	5.0	4,619-5,897	324,782	335,698
Assoc Programmer Analyst-Spec	1.9	2.0	2.0	4,619-5,897	119,070	125,022
Asst Info Systems Analyst	0.9	1.0	1.0	3,106-4,903	37,272	39,132
Temporary Help	1.5	-	-	(123,611)	9,750	9,750
Overtime	-	-	-	(324)	716	716
Totals, Information Systems	17.3	17.0	17.0	$1,242,713	$1,212,775	$1,238,176
Licensing:						
C.E.A. I	1.0	1.0	1.0	6,173-13,381	91,488	91,488
Staff Svcs Mgr I	3.7	4.0	4.0	5,079-6,127	274,171	283,069
Assoc Govtl Prog Analyst	5.4	7.8	7.8	4,440-5,348	453,888	470,350
Office Svcs Supvr II-Gen	1.0	1.0	1.0	2,953-3,590	43,080	43,080
Staff Svcs Analyst-Gen	13.0	13.7	13.7	2,817-4,446	664,285	684,814
Ofc Techn-Typing	7.9	11.0	11.0	2,686-3,264	385,650	397,082
Ofc Techn-Gen	0.9	1.0	1.0	2,638-3,209	38,142	38,498
Mgt Svcs Techn	10.0	12.0	12.0	2,495-3,426	468,831	475,943
Acct Clerk II	1.0	1.0	1.0	2,364-2,876	34,512	34,512
Ofc Asst-Typing	0.4	0.8	0.8	2,074-2,770	26,256	27,123
Temporary Help	1.9	0.2	0.2	(153,976)	18,198	18,198
Overtime	-	-	-	(19,517)	1,785	1,785
Totals, Licensing	46.2	53.5	53.5	$2,215,776	$2,500,286	$2,565,942
Enforcement-Headquarters:						
Deputy Chief	1.0	1.0	1.0	7,152-8,280	104,328	104,328
C.E.A. II	1.0	1.0	1.0	6,173-13,381	108,564	108,564
Supvng Investigator II	1.0	1.0	1.0	6,058-7,679	94,487	96,755
Staff Svcs Mgr II	1.0	1.0	1.0	5,576-6,727	80,724	80,724
Supvng Investigator I	1.0	2.0	2.0	5,369-6,802	128,856	135,288
Staff Svcs Mgr I	4.0	4.0	4.0	5,079-6,127	286,260	291,488
Assoc Govtl Prog Analyst	14.9	16.0	16.0	4,440-5,348	1,000,627	1,015,535
Investigator	1.5	2.0	2.0	3,631-5,631	148,497	150,596
Staff Svcs Analyst-Gen	11.2	12.0	12.0	2,817-4,446	591,143	609,893
Ofc Techn-Typing	1.7	2.0	2.0	2,686-3,264	71,802	73,431
Mgt Svcs Techn	5.2	6.0	6.0	2,495-3,426	239,823	241,536
Ofc Asst-Gen	0.9	1.0	1.0	2,074-2,770	31,661	31,661

ORGANIZATIONAL UNIT	NUMBER OF POSITIONS			EXPENDITURES		
	Filled	Authorized	Proposed	Actual	Estimated	Proposed
Classification	2011-12	2012-13	2013-14	2011-12 (Salary Range)	2012-13	2013-14
Totals, Enforcement-Headquarters	44.4	49.0	49.0	$1,827,354	$2,886,772	$2,939,799
Enforcement-Regional Offices:						
Supvng Investigator II	2.3	3.0	3.0	6,058-7,679	279,149	283,052
Supvng Investigator I	9.1	13.0	13.0	5,369-6,802	1,056,371	1,062,871
Investigator	59.2	74.0	74.0	3,631-5,631	4,970,757	5,089,408
Ofc Techn-Typing	12.3	13.0	13.0	2,686-3,264	505,635	509,144
Ofc Asst-Typing	0.8	1.0	1.0	2,074-2,770	35,112	35,112
Temporary Help	18.9	9.3	9.3	(1,522,595)	1,017,339	1,017,339
Temporary Help-PFIP	-	-	-	(34,540)	29,623	29,623
Overtime	-	-	-	(6,714)	6,897	6,897
Totals, Enforcement-Regional Offices	102.6	113.3	113.3	$7,783,110	$7,900,883	$8,033,446
Probation:						
Staff Svcs Mgr I	1.0	1.0	1.0	5,079-6,127	73,524	73,524
Insp III	3.0	3.0	3.0	3,763-4,525	162,900	162,900
Insp II	8.8	10.0	10.0	3,268-3,932	456,476	461,016
Insp I	3.0	6.0	6.0	2,877-3,424	246,528	246,528
Staff Svcs Analyst-Gen	1.0	1.0	1.0	2,817-4,446	46,092	48,396
Ofc Techn-Typing	0.5	1.0	1.0	2,686-3,264	33,036	34,686
Mgt Svcs Techn	2.9	3.0	3.0	2,495-3,426	123,336	123,336
Temporary Help	-	0.7	0.7	-	72,226	72,226
Overtime	-	-	-	(797)	862	862
Totals, Probation	20.2	25.7	25.7	$948,209	$1,214,980	$1,223,474
Totals, Medical Board	251.2	281.4	281.4	$15,444,812	$17,218,728	$17,526,801
Registered Dispensing Opticians:						
Staff Svcs Analyst-Gen	0.6	0.9	0.9	2,817-4,446	45,736	45,736
Totals, Registered Dispensing Opticians	0.6	0.9	0.9	$29,998	$45,736	$45,736
Totals, Medical Board of California	251.8	282.3	282.3	$15,474,810	$17,264,464	$17,572,537
Acupuncture Board						
Board Member (9)	-	-	-	100/day	7,463	7,463
Exec Ofcr	1.4	1.0	1.0	6,297-6,811	75,564	75,564
Assoc Govtl Prog Analyst	1.6	1.7	1.7	4,400-5,348	105,943	108,035
Special Investigator	-	0.5	0.5	3,902-5,899	23,412	24,583
Staff Svcs Analyst-Gen	2.0	1.8	1.8	2,817-4,446	86,227	87,999
Ofc Techn-Typing	1.2	3.0	3.0	2,686-3,264	107,004	110,336
Overtime	-	-	-	(2,449)	-	-
Temporary Help	0.7	-	-	(13,164)	-	-
Totals, Acupuncture Board	6.9	8.0	8.0	$367,600	$405,613	$413,980
Physical Therapy Board of California						
Board Member (7)	-	-	-	100/day	11,786	11,786
Exec Ofcr	1.0	1.0	1.0	6,297-6,811	77,196	77,196
Staff Svcs Mgr I	1.8	2.0	2.0	5,079-6,127	132,102	138,587
Assoc Govtl Prog Analyst [4]	6.1	5.8	5.6	4,400-5,348	347,263	343,227
Special Investigator I (Non-Peace Officer)	-	1.1	1.1	3,902-5,363	66,244	69,272
Staff Svcs Analyst-Gen [4]	5.0	3.0	2.3	2,817-4,446	140,778	116,602
Ofc Techn-Typing	1.4	1.1	1.1	2,686-3,264	41,347	42,434
Temporary Help	5.2	0.3	0.3	(213,473)	153,767	153,767
Overtime	-	-	-	(17,469)	-	-

ORGANIZATIONAL UNIT	NUMBER OF POSITIONS			EXPENDITURES		
	Filled	Authorized	Proposed	Actual	Estimated	Proposed
Classification	2010-11	2011-12	2012-13	2010-11 (Salary Range)	2011-12	2012-13
Investigator	-	1.0	1.0	3,631-5,631	70,127	70,127
Staff Svcs Analyst-Gen	0.5	1.0	1.0	2,817-4,446	42,043	44,146
Ofc Techn-Typing	-	1.0	1.0	2,686-3,264	32,232	33,844
Mgt Svcs Techn	0.8	1.0	1.0	2,495-3,426	29,940	31,440
Exam Proctor	-	-	-	-	1,881	1,881
Temporary Help	1.5	-	-	(70,448)	65	65
Overtime	-	-	-	(6,435)	-	-
Totals, State Dental Hygiene Committee of California	5.8	7.5	7.5	$323,258	$418,790	$427,957
State Board of Guide Dogs for the Blind						
Board Member (7)	-	-	-	100/day	9,450	9,450
Exec Ofcr	1.0	1.0	1.0	4,424-5,339	61,108	61,108
Ofc Techn-Typing	0.5	0.5	0.5	2,686-3,264	16,206	17,016
Limited Exam/Appt Prog Candidate	-	-	-	2,074-2,770	-	-
Totals, State Board of Guide Dogs for the Blind	1.5	1.5	1.5	$78,593	$86,764	$87,574
Medical Board of California						
Medical Board:						
Executive:						
Board Member (21)	-	-	-	100/day	31,500	31,500
Committee Members (5)	-	-	-	100/day	-	-
Exec Director	1.0	1.0	1.0	9,215-9,968	114,090	114,090
C.E.A. II	0.5	1.0	1.0	7,815-8,616	98,821	98,821
Staff Counsel III-Spec	1.0	1.0	1.0	7,682-9,478	108,481	108,481
C.E.A. I	1.0	1.0	1.0	6,173-7,838	78,139	78,139
Info Ofcr II	1.5	1.0	1.0	5,312-6,409	63,744	66,936
Staff Svcs Mgr I	1.0	0.8	0.8	5,079-6,127	50,673	50,673
Adm Asst I	0.2	1.0	1.0	3.658-4,652	55,440	55,440
Exec Asst	0.1	1.0	1.0	3,288-3,996	47,952	47,952
Ofc Techn-Typing	0.2	0.5	0.5	2,686-3,264	18,679	18,679
Ofc Asst-Typing	0.5	0.5	0.5	2,143-2,826	14,906	15,652
Temporary Help	-	-	-	(1,442)	5,000	5,000
Overtime	-	-	-	(5,985)	924	924
Totals, Executive	7.0	8.8	8.8	$634,573	$688,349	$692,287
Administrative Services:						
Research Prog Spec II	0.2	1.0	1.0	5,309-6,451	77,412	77,412
Assoc Govtl Prog Analyst	5.0	5.0	5.0	4,440-5,348	292,435	297,883
Assoc Budget Analyst	1.3	1.0	1.0	4,440-5,348	55,082	57,840
Staff Svcs Analyst-Gen	1.0	1.0	1.0	2,817-4,446	50,887	50,887
Totals, Administrative Services	7.5	8.0	8.0	$374,628	$475,816	$484,022
Business Services Office/Cashiering:						
Staff Svcs Mgr I	1.0	1.0	1.0	5,079-6,127	68,585	70,127
Assoc Govtl Prog Analyst	1.0	1.0	1.0	4,440-5,348	56,796	59,477
Staff Svcs Analyst-Gen	0.3	1.0	1.0	2,817-4,446	53,352	53,352
Bus Svcs Asst-Spec	4.0	4.0	4.0	2,495-3,708	169,556	170,827
Temporary Help	0.8	0.1	0.1	(60,770)	15,000	15,000
Overtime	-	-	-	(2,841)	959	959
Totals, Business Services Office/Cashiering	7.1	7.1	7.1	$417,599	$364,248	$369,742
Information Systems:						
DP Mgr II	1.0	1.0	1.0	5,849-7,464	85,430	85,430
Sr Info Systems Analyst-Spec	1.0	1.0	1.0	5,571-7,109	81,367	81,367

