State of California
State and Consumer Services Agency

MEDICAL BOARD OF CALIFORNIA

EDUCATION AND WELLNESS COMMITTEE

July 17, 2013

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QUARTERLY BOARD MEETING

July 18-19, 2013

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MEDICAL BOARD OF CALIFORNIA
BOARD MEETING SCHEDULE

Courtyard by Marriott
Sacramento Cal Expo
1782 Tribute Road
Sacramento, CA 95815

July 17-19, 2013

Wednesday, July 17

- **1:00 p.m. – 5:00 p.m.** **Education & Wellness Committee**
  (Members: Yaroslavsky (Chair), Diego, Levine, Salomonson, Schipske)

Thursday, July 18

- **8:00 a.m. – 12:00 p.m.** **Panel A**
  (*Members: Yaroslavsky (Chair), Salomonson (Vice Chair), Bishop, Diego, Serrano Sewell, Yip)*

- **9:00 a.m. – 12:00 p.m.** **Panel B**
  (Members: Low (Chair), GnanaDev (Vice Chair), Levine, Pines, Schipske, Tagami)

- **12:00 p.m. – 1:00 p.m.** ***Lunch Break***

- **1:00 p.m. – 5:30 p.m.** **Full Board Meeting**
  (All Members)

Friday, July 19

- **8:00 a.m. – 9:