ORGANIZATIONAL UNIT	NUMBER OF POSITIONS			EXPENDITURES		
	Filled	Authorized	Proposed	Actual	Estimated	Proposed
Classification	2010-11	2011-12	2012-13	2010-11 (Salary Range)	2011-12	2012-13
Systems Software Spec II-Tech	2.0	2.0	2.0	5,561-7,097	154,424	158,082
Staff Programmer Analyst-Spec	1.0	1.0	1.0	5,065-6,466	74,007	74,007
Staff Info Systems Analyst-Spec	3.0	3.0	3.0	5,065-6,466	222,021	222,021
Assoc Info Systems Analyst-Spec	3.8	4.0	4.0	4,619-5,897	246,841	255,809
Assoc Programmer Analyst-Spec	2.0	2.0	2.0	4,619-5,897	121,586	127,152
Assoc Govtl Prog Analyst	-	1.0	1.0	4,440-5,348	52,800	55,440
Assoc Info Systems Analyst	1.2	1.0	1.0	3,106-4,903	48,087	50,494
Staff Svcs Analyst-Gen	-	1.0	1.0	2,817-4,446	33,804	35,494
Temporary Help	2.4	-	-	(174,925)	9,750	9,750
Overtime	-	-	-	(3,626)	716	716
Totals, Information Systems	17.4	17.0	17.0	$1,170,818	$1,130,833	$1,155,762
Licensing:						
C.E.A. I	0.9	1.0	1.0	6,173-13,381	83,106	83,106
Staff Svcs Mgr I	3.6	4.0	4.0	5,079-6,127	265,849	272,773
Assoc Govtl Prog Analyst	5.2	4.8	4.8	4,440-5,348	270,088	281,121
Office Svcs Supvr II-Gen	1.0	1.0	1.0	2,953-3,590	41,090	41,090
Staff Svcs Analyst-Gen	12.6	12.7	12.7	2,817-4,446	581,620	601,756
Jr Staff Analyst-Gen	-	2.0	2.0	2,817-3,708	67,608	70,992
Ofc Techn-Typing	8.8	12.8	12.8	2,686-3,264	449,504	460,944
Ofc Techn-Gen	0.7	1.0	1.0	2,638-3,209	34,782	36,526
Mgt Svcs Techn	11.8	12.0	12.0	2,495-3,426	462,690	466,821
Acct Clerk II	1.0	1.0	1.0	2,364-2,876	32,918	32,918
Ofc Asst-Gen	0.1	-	-	2,074-2,770	-	-
Limited Exam/Appt Prog Candidate	0.2	1.0	1.0	2,074-2,770	32,232	33,844
Temporary Help	3.7	0.2	0.2	(271,903)	18,198	18,198
Overtime	-	-	-	(7,202)	1,785	1,785
Totals, Licensing	49.6	53.5	53.5	$2,279,050	$2,341,470	$2,401,874
Enforcement-Headquarters:						
Deputy Chief	1.0	1.0	1.0	7,152-8,280	99,738	99,738
C.E.A.	1.0	1.0	1.0	6,173-13,381	103,548	103,548
Supvng Investigator II	0.9	2.0	2.0	6,058-7,679	145,392	152,664
Staff Svcs Mgr II	1.0	1.0	1.0	5,576-6,727	76,995	76,995
Supvng Investigator I	2.0	2.0	2.0	5,369-6,802	162,187	162,187
Staff Svcs Mgr I	3.9	5.0	5.0	5,079-6,127	325,689	337,030
Assoc Govtl Prog Analyst	15.1	15.0	15.0	4,440-5,348	868,655	891,809
Special Investigator I (Non-Peace Officer)	-	18.0	18.0	3,902-5,363	842,832	884,970
Investigator	1.0	1.0	1.0	3,631-5,631	64,818	65,650
Staff Svcs Analyst-Gen	10.1	10.0	10.0	2,817-4,446	448,589	457,172
Jr Staff Analyst-Gen	-	2.0	2.0	2,817-3,708	67,608	70,992
Ofc Techn-Typing	2.6	2.6	2.6	2,686-3,264	93,008	94,615
Mgt Svcs Techn	5.7	6.0	6.0	2,495-3,426	233,578	235,278
Ofc Asst-Gen	0.2	1.0	1.0	2,074-2,770	30,125	30,125
Totals, Enforcement-Headquarters	44.5	67.6	67.6	$1,827,354	$3,562,762	$3,662,773
Enforcement-Regional Offices:						
Supvng Investigator II	2.7	3.0	3.0	6,058-7,679	253,085	256,721
Supvng Investigator I [2]	11.8	11.0	11.0	5,369-6,802	837,421	851,681
Sr Investigator [2]	35.6	37.0	37.0	4,888-6,194	2,603,712	2,639,892
Investigator	32.4	34.0	34.0	3,631-5,631	1,901,649	1,964,980
Ofc Techn-Typing	12.8	12.0	12.0	2,686-3,264	437,771	443,075

ORGANIZATIONAL UNIT	NUMBER OF POSITIONS			EXPENDITURES		
	Filled	Authorized	Proposed	Actual	Estimated	Proposed
Classification	2010-11	2011-12	2012-13	2010-11 (Salary Range)	2011-12	2012-13
Ofc Asst-Typing	0.6	2.0	2.0	2,143-2,826	67,458	67,458
Physical Fitness Incentive	-	-	-	(31,005)	29,623	29,623
Temporary Help	16.7	9.3	9.3	(1,210,394)	1,024,236	1,024,236
Overtime	-	-	-	(17,848)	6,897	6,897
Totals, Enforcement-Regional Offices	112.6	108.3	108.3	$7,651,050	$7,161,852	$7,284,563
Probation:						
Staff Svcs Mgr I	1.0	1.0	1.0	5,079-6,127	70,127	70,127
Assoc Govtl Prog Analyst	0.4	1.0	1.0	4,440-5,348	52,800	55,440
Insp III	3.0	3.0	3.0	3,763-4,525	155,373	155,373
Insp II	8.6	11.0	11.0	3,268-3,932	481,682	490,172
Investigator Asst	-	1.0	1.0	2,987-3,565	35,844	37,636
Insp I	4.4	5.0	5.0	2,877-3,424	191,284	193,010
Ofc Techn-Typing	1.0	1.0	1.0	2,686-3,264	33,621	35,302
Mgt Svcs Techn	1.3	2.0	2.0	2,495-3,426	69,153	70,650
Temporary Help	-	0.7	0.7	-	72,226	72,226
Overtime	-	-	-	(412)	862	862
Totals, Probation	19.7	25.7	25.7	$850,627	$1,162,972	$1,180,798
Totals, Medical Board	265.4	296.0	296.0	$15,205,700	$16,888,302	$17,231,821
Registered Dispensing Opticians:						
Staff Svcs Analyst-Gen	0.6	0.9	0.9	2,817-4,446	43,518	43,518
Totals, Registered Dispensing Opticians	0.6	0.9	0.9	$28,396	$43,518	$43,518
Totals, Medical Board of California	266.0	296.9	296.9	$15,234,096	$16,931,820	$17,275,339
Acupuncture Board						
Board Member (9)	-	-	-	100/day	7,463	7,463
Exec Ofcr	1.0	1.0	1.0	6,297-6,811	77,956	77,956
Assoc Govtl Prog Analyst	2.0	2.0	2.0	4,400-5,348	116,293	119,051
Special Investigator I (Non-Peace Officer)	-	1.0	1.0	3,902-5,899	46,824	49,165
Staff Svcs Analyst-Gen	1.9	2.0	2.0	2,817-4,446	86,022	87,903
Ofc Techn-Typing	1.9	3.0	3.0	2,686-3,264	103,022	106,238
Overtime	-	-	-	(42)	-	-
Temporary Help	0.4	-	-	(8,667)	-	-
Totals, Acupuncture Board	7.2	9.0	9.0	$343,045	$437,580	$447,776
Physical Therapy Board of California						
Board Member (7)	-	-	-	100/day	11,786	11,786
Exec Ofcr	1.0	1.0	1.0	6,297-6,811	77,956	77,956
Staff Svcs Mgr I	1.0	2.0	2.0	5,079-6,127	131,075	134,122
Assoc Govtl Prog Analyst [2]	5.9	9.1	6.5	4,400-5,348	466,222	378,411
Special Investigator I (Non-Peace Officer)	-	0.5	0.5	3,902-5,363	23,412	24,583
Staff Svcs Analyst-Gen	1.7	3.3	3.3	2,817-4,446	137,514	141,851
Ofc Techn-Typing	1.0	2.1	2.1	2,686-3,264	73,149	74,938
Temporary Help	10.5	0.3	0.3	(357,219)	3,767	3,767
Overtime	-	-	-	(1,197)	-	-
Totals, Physical Therapy Board of California	21.1	18.3	15.7	$975,382	$924,881	$847,414
Physician Assistant Committee						
Committee Members (9)	-	-	-	100/day	16,000	16,000
Exec Ofcr	1.0	1.0	1.0	6,297-6,811	77,956	77,956
Assoc Govtl Prog Analyst [3]	2.0	2.5	2.1	4,400-5,348	148,822	127,702
Staff Svcs Analyst-Gen	1.0	1.0	1.0	2,817-4,446	50,887	50,887
Mgt Svcs Techn	0.3	0.5	0.5	2,495-3,426	14,970	15,720

ORGANIZATIONAL UNIT	NUMBER OF POSITIONS			EXPENDITURES		
	Filled	Authorized	Proposed	Actual	Estimated	Proposed
Classification	2009-10	2010-11	2011-12	2009-10 (Salary Range)	2010-11	2011-12
Exec Ofcr	1.0	1.0	1.0	6,297-6,811	81,732	81,732
Assoc Govtl Prog Analyst	1.1	1.0	1.0	4,440-5,348	55,440	58,212
Special Investigator I (Non-Peace Officer)	-	0.4	0.5	3,902-5,363	17,559	24,294
Investigator	-	0.5	1.0	2,987-5,631	21,786	44,664
Staff Svcs Analyst-Gen	1.0	2.0	2.0	2,817-4,446	73,099	76,755
Mgt Svcs Techn	1.0	1.0	1.0	2,495-3,426	35,680	37,463
Ofc Asst-Typing	-	1.0	1.0	2,143-2,826	32,232	33,840
Exam Proctor	0.1	-	-	(842)	1,881	1,881
Temporary Help	0.8	-	-	(53,262)	65	65
Overtime	-	-	-	(7,708)	-	-
Totals, State Dental Hygiene Committee of California	5.0	6.9	7.5	$252,637	$343,874	$383,306
State Board of Guide Dogs for the Blind						
Board Member (7)	-	-	-	100/day	9,450	9,450
Exec Ofcr	1.0	1.0	1.0	4,424-5,339	64,068	64,068
Ofc Techn-Typing	0.2	0.5	0.5	2,686-3,264	16,116	16,920
Limited Exam/Appt Prog Candidate	0.1	-	-	2,074-2,770	-	-
Totals, State Board of Guide Dogs for the Blind	1.3	1.5	1.5	$68,409	$89,634	$90,438
Medical Board of California						
Medical Board:						
Executive:						
Board Member (21)	-	-	-	100/day	31,500	31,500
Committee Members (5)	-	-	-	100/day	-	-
Exec Director	1.2	1.0	1.0	9,215-9,968	119,616	119,616
Staff Counsel III-Spec	1.0	1.0	1.0	7,682-9,478	112,904	113,736
C.E.A. I	1.2	2.0	2.0	6,173-13,381	185,316	185,316
Info Ofcr II	1.0	1.0	1.0	5,312-6,409	76,908	76,908
Staff Svcs Mgr I	1.0	0.8	0.8	5,079-6,127	58,819	58,819
Staff Svcs Analyst-Gen	0.8	1.0	1.0	2,817-4,446	33,804	35,496
Ofc Techn-Typing	1.3	1.5	1.5	2,686-3,264	57,156	58,055
Ofc Asst-Typing	0.5	0.5	0.5	2,143-2,826	14,884	15,628
Temporary Help	-	-	-	(159)	5,000	5,000
Overtime	-	-	-	(9,920)	924	924
Totals, Executive	8.0	8.8	8.8	$600,353	$696,831	$700,998
Administrative Services:						
Research Prog Spec II	1.3	1.0	1.0	5,309-6,451	63,708	66,888
Assoc Govtl Prog Analyst	3.8	5.0	5.0	4,440-5,348	292,667	300,879
Assoc Budget Analyst	1.0	1.0	1.0	4,440-5,348	64,176	64,176
Staff Svcs Analyst-Gen	1.3	1.0	1.0	2,817-4,446	53,352	53,352
Totals, Administrative Services	7.4	8.0	8.0	$433,853	$473,903	$485,295
Business Services Office/Cashiering:						
Staff Svcs Mgr I	0.8	1.0	1.0	5,079-6,127	33,804	35,496
Assoc Govtl Prog Analyst	0.8	1.0	1.0	4,440-5,348	56,715	59,547
Staff Svcs Analyst-Gen	0.9	1.0	1.0	2,817-4,446	68,785	71,907
Bus Svcs Asst-Spec	4.0	4.0	4.0	2,495-3,708	173,715	175,233
Temporary Help	0.6	0.1	0.1	(41,692)	15,000	15,000
Overtime	-	-	-	(37,345)	959	959
Totals, Business Services Office/Cashiering	7.1	7.1	7.1	$766,631	$348,978	$358,142
Information Systems:						
DP Mgr II	1.0	1.0	1.0	5,849-7,464	89,568	89,568

ORGANIZATIONAL UNIT	NUMBER OF POSITIONS			EXPENDITURES		
	Filled	Authorized	Proposed	Actual	Estimated	Proposed
Classification	2009-10	2010-11	2011-12	2009-10 (Salary Range)	2010-11	2011-12
Sr Info Systems Analyst-Spec	0.7	1.0	1.0	5,571-7,109	84,028	85,308
Systems Software Spec II-Tech	2.0	2.0	2.0	5,561-7,097	158,252	161,904
Staff Programmer Analyst-Spec	1.0	1.0	1.0	5,065-6,466	77,592	77,592
Staff Info Systems Analyst-Spec	3.3	3.0	3.0	5,065-6,466	231,299	232,776
Assoc Info Systems Analyst-Spec	2.0	2.0	2.0	4,619-5,897	132,900	136,008
Assoc Programmer Analyst-Spec	1.6	2.0	2.0	4,619-5,897	121,395	127,475
Assoc Govtl Prog Analyst	1.0	1.0	1.0	4,440-5,348	64,176	64,176
Assoc Info Systems Analyst	2.8	3.0	3.0	3,106-4,903	159,630	164,674
Staff Svcs Analyst-Gen	1.0	1.0	1.0	2,817-4,446	51,504	53,352
Info Systems Techn	0.2	-	-	2,480-3,737	-	-
Temporary Help	2.9	0.1	0.1	(189,397)	9,750	9,750
Overtime	-	-	-	(2,729)	716	716
Totals, Information Systems	19.5	17.1	17.1	$1,160,090	$1,180,810	$1,203,299
Licensing:						
C.E.A. I	1.3	1.0	1.0	6,173-13,381	74,076	74,076
Staff Svcs Mgr I	3.0	4.0	4.0	5,079-6,127	268,944	275,040
Assoc Govtl Prog Analyst	4.0	6.8	5.8	4,440-5,348	387,904	345,696
Office Svcs Supvr II-Gen	1.0	1.0	1.0	2,953-3,590	43,080	43,080
Staff Svcs Analyst-Gen	10.7	13.7	13.7	2,817-4,446	582,940	602,932
Ofc Techn-Typing	8.7	10.8	11.8	2,686-3,264	384,291	428,908
Ofc Techn-Gen	0.3	1.0	1.0	2,638-3,209	31,656	33,240
Mgt Svcs Techn	10.7	13.0	13.0	2,495-3,426	497,769	506,160
Acct Clerk II	1.0	1.0	1.0	2,364-2,876	34,512	34,512
Ofc Asst-Typing	0.2	-	-	2,143-2,826	-	-
Ofc Asst-Gen	1.0	1.0	1.0	2,074-2,770	33,240	33,240
Limited Exam/Appt Prog Candidate	0.2	-	-	2,074-2,770	-	-
Temporary Help	6.7	0.2	0.2	(443,018)	18,198	18,198
Overtime	-	-	-	(122,240)	1,785	1,785
Totals, Licensing	48.8	53.5	53.5	$2,305,960	$2,358,395	$2,396,867
Enforcement-Headquarters:						
Deputy Chief	1.0	1.0	1.0	7,152-8,280	104,328	104,328
C.E.A.	1.0	1.0	1.0	6,173-13,381	108,564	108,564
Supvng Investigator II	1.8	2.0	2.0	6,058-7,679	195,353	195,353
Staff Svcs Mgr II	1.0	3.0	3.0	5,576-6,727	202,620	208,716
Supvng Investigator I	2.0	2.0	2.0	5,369-6,802	168,913	168,913
Staff Svcs Mgr I	2.6	3.0	3.0	5,079-6,127	212,218	218,262
Sr Investigator	0.1	-	-	4,888-6,194	-	-
Assoc Govtl Prog Analyst	16.1	17.0	17.0	4,440-5,348	1,026,600	1,058,026
Special Investigator I (Non-Peace Officer)	-	15.4	20.5	3,902-5,363	721,090	995,890
Investigator	1.0	1.0	1.0	3,631-5,631	65,232	67,899
Staff Svcs Analyst-Gen	9.1	9.0	9.0	2,817-4,446	466,390	470,388
Ofc Techn-Typing	2.8	2.6	2.6	2,686-3,264	96,286	99,140
Mgt Svcs Techn	6.9	7.0	7.0	2,495-3,426	283,748	287,460
Totals, Enforcement-Headquarters	45.4	64.0	69.1	$2,258,763	$3,651,342	$3,982,939
Enforcement-Regional Offices:						
Supvng Investigator II	2.9	3.0	3.0	6,058-7,679	261,059	265,235
Supvng Investigator I [2]	12.0	12.0	11.0	5,369-6,802	915,185	839,730
Sr Investigator [2]	34.2	39.0	37.0	4,888-6,194	2,909,366	2,818,118
Investigator	28.2	36.0	34.0	3,631-5,631	2,070,041	2,026,623

ORGANIZATIONAL UNIT	NUMBER OF POSITIONS			EXPENDITURES		
	Filled	Authorized	Proposed	Actual	Estimated	Proposed
Classification	2009-10	2010-11	2011-12	2009-10 (Salary Range)	2010-11	2011-12
Ofc Techn-Typing [2]	12.1	13.0	12.0	2,686-3,264	492,226	459,517
Ofc Asst-Typing	2.5	3.0	3.0	2,143-2,826	95,400	97,590
Physical Fitness Incentive	-	-	-	(27,885)	29,623	29,623
Temporary Help	21.7	9.2	9.2	(1,441,169)	1,024,236	1,024,236
Overtime	-	-	-	(31,866)	6,897	6,897
Totals, Enforcement-Regional Offices	113.6	115.2	109.2	$8,788,309	$7,804,033	$7,567,569
Probation:						
Staff Svcs Mgr I	1.0	1.0	1.0	5,079-6,127	73,524	73,524
Assoc Govtl Prog Analyst	1.0	1.0	1.0	4,440-5,348	64,176	64,176
Insp III	3.0	3.0	3.0	3,763-4,525	162,472	162,900
Insp II	7.2	9.0	9.0	3,268-3,932	409,638	418,915
Investigator Asst	0.4	1.0	1.0	2,987-3,565	40,740	40,740
Insp I	5.4	7.0	7.0	2,877-3,424	284,386	286,392
Ofc Techn-Typing	0.8	1.0	1.0	2,686-3,264	33,572	35,250
Mgt Svcs Techn	2.0	2.0	2.0	2,495-3,426	82,224	82,224
Temporary Help	-	0.7	0.7	-	72,226	72,226
Overtime	-	-	-	(1,446)	862	862
Totals, Probation	20.8	25.7	25.7	$839,146	$1,223,820	$1,237,209
Totals, Medical Board	270.6	299.4	298.5	$14,744,002	$17,738,112	$17,932,318
Registered Dispensing Opticians:						
Staff Svcs Analyst-Gen	0.5	0.9	0.9	2,817-4,446	45,736	45,736
Totals, Registered Dispensing Opticians	0.5	0.9	0.9	$22,084	$45,736	$45,736
Totals, Medical Board of California	271.1	300.3	299.4	$14,766,086	$17,783,848	$17,978,054
Acupuncture Board						
Board Member (9)	-	-	-	100/day	7,463	7,463
Exec Ofcr	1.0	1.0	1.0	6,297-6,811	81,732	81,732
Assoc Govtl Prog Analyst	1.8	2.0	2.0	4,400-5,348	116,954	121,926
Special Investigator I (Non-Peace Officer)	-	0.8	1.0	3,902-5,363	35,118	48,580
Staff Svcs Analyst-Gen	2.2	2.0	2.0	2,817-4,446	103,162	105,649
Ofc Techn-Typing	2.7	3.0	3.0	2,686-3,264	108,767	112,996
Temporary Help	0.4	-	-	(8,153)	-	-
Totals, Acupuncture Board	8.1	8.8	9.0	$346,289	$453,196	$478,346
Physical Therapy Board of California						
Board Member (7)	-	-	-	100/day	11,786	11,786
Exec Ofcr	1.0	1.0	1.0	6,297-6,811	81,732	81,732
Staff Svcs Mgr I	1.0	2.0	2.0	5,079-6,127	134,472	137,524
Assoc Govtl Prog Analyst	5.5	8.2	9.1	4,400-5,348	461,006	527,633
Special Investigator I (Non-Peace Officer)	-	0.4	0.5	3,902-5,363	17,559	24,290
Staff Svcs Analyst-Gen	2.1	3.3	3.3	2,817-4,446	141,690	146,574
Ofc Techn-Typing	1.3	1.6	2.1	2,686-3,264	57,155	77,152
Temporary Help	9.5	0.3	0.3	(301,329)	3,767	3,767
Overtime	-	-	-	(8,819)	-	-
Totals, Physical Therapy Board of California	20.4	16.8	18.3	$862,098	$909,167	$1,010,458
Physician Assistant Committee						
Committee Members (9)	-	-	-	100/day	16,000	16,000
Exec Ofcr	1.0	1.0	1.0	6,297-6,811	81,732	81,732
Assoc Govtl Prog Analyst	2.0	2.4	2.5	4,400-5,348	148,152	155,742
Staff Svcs Analyst-Gen	1.0	1.0	1.0	2,817-4,446	53,352	53,352
Mgt Svcs Techn	0.5	0.5	0.5	2,495-3,426	20,556	20,556

<u>Agenda Item 8d – Senate Bill 100 (Price)</u>
<u>Task Force on Outpatient Surgery Settings</u>

Bullet 1 – Website

Pages 1-3

Home » Outpatient Surgery 20130520

Outpatient Surgery Settings

QUICK LINKS:
- A-Z Index
- Address of Record
- Continuing Medical Education
- Duplicate License/Certificate
- Fictitious Name Permit
- License Renewal
- License Verification (formerly known as Letters of Good Standing)
- Online Licensing for Physicians and Surgeons
- Ordering Public Documents
- State Job Opportunities for Physicians

WHO MUST BE ACCREDITED OR LICENSED?

California law prohibits physicians from performing some outpatient surgery, unless it is performed in an accredited or licensed setting.

Section 2216 of the Business and Professions Code (B&P) specifies that 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 Health and Safety Code 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 Health and Safety Code Section 1248 shall apply.

ACCREDITED OUTPATIENT SURGERY SETTINGS:

Pursuant to the enactment of SB 100, effective January 1, 2012, **Health and Safety Code (H&S) Section 1248.2 (b), (c), and (d)** now provides that the Board shall obtain and maintain a list of accredited outpatient settings from the information provided by the accreditation agencies approved by the Board. The Board 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 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

Disclaimer

The information contained in the Outpatient Surgery Setting Database has been received from an approved accreditation agency in accordance with the provisions of Section 1248.2 of the H&S Code and, pursuant to that section, is displayed on the Board's Internet site. The Board cannot guarantee the accuracy of the information provided. Upon receipt of updated information from an accreditation agency, the information will be made available in the database.

Search for an Outpatient Surgery Setting

- Outpatient Surgery Settings FAQS
- Outpatient Setting Complaint Overview/Process
- Consumer Complaint Form
- Consumer Complaint Form

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agency.

4. The effective and expiration dates of the accreditation.

Accrediting agencies approved by the Board shall notify the Board and update the Board on all outpatient settings that are accredited.

As outlined in **Health and Safety Code (H&S) Section 1248.1** certain outpatient surgery settings are excluded from the accreditation requirement, such as ambulatory surgical centers certified to participate in the Medicare program under Title XVIII, health facilities licensed as general acute care hospitals, federally operated clinics, facilities on recognized tribal reservations, and facilities used by dentists or physicians in compliance with Article 2.7 or Article 2.8 of Chapter 4 of Division 2 of the B&P Code.

For further information concerning this law, or for assistance in determining accreditation or licensure of an outpatient surgery setting, please contact Susan Morrish, Licensing Program Analyst, at (916) 263-2393 or susan.morrish@mbc.ca.gov.

The Board currently approves the following Accreditation Agencies:

Amercian Association for Accreditation of Ambulatory Surgery Facilities Inc. (AAAASF)
5101 Washington Street, Suite 2F, Gurnee, IL 60031
Telephone #: (847) 775-1970
Fax #: (847) 775-1985
www.aaaasf.org

Accreditation Association for Ambulatory Health Care (AAAHC)
5200 Old Orchard Road, Suite 200, Skokie, IL 60077
Telephone #: (847) 853-6063 or (847) 853-6060
Fax #: (847) 853-9028
www.aaahc.org

The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
Telephone #: (630) 792-5261
Fax #: (630) 792-5005
www.jointcommission.org

Institute for Medical Quality (IMQ)
221 Main Street, suite 210, San Francisco, CA 94105
Telephone #: (415) 882-5173
Fax #: (415) 882-5149
www.imq.org

(Spanish)

Types of Settings Not Required on List

Note: When completing the complaint form, please put the name of the outpatient setting in the "Other" box

LICENSED OUTPATIENT SURGERY SETTINGS:

To find out if an outpatient surgery setting is licensed by the California Department of Public Health, click HERE.

CENTERS FOR MEDICAL & MEDICAID SERVICES (CMS):

- CMS - Acronyms
- CMS - Glossary
- CMS - Approved Accreditation Organization Contact Information
- CMS – Accrediting Organization Complaint Contacts

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<u>Agenda Item 8d – Senate Bill 100 (Price)</u>
<u>Task Force on Outpatient Surgery Settings</u>

Bullet 2 - Complaint Process

Pages 4-10

SB 100 – Outpatient Surgery Settings

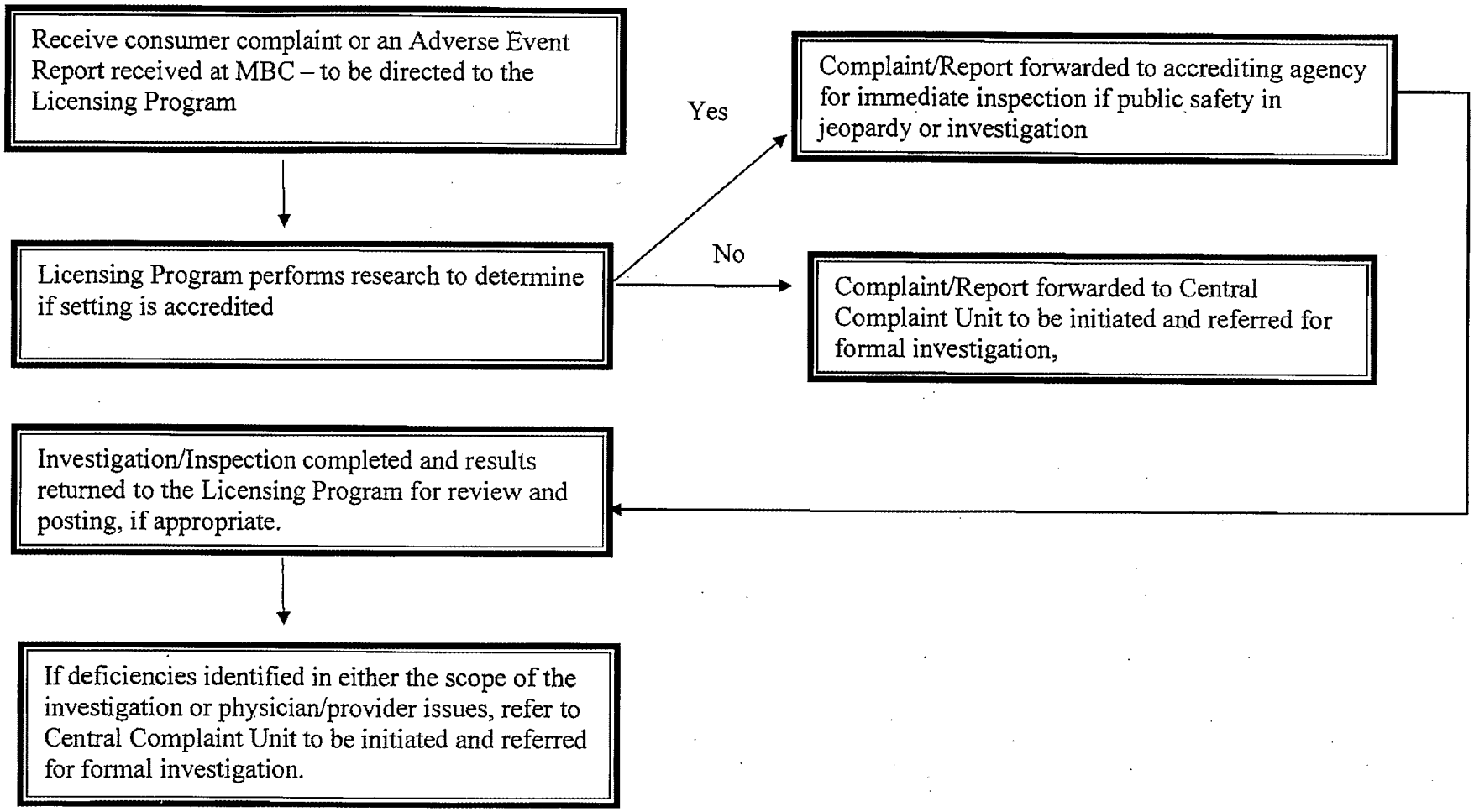
The bill requires MBC to maintain and publish a list of all accredited outpatient settings and provide information regarding the status of their accreditation. This portion of the statutory requirements is assigned to the Licensing Program and the status of implementation was reported directly to the Licensing Committee.

SB 100 also required the Medical Board to investigate complaints related to a violation of Health and Safety Code Section 1248 and, upon discovery that an outpatient setting is not in compliance with a specific provision, bring an action through or in conjunction with a district attorney to enjoin the outpatient setting's operation. In addition, SB 100 made outpatient settings subject to the adverse event reporting requirements currently required for licensing health facilities. Adverse events are reported to the Department of Public Health and the setting can be subject to penalties by Public Health for failing to report adverse events.

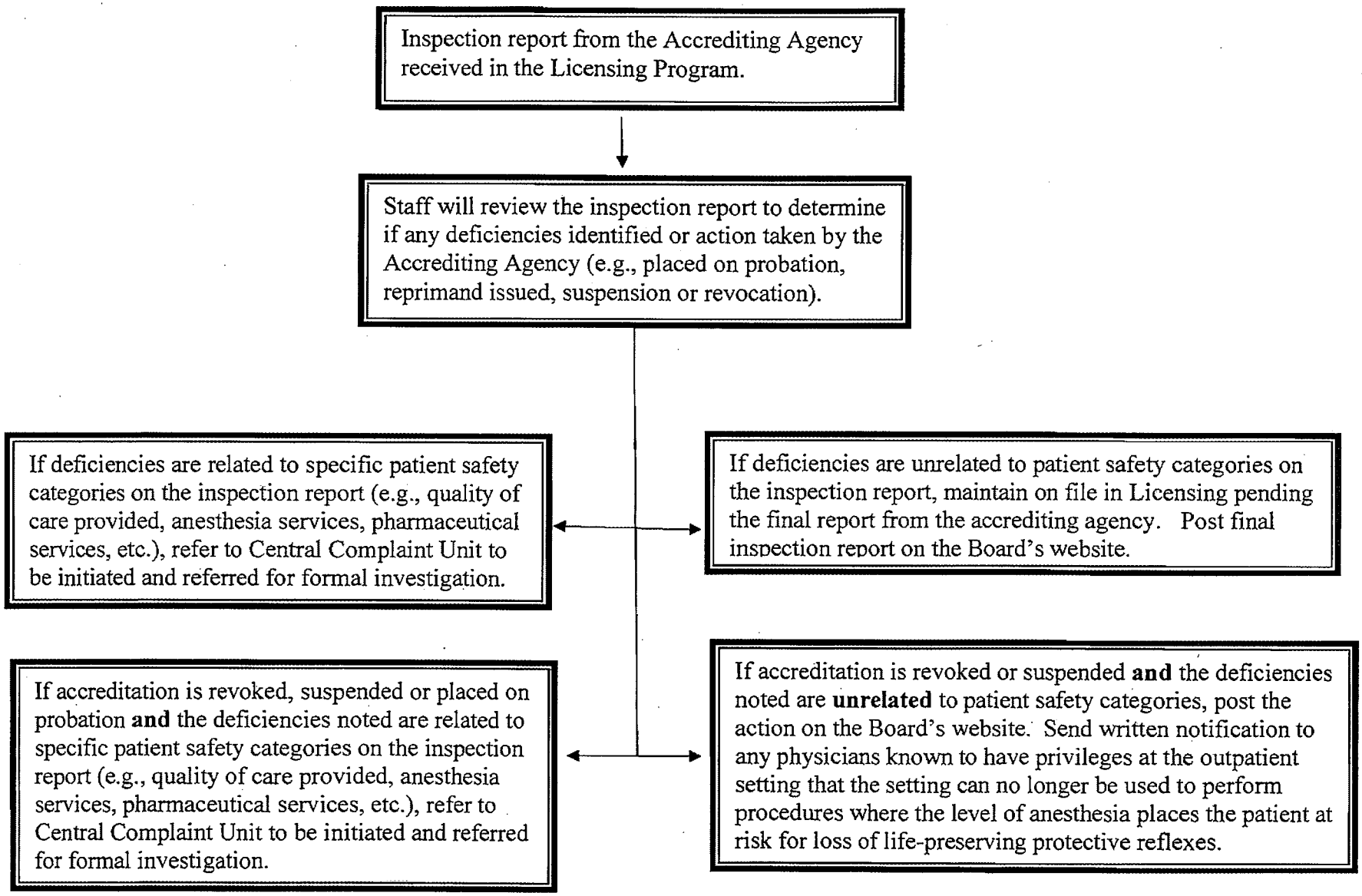
The following identifies the responsibilities assigned in statute to pertinent entities as it relates to oversight and response to patient care concerns:

H & S Section	Accrediting Agency	Medical Board
1248.35	Every outpatient setting shall be inspected no less often than 3 years.	May inspect the setting as often as necessary and shall ensure the accrediting agency conducts the required inspection
	If the results of the inspection conclude that the setting is out of compliance, they must issue a deficiency report and may 1) require correction, 2) issue a reprimand; 3) place the setting on probation; or 4) suspend or revoke the accreditation.	The accrediting agency must report within 24 hours if the setting has been issued a reprimand, been placed on probation or had the accreditation suspended or revoked.
	Shall inspect the setting within 24 hours upon receipt of a complaint from the Board that the setting poses an immediate risk to the public	Shall receive the findings of the inspection within five business days
	Shall investigate any complaint received from the Board within 30 days	Shall receive the findings of the investigation within 30 days
		Reports on the results of any inspection shall be maintained on file and final inspection reports shall be public record open to public inspection.
1248.7		Shall investigate all complaints concerning a violation of this chapter and, where appropriate, through or in conjunction with a DA may bring action to enjoin the setting's operation.

Complaint Process



Enforcement Response to Action taken by an Accrediting Agency



MEDICAL BOARD OF CALIFORNIA
Executive Office

December 11, 2012

Ron Chapman, MD, MPH, Director
California Department of Public Health
PO Box 997377, MS 0500
Sacramento, CA 95899-7377

Re: Adverse Outcome Reports

Dear Director Chapman:

As Executive Director of the Medical Board of California (Board), I write to request the assistance of the California Department of Public Health (CDPH) regarding the implementation of Senate Bill 100 (Ch. 645, Stats. 2011). As you are aware, key provisions of SB 100 require outpatient surgery settings to report adverse events to CDPH.

This reporting requirement has created some challenges because CDPH, following the *Capen* decision, may not have jurisdiction over an outpatient setting for which it receives an adverse report, as that setting may be accredited by an accrediting agency approved by the Board.

It is the Board's understanding that CDPH has received several adverse event reports for accredited (but not CDPH – licensed) settings, but has not yet transmitted those reports to the Medical Board. This is due to the lack of an executed Memorandum of Understanding (MOU) between the two agencies, that CDPH believes is necessary. CDPH has advised the Board that it has MOU's drafted for other agencies and will provide the Board with an MOU for the Board's review. Please be advised that the Board is committed to reviewing the CDPH MOU promptly to execute this agreement.

While the MOU is being completed, it would seem that public policy and consumer protection would best be served by having CDPH promptly dispatch those reports to the Board, since current statute already allows government agencies to share information. The Board and CDPH have been sharing information in the past without an MOU. Accordingly, the Board hereby requests that CDPH transmit to the Board for review and assessment any of these adverse events reports that it has found to be non-jurisdictional to CDPH. The Board, as a health oversight agency, will treat the reports as confidential to the extent permitted by law.

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2389 Fax (916) 263-2387 www.mbc.ca.gov

I thank you for your attention to this request. Please have your staff contact Curtis (Curt) Worden, Chief of Licensing at (916) 274-2986 or by email Curt.Worden@mbc.ca.gov or Susan Cady, Manager, Enforcement Program, Central Complaint Unit (916) 263-2644 or by email Susan.Cady@mbc.ca.gov or you may contact me directly if you have any questions on this matter.

Sincerely,

Linda K. Whitney
Executive Director

cc: Curtis Worden, Chief of Licensing
A. Renee Threadgill, Chief of Enforcement
Susan Cady, Manager, Enforcement Program, Central Compliant Unit

State of California—Health and Human Services Agency
California Department of Public Health

RON CHAPMAN, MD, MPH
Director & State Health Officer

EDMUND G. BROWN JR.
Governor

April 15, 2013

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

Dear Ms. Whitney:

Thank you for your letter to the California Department of Public Health (CDPH) concerning the reporting of adverse events of accredited outpatient surgery settings. I apologize for the delay in responding to your inquiry.

As requested in your letter, you are seeking to have CDPH transmit to the Medical Board of California (Board), any reportable adverse event reports that have been received from accredited, but not CDPH licensed, outpatient surgery settings. In response to your request, CDPH's Licensing and Certification (L&C) Program has researched their database and identified six (6) adverse events in outpatient surgery centers that meet this request; these will be referred to the Board.

We have determined that L&C can provide adverse event incident information to the Board without the need for a Data Use Agreement (DUA) between the Board and the Centers for Medicare and Medicaid Services (CMS), as long as the information provided does not include specific patient identifier information. A representative from our Systems Technology and Research (STAR) Branch will be in contact with information on applying for a DUA with CMS should you be interested in details that include patient identifiers.

The Board must determine if an Inter-Agency Agreement (IAA) is necessary to notify L&C of enforcement actions the Board may take or if the Board becomes aware of failures to report an adverse event to L&C. Please contact our Office of Legal Services if an IAA must be developed.

-Continued on next page-

If you have additional questions regarding this matter, please contact Scott Vivona, Chief of Field Operations of L&C, at (916) 440-7377.

Sincerely,

Debby Rogers, RN, MS, FAEN
Deputy Director

<u>Agenda Item 8d – Senate Bill 100 (Price)</u>
<u>Task Force on Outpatient Surgery Settings</u>

Bullet 3 – Accreditation Standards

Pages 11-16

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: May 23, 2013
ATTENTION: Board Members
SUBJECT: Outpatient Surgery Settings; Accreditation Standards

STAFF CONTACT: Curtis J. Worden, Chief of Licensing

PURPOSE:

To provide the Board members with information regarding the standards established in law and regulation for the accreditation of outpatient settings at which a certain level of anesthesia is administered to patients. The Board's Outpatient Setting Task Force will be reviewing these standards in the future to make a recommendation to the Board members regarding the need for possible revisions to existing statute or new regulations.

BACKGROUND:

The Medical Board of California (Board) is the state agency charged with the responsibility of licensing and disciplining physicians and surgeons. Additionally, the Board is charged with the responsibility of adopting standards for the accreditation of outpatient settings, and these standards are to be used by accreditation agencies. The Board currently has four approved accreditation agencies.

SUMMARY:

State law requires the Board to adopt standards for accreditation of outpatient surgery settings, and the outpatient surgery settings standards can be found in Health and Safety Code (H&S) §1248.15 (Attachment 1).

Please note that the outpatient surgery setting standards are minimum standards and the Board may adopt regulations that clarify/define the accreditation criteria [Attachment 1, H&S § 1248.15(a)]. Each accreditation agency approved by the Board must use these standards as minimum criteria for accreditation but may utilize more comprehensive criteria.

Accreditation agencies may have additional standards that an outpatient surgery setting must meet to receive accreditation by that specific accreditation agency, that is in addition to the minimum standards pursuant to H&S § 1248.15.

Note: An outpatient surgery setting may elect to be accredited by more than one accreditation agency.

The Board also has the authority to adopt regulations on outpatient surgery settings that offer in vitro fertilization services and may also adopt regulations regarding procedures that should be performed in licensed or accredited outpatient surgery setting [Attachment 1, H&S § 1248.15 (e) and (f)].

Due to time constraints, Board staff has not had the time to research and prepare a side-by-side comparison of each of the approved accreditation agencies' additional standards. Staff will be working on obtaining that information if it is available to the Board's staff for the July meeting.

Staff recommends obtaining input from the approved accreditation agencies to determine what the accreditation agencies may have identified as additional minimum standards that they use that the Board may wish to consider for possible development of additional regulations for consumer protection.

ATTACHMENT 1

HEALTH AND SAFETY CODE

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.)

Regulatory Authority for the Disciplinary Guidelines

California Code of Regulations
Title 16. Professional and Vocational Regulations
Division 13. Medical Board of California
Chapter 2. Division of Medical Quality
Article 4 Disciplinary Guidelines
Section 1361. Disciplinary Guidelines.

"In reaching a decision on a disciplinary action under the Administrative Procedure Act (Government Code section 11400 et seq.), the Medical Board of California shall consider the disciplinary guidelines entitled "Manual of Model Disciplinary Orders and Disciplinary Guidelines" (11th Edition/2011) which are hereby incorporated by reference. Deviation from these orders and guidelines, including the standard terms of probation, is appropriate where the Medical Board of California in its sole discretion determines by adoption of a proposed decision or stipulation that the facts of the particular case warrant such a deviation -for example: the presence of mitigating factors; the age of the case; evidentiary problems."

Note: Authority cited: Section 2018, Business and Professions Code; and Section 11400.20, Government Code. Reference: Sections 2227, 2228, 2229 and 2234, Business and Professions Code; and Sections 11400.20 and 11425.50(e), Government Code.

HISTORY

1. Amendment of article heading and new section filed 5-1-97; operative 5-31-97 (Register 97, No. 18). For prior history, see Register 95, No. 33.

2. Amendment filed 1-27-2000; operative 2-26-2000 (Register 2000, No. 4).

3. Amendment of section and Note filed 9-29-2003; operative 10-29-2003 (Register 2003, No. 40).

4. Amendment filed 8-15-2008; operative 9-14-2008 (Register 2008, No. 33).

5. Amendment filed 12-12-2011; operative 1-11-2012 (Register 2011, No. 50).

State of California

State and Consumer Services Agency

MEDICAL BOARD OF CALIFORNIA
MANUAL OF MODEL DISCIPLINARY ORDERS AND DISCIPLINARY GUIDELINES

11th Edition

2011

STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA

State of California
State and Consumer Services Agency
MEDICAL BOARD OF CALIFORNIA
MANUAL OF MODEL DISCIPLINARY ORDERS
AND DISCIPLINARY GUIDELINES
11th Edition
2011
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA

The Board produced this Manual of Model Disciplinary Orders and Disciplinary Guidelines, 11th Edition for the intended use of those involved in the physician disciplinary process: Administrative Law Judges, defense attorneys, physicians-respondents, trial attorneys from the Office of the Attorney General, and the Board's disciplinary panel members who review proposed decisions and stipulations and make final decisions. These guidelines are not binding standards.

The Federation of State Medical Boards and other state medical boards have requested and received this manual. All are welcome to use and copy any part of this material for their own work.

For additional copies of this manual, please write to the address below or visit http://www.medbd.ca.gov/publications/disciplinary_guide.pdf:

Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
Phone (916) 263-2466

Revisions to the Manual of Model Disciplinary Orders and Disciplinary Guidelines are made periodically. Listed below are the most recent changes included in the 11th edition approved by the Board following open discussion at a public meeting.

Summary of Changes

The former "Disciplinary Guidelines – Index" printed after the last "Standard Conditions" has been moved to the Table of Contents (a formatting change only) and has been renamed the "Recommended Range of Penalties for Violations" for clarity.

Model Condition Number:

5. Controlled Substances – Total Restriction
Eliminated the term "good faith" prior examination to reflect amendments made to statute that now requires an "appropriate prior examination and a medical indication" and adds "furnish" to the list of prohibited activities.

7. Controlled Substances – Partial Restriction
Eliminated the term “good faith” prior examination to reflect amendments made to statute that now requires an “appropriate prior examination and a medical indication” and adds “furnish” to the list of prohibited activities.

8. Controlled Substances - Maintain Records and Access To Records and Inventories
Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation.

9. Controlled Substances - Abstain From Use
Added language that respondent shall cease the practice of medicine based upon a positive biological fluid test and that the Board must meet time requirements for filing an Accusation and/or Petition to Revoke and hold a hearing.

10. Alcohol - Abstain From Use
Added language that respondent shall cease the practice of medicine based upon a positive biological fluid test and that the Board must meet requirements for filing an Accusation and/or Petition to Revoke and hold a hearing.

11. Biological Fluid Testing
Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation. Expands the parameters of biological fluid testing to include various testing mechanisms. Added language that respondent shall cease the practice of medicine for failing to cooperate with biological fluid testing and that the Board must meet requirements for filing an Accusation and/or Petition to Revoke and hold a hearing.

12. Community Service - Free Services
Reworded the language regarding non-medical community service.

13. Education Course
Deleted language limiting the education program or course to classroom, conference or seminar settings.

14. Prescribing Practices Course
Added language to require the course be equivalent to the course offered at the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine. Also added language requiring the respondent to provide pertinent documents to the program and amended the language regarding completion of the course.

15. Medical Record Keeping Course
Added language to require the course be equivalent to the course offered at the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine. Also added language requiring the respondent to provide pertinent documents to the program and amended the language regarding completion of the course.

16. Professionalism Program (Ethics Course)
Amended the name and language to comport with subsequent regulations setting requirements for a professionalism program (previously referred to as an ethics course). Also added

language requiring the respondent to provide pertinent documents to the program and amended the language regarding completion of the course.

17. Professional Boundaries Program
Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation. Added language permitting discretionary acceptance of a course taken prior to the effective date of the decision.

18. Clinical Training Program
Amended the language regarding completion of program and replaced the terms specialty and sub specialty with area of practice in which respondent was deficient.
Added language that respondent shall cease the practice of medicine for failing to successfully complete the clinical training program. Also eliminated the subsequent optional term and made it a requirement.

19. Oral or Written Examination
Added that if the examination is an oral examination, it is to be administered in accordance with Business and Professions Code section 2293(a) and (b). Also eliminated the subsequent optional term and made it a requirement. Made technical changes.

20. Psychiatric Evaluation
Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation.

21. Psychotherapy
Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation.

22. Medical Evaluation and Treatment
Added language requiring the respondent to provide pertinent documents/information to the evaluating physician. Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation.

23. Monitoring - Practice/Billing
Restructured the formatting to clarify the type of monitor required. Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation. Added language that respondents shall cease the practice of medicine until they obtain a monitor if they do not meet the required timeline for obtaining a monitor.

24. Solo Practice Prohibition
Clarified the title to show it was a prohibition and clarified what constitutes solo practice. Added language that respondent shall cease the practice of medicine for failing to secure an approved practice setting within 60 days.

25. Third Party Chaperone
Restructured the formatting to clarify the type of patient in which respondent is required to have a chaperone. Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation. In addition, language was added prohibiting employment termination of a chaperone for reporting to the Board. Added language that respondent shall cease the practice of medicine for failing to have an approved third-party chaperone.

26. Prohibited Practice
Restructured the formatting of the condition to clarify the type of practice prohibition and to require that all patients be notified of prohibition. Deleted language that required a written notification in addition to oral. Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation.

27. Notification
Required notification to be within seven days of the effective date of the decision rather than prior to practicing medicine.

28. Supervision of Physician Assistants
No change.

29. Obey All Laws
No change**.**

30. Quarterly Declarations
No change.

31. General Probation Requirements
Reformatted the conditions and added clarification regarding notification of residence or practice out-of-state and of email and telephone number.

32. Interview with the Board or its designee
Reworded for clarity.

***Formerly* 33. Residing or Practicing Out-of-State**
Deleted condition due to combining conditions 33 and 34 to clarify non-practice regardless of physician location.

***Formerly* 34. Failure to Practice Medicine- California Resident**
Deleted condition due to combining conditions 33 and 34 to clarify non-practice regardless of physician location.

New 33. Non-Practice While on Probation
Combined former conditions #33 and #34. Clarified non-practice regardless of physician location. Added clinical training for non-practice of more than 18 calendar months, defined non-practice, and required physician to practice in two years.

34. Completion of Probation
Formerly # 35, it is re-numbered to reflect the combination of conditions #33 and #34. Reference to “cost recovery” is deleted condition due to elimination of authority to order cost recovery. See Business and Professions Code section 125.3(k).

35. Violation of Probation
Formerly # 36, it is re-numbered to reflect the combination of conditions #33 and #34.

***Formerly* 37. Cost Recovery**
Deleted condition due to elimination of authority to order cost recovery. See Business and Professions Code section 125.3(k).

36. License Surrender
Formerly 38, it is re-numbered to reflect the combination of conditions #33 and #34 and the deletion of condition #37. Also, reworded for clarity.

37. Probation Monitoring Costs
Formerly 39, it is re-numbered to reflect the combination of conditions #33 and #34 and the deletion of condition #37. Also, deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation.

STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
MANUAL OF MODEL DISCIPLINARY ORDERS AND DISCIPLINARY GUIDELINES

Business and Professions Code section 2229 mandates protection of the public shall be the highest priority for the Medical Board and for the Administrative Law Judges of the Medical Quality Hearing Panel. Section 2229 further specifies that, to the extent not inconsistent with public protection, disciplinary actions shall be calculated to aid in the rehabilitation of licensees. To implement the mandates of section 2229, the Board has adopted the Manual of Model Disciplinary Orders and Disciplinary Guidelines (guidelines), 11th Edition. Consistent with the mandates of section 2229, these guidelines set forth the discipline the Board finds appropriate and necessary for the identified violations. In addition to protecting the public and, where not inconsistent, rehabilitating the licensee, the Board finds that imposition of the discipline set forth in the guidelines will promote uniformity, certainty and fairness, and deterrence, and, in turn, further public protection.

The Board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility, demonstrated willingness to undertake Board- ordered rehabilitation, the age of the case, and evidentiary problems, Administrative Law Judges hearing cases on behalf of the Board and proposed settlements submitted to the Board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

The Model Disciplinary Orders contain three sections: three (3) Disciplinary Orders; twenty-three (23) Optional Conditions whose use depends on the nature and circumstances of the particular case; and eleven (11) Standard Conditions that generally appear in all probation cases. All orders should place the Disciplinary Order(s) first, Optional Condition(s) second, and Standard Condition(s) third.

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MODEL DISCIPLINARY ORDERS

1. Revocation - Single Cause

Certificate No._____ issued to respondent _____ is revoked.

2. Revocation - Multiple Causes

Certificate No. _____ issued to respondent _____ is revoked pursuant to determination of Issues (e.g. I, II, and III), separately and for all of them.

3. Standard Stay Order

However, revocation stayed and respondent is placed on probation for (e.g., ten) years upon the following terms and conditions.

OPTIONAL CONDITIONS

4. Actual Suspension

As part of probation, respondent is suspended from the practice of medicine for (e.g., 90 days) beginning the sixteenth (16th) day after the effective date of this decision.

5. Controlled Substances - Total Restriction

Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined in the California Uniform Controlled Substances Act.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5.

If respondent forms the medical opinion, after an appropriate prior examination and a medical indication, that a patient's medical condition may benefit from the use of marijuana, respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and a medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, respondent shall inform the patient or the patient's primary caregiver that respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

6. Controlled Substances - Surrender of DEA Permit

Respondent is prohibited from practicing medicine until respondent provides documentary proof to the Board or its designee that respondent's DEA permit has been surrendered to the Drug Enforcement Administration for cancellation, together with any state prescription forms and all controlled substances order forms. Thereafter, respondent shall not reapply for a new DEA permit without the prior written consent of the Board or its designee.

7. Controlled Substances - Partial Restriction

Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substances Act, except for those drugs listed in Schedule(s)_____(e.g., IV and V) of the Act.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If respondent forms the medical opinion, after an appropriate prior examination and medical indication, that a patient's medical condition may benefit from the use of marijuana, respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, respondent shall inform the patient or the patient's primary caregiver that respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

Note: Also use Condition 8, which requires that separate records be maintained for all controlled substances prescribed.

(Option)
Respondent shall immediately surrender respondent's current DEA permit to the Drug Enforcement Administration for cancellation and reapply for a new DEA permit limited to those Schedules authorized by this order. Within 15 calendar days after the effective date of this Decision, respondent shall submit proof that respondent has surrendered respondent's DEA permit to the Drug Enforcement Administration for cancellation and re-issuance. Within 15 calendar days after the effective date of issuance of a new DEA permit, respondent shall submit a true copy of the permit to the Board or its designee.

8. Controlled Substances- Maintain Records and Access to Records and Inventories

Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the

personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all the following: 1) the name and address of patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

9. Controlled Substances - Abstain From Use

Respondent shall abstain completely from the personal use or possession of controlled substances as defined in the California Uniform Controlled Substances Act, dangerous drugs as defined by Business and Professions Code section 4022, and any drugs requiring a prescription. This prohibition does not apply to medications lawfully prescribed to respondent by another practitioner for a bona fide illness or condition.

Within 15 calendar days of receiving any lawfully prescribed medications, respondent shall notify the Board or its designee of the: issuing practitioner's name, address, and telephone number; medication name, strength, and quantity; and issuing pharmacy name, address, and telephone number.

If respondent has a confirmed positive biological fluid test for any substance (whether or not legally prescribed) and has not reported the use to the Board or its designee, respondent shall receive a notification from the Board or its designee to immediately cease the practice of medicine. The respondent shall not resume the practice of medicine until final decision on an accusation and/or a petition to revoke probation. An accusation and/or petition to revoke probation shall be filed by the Board within 15 days of the notification to cease practice. If the respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide the respondent with a hearing within 30 days of the request, unless the respondent stipulates to a later hearing. A decision shall be received from the Administrative Law Judge or the Board within 15 days unless good cause can be shown for the delay. The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within 15 days of the issuance of the notification to cease practice or does not provide respondent with a hearing within 30 days of a such a request, the notification of cease practice shall be dissolved.

10. Alcohol - Abstain From Use

Respondent shall abstain completely from the use of products or beverages containing alcohol.

If respondent has a confirmed positive biological fluid test for alcohol, respondent shall receive a notification from the Board or its designee to immediately cease the practice of medicine. The respondent shall not resume the practice of medicine until final decision on an accusation and/or a petition to revoke probation. An accusation and/or petition to revoke probation shall be filed by the Board within 15 days of the notification to cease practice. If the respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide the respondent with a hearing within 30 days of the request, unless the respondent stipulates to a later hearing. A decision shall be received from the Administrative Law Judge or the Board

within 15 days unless good cause can be shown for the delay. The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within 15 days of the issuance of the notification to cease practice or does not provide respondent with a hearing within 30 days of a such a request, the notification of cease practice shall be dissolved.

11. Biological Fluid Testing

Respondent shall immediately submit to biological fluid testing, at respondent's expense, upon request of the Board or its designee. "Biological fluid testing" may include, but is not limited to, urine, blood, breathalyzer, hair follicle testing, or similar drug screening approved by the Board or its designee. Prior to practicing medicine, respondent shall contract with a laboratory or service approved in advance by the Board or its designee that will conduct random, unannounced, observed, biological fluid testing. The contract shall require results of the tests to be transmitted by the laboratory or service directly to the Board or its designee within four hours of the results becoming available. Respondent shall maintain this laboratory or service contract during the period of probation.

A certified copy of any laboratory test result may be received in evidence in any proceedings between the Board and respondent.

If respondent fails to cooperate in a random biological fluid testing program within the specified time frame, respondent shall receive a notification from the Board or its designee to immediately cease the practice of medicine. The respondent shall not resume the practice of medicine until final decision on an accusation and/or a petition to revoke probation. An accusation and/or petition to revoke probation shall be filed by the Board within 15 days of the notification to cease practice. If the respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide the respondent with a hearing within 30 days of the request, unless the respondent stipulates to a later hearing. A decision shall be received from the Administrative Law Judge or the Board within 15 days unless good cause can be shown for the delay. The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within 15 days of the issuance of the notification to cease practice or does not provide respondent with a hearing within 30 days of a such a request, the notification of cease practice shall be dissolved.

12. Community Service - Free Services

[Medical community service shall only be authorized in cases not involving quality of care.]

Within 60 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval a community service plan in which respondent shall within the first 2 years of probation, provide_____ hours of free services (e.g., medical or nonmedical) to a community or non-profit organization. If the term of probation is designated for 2 years or less, the community service hours must be completed not later than 6 months prior to the completion of probation.

Prior to engaging in any community service respondent shall provide a true copy of the Decision(s) to the chief of staff, director, office manager, program manager, officer, or the chief executive officer at every community or non-profit organization where respondent provides community service and shall submit proof of compliance to the Board or its designee within 15 calendar days. This condition shall also apply to any change(s) in community service.

Community service performed prior to the effective date of the Decision shall not be accepted in fulfillment of this condition.

13. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

14. Prescribing Practices Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices equivalent to the Prescribing Practices Course at the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

15. Medical Record Keeping Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping equivalent to the Medical Record Keeping Course offered by the

Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

16. Professionalism Program (Ethics Course)

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

17. Professional Boundaries Program

Within 60 calendar days from the effective date of this Decision, respondent shall enroll in a professional boundaries program equivalent to the Professional Boundaries Program offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine ("Program"). Respondent, at the Program's discretion, shall undergo and complete the Program's assessment of respondent's competency, mental health and/or neuropsychological performance, and at minimum, a 24 hour program of interactive education and training in the area of boundaries, which takes into account data obtained from the

assessment and from the Decision(s), Accusation(s) and any other information that the Board or its designee deems relevant. The Program shall evaluate respondent at the end of the training and the Program shall provide any data from the assessment and training as well as the results of the evaluation to the Board or its designee.

Failure to complete the entire Program not later than six (6) months after respondent's initial enrollment shall constitute a violation of probation unless the Board or its designee agrees in writing to a later time for completion. Based on respondent's performance in and evaluations from the assessment, education, and training, the Program shall advise the Board or its designee of its recommendation(s) for additional education, training, psychotherapy and other measures necessary to ensure that respondent can practice medicine safely. Respondent shall comply with Program recommendations. At the completion of the Program, respondent shall submit to a final evaluation. The Program shall provide the results of the evaluation to the Board or its designee. The professional boundaries program shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

The Program has the authority to determine whether or not respondent successfully completed the Program.

A professional boundaries course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

(Option # 1: Condition Precedent)
Respondent shall not practice medicine until respondent has successfully completed the Program and has been so notified by the Board or its designee in writing.

(Option # 2: Condition Subsequent)
If respondent fails to complete the Program within the designated time period, respondent shall cease the practice of medicine within three (3) calendar days after being notified by the Board or its designee that respondent failed to complete the Program.

18. Clinical Training Program

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program"). Respondent shall successfully complete the Program not later than six (6) months after respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to respondent's area of practice in which respondent was alleged to be deficient, and at minimum, a 40 hour program of clinical education in the area of practice in which respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s),

Accusation(s), and any other information that the Board or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on respondent's performance and test results in the assessment and clinical education, the Program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination. Determination as to whether respondent successfully completed the examination or successfully completed the program is solely within the program's jurisdiction.

[**Note:** The following language shall be included in this condition unless Option #1 is included: If respondent fails to enroll, participate in, or successfully complete the clinical training program within the designated time period, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical training program have been completed. If the respondent did not successfully complete the clinical training program, the respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.]

(Option #1: Condition Precedent)
Respondent shall not practice medicine until respondent has successfully completed the Program and has been so notified by the Board or its designee in writing, except that respondent may practice in a clinical training program approved by the Board or its designee. Respondent's practice of medicine shall be restricted only to that which is required by the approved training program.

(Option #2)
Within 60 days after respondent has successfully completed the clinical training program, respondent shall participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation, or until the Board or its designee determines that further participation is no longer necessary.

19. Oral and/or Written Examination

[**NOTE:** This condition should **only** be used where a clinical training program is not appropriate.]

Within 60 calendar days of the effective date of this Decision, respondent shall take and pass an oral and/or written examination, administered by the Board or its designee. The Board or its designee shall designate a subject matter and administer the oral and/or written.

If the examination is an oral examination, it shall be conducted in accordance with section 2293(a) and (b) of the Code.

If respondent is required to take and pass a written exam, that examination shall be either the Special Purpose Examination (SPEX) or an equivalent examination as determined by the Board or its designee.

If respondent fails the first examination, respondent shall be allowed to take and pass a second examination.

Failure to pass the required oral and/or written examination within 180 calendar days after the effective date of this Decision is a violation of probation. Respondent shall pay the costs of all examinations.

[**Note:** The following language shall be included in this condition unless Option #1 is included: If respondent fails to pass the first examination, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not practice medicine until respondent successfully passes the examination, as evidenced by written notice to respondent from the Board or its designee.]

(Option 1: Condition Precedent)
Respondent shall not practice medicine until respondent has passed the required examination and has been so notified by the Board or its designee in writing. This prohibition shall not bar respondent from practicing in a clinical training program approved by the Board or its designee. Respondent's practice of medicine shall be restricted only to that which is required by the approved training program.
Note: The condition precedent option is particularly recommended in cases where respondent has been found to be incompetent, repeatedly negligent, or grossly negligent.

20. Psychiatric Evaluation

Within 30 calendar days of the effective date of this Decision, and on whatever periodic basis thereafter may be required by the Board or its designee, respondent shall undergo and complete a psychiatric evaluation (and psychological testing, if deemed necessary) by a Board-appointed board certified psychiatrist, who shall consider any information provided by the Board or designee and any other information the psychiatrist deems relevant, and shall furnish a written evaluation report to the Board or its designee. Psychiatric evaluations conducted prior to the effective date of the Decision shall not be accepted towards the fulfillment of this requirement. Respondent shall pay the cost of all psychiatric evaluations and psychological testing.

Respondent shall comply with all restrictions or conditions recommended by the evaluating psychiatrist within 15 calendar days after being notified by the Board or its designee.

(Option: Condition Precedent)
Respondent shall not engage in the practice of medicine until notified by the Board or its designee that respondent is mentally fit to practice medicine safely. The period of time that respondent is not practicing medicine shall not be counted toward completion of the term of probation.

21. Psychotherapy

Within 60 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval the name and qualifications of a California-licensed

board certified psychiatrist or a licensed psychologist who has a doctoral degree in psychology and at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders. Upon approval, respondent shall undergo and continue psychotherapy treatment, including any modifications to the frequency of psychotherapy, until the Board or its designee deems that no further psychotherapy is necessary.

The psychotherapist shall consider any information provided by the Board or its designee and any other information the psychotherapist deems relevant and shall furnish a written evaluation report to the Board or its designee. Respondent shall cooperate in providing the psychotherapist any information and documents that the psychotherapist may deem pertinent.

Respondent shall have the treating psychotherapist submit quarterly status reports to the Board or its designee. The Board or its designee may require respondent to undergo psychiatric evaluations by a Board-appointed board certified psychiatrist. If, prior to the completion of probation, respondent is found to be mentally unfit to resume the practice of medicine without restrictions, the Board shall retain continuing jurisdiction over respondent's license and the period of probation shall be extended until the Board determines that respondent is mentally fit to resume the practice of medicine without restrictions.

Respondent shall pay the cost of all psychotherapy and psychiatric evaluations.

Note: This condition is for those cases where the evidence demonstrates that the respondent has had impairment (impairment by mental illness, alcohol abuse and/or drug self-abuse) related to the violations but is not at present a danger to respondent's patients.

22. Medical Evaluation and Treatment

Within 30 calendar days of the effective date of this Decision, and on a periodic basis thereafter as may be required by the Board or its designee, respondent shall undergo a medical evaluation by a Board-appointed physician who shall consider any information provided by the Board or designee and any other information the evaluating physician deems relevant and shall furnish a medical report to the Board or its designee. Respondent shall provide the evaluating physician any information and documentation that the evaluating physician may deem pertinent.

Following the evaluation, respondent shall comply with all restrictions or conditions recommended by the evaluating physician within 15 calendar days after being notified by the Board or its designee. If respondent is required by the Board or its designee to undergo medical treatment, respondent shall within 30 calendar days of the requirement notice, submit to the Board or its designee for prior approval the name and qualifications of a California licensed treating physician of respondent's choice. Upon approval of the treating physician, respondent shall within 15 calendar days undertake medical treatment and shall continue such treatment until further notice from the Board or its designee.

The treating physician shall consider any information provided by the Board or its designee or any other information the treating physician may deem pertinent prior to commencement of treatment. Respondent shall have the treating physician submit quarterly reports to the Board or its designee indicating whether or not the respondent is capable of practicing medicine safely. Respondent shall provide the Board or its designee with any and all medical records pertaining to treatment, the Board or its designee deems necessary.

If, prior to the completion of probation, respondent is found to be physically incapable of resuming the practice of medicine without restrictions, the Board shall retain continuing jurisdiction over respondent's license and the period of probation shall be extended until the Board determines that respondent is physically capable of resuming the practice of medicine without restrictions. Respondent shall pay the cost of the medical evaluation(s) and treatment.

(Option- Condition Precedent)
Respondent shall not engage in the practice of medicine until notified in writing by the Board or its designee of its determination that respondent is medically fit to practice safely.

Note: This condition is for those cases where the evidence demonstrates that medical illness or disability was a contributing cause of the violations.

23. Monitoring - Practice/Billing

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as a _____[**insert:** practice, billing, or practice and billing] monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's _____ [**insert:** practice, billing, or practice and billing] shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standard~~s~~ of practice of _____[**insert:** medicine or billing, or both], and whether respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

24. Solo Practice Prohibition

Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) respondent is the sole physician practitioner at that location.

If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, the respondent's practice setting changes and the respondent is no longer practicing in a setting in compliance with this Decision, the respondent shall notify the Board or its designee within 5 calendar days of the practice setting change. If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume practice until an appropriate practice setting is established.

25. Third Party Chaperone

During probation, respondent shall have a third party chaperone present while consulting, examining or treating _____[**insert:** male, female, or minor] patients. Respondent shall, within 30 calendar days of the effective date of the Decision, submit to the Board or its designee for prior approval name(s) of persons who will act as the third party chaperone.

If respondent fails to obtain approval of a third party chaperone within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a chaperone is approved to provide monitoring responsibility.

Each third party chaperone shall sign (in ink or electronically) and date each patient medical record at the time the chaperone's services are provided. Each third party chaperone shall read the Decision(s) and the Accusation(s), and fully understand the role of the third party chaperone.

Respondent shall maintain a log of all patients seen for whom a third party chaperone is required. The log shall contain the: 1) patient initials, address and telephone number; 2) medical record number; and 3) date of service. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

Respondent is prohibited from terminating employment of a Board-approved third party chaperone solely because that person provided information as required to the Board or its designee.

If the third party chaperone resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name of the person(s) who will act as the third party chaperone. If respondent fails to obtain approval of a replacement chaperone within 60 calendar days of the resignation or unavailability of the chaperone, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement chaperone is approved and assumes monitoring responsibility.

(Option)

Respondent shall provide written notification to respondent's patients that a third party chaperone shall be present during all consultations, examination, or treatment with [**insert:** male, female or minor] patients. Respondent shall maintain in the patient's file a copy of the written notification, shall make the notification available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the notification for the entire term of probation.

26. Prohibited Practice

During probation, respondent is prohibited from _____ [**insert:** practicing, performing, or treating] _____[**insert:** a specific medical procedure; surgery; on a specific patient population]. After the effective date of this Decision, all patients being treated by the respondent shall be notified that the respondent is prohibited from _____ [**insert:** practicing, performing or treating] _____ [**insert:** a specific medical procedure; surgery; on a specific patient population]. Any new patients must be provided this notification at the time of their initial appointment.

Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

STANDARD CONDITIONS

27. Notification

Within seven (7) days of the effective date of this Decision, the respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

28. Supervision of Physician Assistants

During probation, respondent is prohibited from supervising physician assistants.

29. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

30. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

31. General Probation Requirements

Compliance with Probation Unit
Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes
Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice
Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal
Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California
Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

32. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

33. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

34. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

35. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

36. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his or her license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

37. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

RECOMMENDED RANGE OF PENALTIES FOR VIOLATIONS

DISCIPLINARY ACTION TAKEN BY OTHERS [B&P 141(a) & 2305]
Minimum penalty: Same for similar offense in California
Maximum penalty: Revocation

MISLEADING ADVERTISING (B&P 651 & 2271)
Minimum penalty: Stayed revocation, 1 year~~s~~ probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Education Course [13]
3. Professionalism Program (Ethics Course) [16]
4. Monitoring-Practice/Billing [23]
5. Prohibited Practice [26]

EXCESSIVE PRESCRIBING (B&P 725), or
PRESCRIBING WITHOUT AN APPROPRIATE PRIOR EXAMINATION (B&P 2242)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Controlled Substances-Total DEA restriction [5],
   Surrender DEA permit [6] or
   Partial DEA restriction [7]
3. Maintain Records and Access to Records and Inventories [8]
4. Education Course [13]
5. Prescribing Practices Course [14]
6. Medical Record Keeping Course [15]
7. Professionalism Program (Ethics Course) [16]
8. Clinical Training Program [18]
9. Monitoring-Practice/Billing [23]

EXCESSIVE TREATMENTS (B&P 725)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Education Course [13]
3. Medical Record Keeping Course [15]
4. Professionalism Program (Ethics Course) [16]
5. Clinical Training Program [18]
6. Monitoring-Practice/Billing [23]
7. Prohibited Practice [26]

SEXUAL MISCONDUCT (B&P 726)
Minimum penalty: Stayed revocation, 7 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Education Course [13]
3. Professionalism Program (Ethics Course) [16]
4. Professional Boundaries Program [17]
5. Psychiatric Evaluation [20]
6. Psychotherapy [21]
7. Monitoring-Practice/Billing [23]
8. Third Party Chaperone [25]
9. Prohibited Practice [26]

SEXUAL EXPLOITATION (B&P 729)
Minimum penalty: Revocation
Effective January 1, 2003, Business and Professions Code 2246 was added to read, "Any proposed decision or decision issued under this article that contains any finding of fact that the licensee engaged in any act of sexual exploitation, as described in paragraphs (3) to (5), inclusive, of subdivision (b) of Section 729, with a patient shall contain an order of revocation. The revocation shall not be stayed by the administrative law judge."

MENTAL OR PHYSICAL ILLNESS (B&P 820)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Oral or Written Examination [19]
2. Psychiatric Evaluation [20]
3. Psychotherapy [21]
4. Medical Evaluation and Treatment [22]
5. Monitoring-Practice/Billing [23]
6. Solo Practice Prohibition [24]
7. Prohibited Practice [26]

REGISTRATION AS A SEX OFFENDER (B&P 2232)
Minimum penalty: Revocation
Section 2232(a) of the Business and Professions Code provides that "Except as provided in subdivisions (b), (c), and (d), the board shall promptly revoke the license of any person who, at any time after January 1, 1947, has been required to register as a sex offender pursuant to the provisions of section 290 of the Penal Code."

GENERAL UNPROFESSIONAL CONDUCT (B&P 2234), or
GROSS NEGLIGENCE [B&P 2234 (b)], or
REPEATED NEGLIGENT ACTS [B&P 2234(c)], or
INCOMPETENCE [B&P 2234(d)], or
FAILURE TO MAINTAIN ADEQUATE RECORDS (B&P 2266)
Minimum penalty: Stayed revocation, 5 years probation
NOTE: In cases charging repeated negligent acts with one patient, a public reprimand may, in appropriate circumstances, be ordered.
Maximum penalty: Revocation

1. Education course [13]
2. Prescribing Practices Course [14]
3. Medical Record Keeping Course [15]
4. Professionalism Program (Ethics Course) [16]
5. Clinical Training Program [18]
6. Monitoring-Practice/Billing [23]
7. Solo Practice Prohibition [24]
8. Prohibited Practice [26]

DISHONESTY - Substantially related to the qualifications, functions or duties of a physician and surgeon and *arising from* or occurring during patient care, treatment, management or billing [B&P 2234(e)]
Minimum penalty: Stayed revocation, one year suspension at least 7 years probation
Maximum penalty: Revocation

1. Professionalism Program (Ethics Course) [16]
2. Psychiatric Evaluation [20]
3. Medical Evaluation [22]
4. Monitoring-Practice/Billing [23]
5. Solo Practice Prohibition [24]
6. Prohibited Practice [26]
7. Victim Restitution

DISHONESTY - Substantially related to the qualifications, function or duties of a physician and surgeon but *not arising from* or occurring during patient care, treatment, management or billing [BP 2234 (e)]
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Community Service [12]
3. Professionalism Program (Ethics Course) [16]
4. Psychiatric Evaluation [20]
5. Medical Evaluation [22]
6. Monitoring-Practice/Billing (if financial dishonesty or conviction of financial crime) [23]
7. Victim Restitution

PROCURING LICENSE BY FRAUD (B&P 2235)

1. Revocation [1] [2]

CONVICTION OF CRIME - Substantially related to the qualifications, functions or duties of a physician and surgeon and *arising from* or occurring during patient care, treatment, management or billing (B&P 2236)
Minimum penalty: Stayed revocation, one year suspension, at least 7 years probation
Maximum penalty: Revocation
1. Community Service [12]
2. Professionalism Program (Ethics Course) [16]
3. Psychiatric Evaluation [20]
4. Medical Evaluation and Treatment [22]
5. Monitoring-Practice/Billing [23]
6. Solo Practice Prohibition [24]
7. Prohibited Practice [26]
8. Victim Restitution

CONVICTION OF CRIME - Felony conviction substantially related to the qualifications, functions or duties of a physician and surgeon but *not arising from* or occurring during patient care, treatment, management or billing (B&P 2236)
Minimum penalty: Stayed revocation, 7 years probation
Maximum penalty: Revocation
1. Suspension of 30 days or more [4]
2. Community Service [12]
3. Professionalism Program (Ethics Course) [16]
4. Psychiatric Evaluation [20]
5. Medical Evaluation and Treatment [22]
6. Monitoring-Practice/Billing (if dishonesty or conviction of a financial crime) [23]
7. Victim Restitution

CONVICTION OF CRIME - Misdemeanor conviction substantially related to the qualifications, functions or duties of a physician and surgeon but *not arising from* or occurring during patient care, treatment, management or billing (B&P 2236)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Community Service [12]
2. Professionalism Program (Ethics Course) [16]
3. Psychiatric Evaluation [20]
4. Medical Evaluation and Treatment [22]
5. Victim Restitution

CONVICTION OF DRUG VIOLATIONS (B&P 2237), or
VIOLATION OF DRUG STATUTES (B&P 2238), or
EXCESSIVE USE OF CONTROLLED SUBSTANCES (B&P 2239), or
PRACTICE UNDER THE INFLUENCE OF NARCOTIC (B&P 2280)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Controlled Substances - Total DEA restriction [5],
   Surrender DEA permit [6], or
   Partial DEA restriction [7]

3. Maintain Drug Records and Access to Records and Inventories [8]
4. Controlled Substances - Abstain From Use [9]
5. Alcohol-Abstain from Use [10]
6. Biological Fluid Testing [11]
7. Education Course [13]
8. Prescribing Practices Course [14]
9. Medical Record Keeping Course [15]
10. Professionalism Program (Ethics Course) [16]
11. Psychiatric Evaluation [20]
12. Psychotherapy [21]
13. Medical Evaluation and Treatment [22]
14. Monitoring-Practice/Billing [23]
15. Prohibited Practice [26]

ILLEGAL SALES OF CONTROLLED SUBSTANCES (B&P 2238)
Revocation [1] [2]

EXCESSIVE USE OF ALCOHOL (B&P 2239) or
PRACTICE UNDER THE INFLUENCE OF ALCOHOL (B&P 2280)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Controlled Substances-Abstain From Use [9]
3. Alcohol-Abstain from Use [10]
4. Biological Fluid Testing [11]
5. Professionalism Program (Ethics Course) [16]
6. Psychiatric Evaluation [20]
7. Psychotherapy [21]
8. Medical Evaluation and Treatment [22]
9. Monitoring-Practice/Billing [23]

PRESCRIBING TO ADDICTS (B&P 2241)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Controlled Substances- Total DEA restriction [5],
   Surrender DEA permit [6], or
   Partial restriction [7]
3. Maintain Drug Records and Access to Records and Inventories [8]
4. Education Course [13]
5. Prescribing Practices Course [14]
6. Medical Record Keeping Course [15]
7. Professionalism Program (Ethics Course) [16]
8. Clinical Training Program [18]
9. Monitoring-Practice/Billing [23]
10. Prohibited Practice [26]

ILLEGAL CANCER TREATMENT (B&P 2252 and 2258)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Education course [13]
3. Prescribing Practices Course [14]
4. Professionalism Program (Ethics Course) [16]
5. Clinical Training Program [18]
6. Monitoring-Practice/Billing [23]
7. Prohibited Practice [26]

MAKING FALSE STATEMENTS (B&P 2261), or
ALTERATION OF MEDICAL RECORDS (B&P 2262)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Medical Record Keeping Course [15]
3. Professionalism Program (Ethics Course) [16]
4. If fraud involved, see “Dishonesty” guidelines

AIDING AND ABETTING UNLICENSED PRACTICE (B&P 2264)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Education Course [13]
3. Professionalism Program (Ethics Course) [16]
4. Monitoring-Practice/Billing [23]
5. Prohibited Practice [26]

FICTITIOUS NAME VIOLATION (B&P 2285)
Minimum penalty: Stayed revocation, one year probation
Maximum penalty: Revocation

IMPERSONATION OF APPLICANT IN EXAM (B&P 2288)
1. Revocation [1] [2]

PRACTICE DURING SUSPENSION (B&P 2306)
1. Revocation [1] [2]

BUSINESS ORGANIZATION IN VIOLATION OF CHAPTER (B&P 2417)
Minimum penalty: Revocation
Effective January 1, 2002, Business and Professions Code section 2417 was added to read, in part, "(b) A physician and surgeon who practices medicine with a business organization knowing that it is owned or operated in violation of Section 1871.4 of the Insurance Code, Section 14107 or 14107.2 of the Welfare and Institutions Code, or Section 549 or 550 of the Penal Code shall have his or her license to practice permanently revoked."

VIOLATION OF PROBATION
Minimum penalty: 30 day suspension
Maximum penalty: Revocation
The maximum penalty should be given for repeated similar offenses or for probation violations revealing a cavalier or recalcitrant attitude. A violation of any of the following conditions of probation should result in, at minimum, a 60 day suspension:

1. Controlled Substances -Maintain Records and Access to Records and Inventories [8]
2. Biological Fluid Testing [11]
3. Professional Boundaries Program [17]
4. Psychiatric Evaluation [20]
5. Psychotherapy [21]
6 Medical Evaluation and Treatment [22]
7 Third Party Chaperone [25]

It is the expectation of the Medical Board of California that the appropriate penalty for a physician who did not successfully complete a clinical training program ordered as part of his or her probation is revocation.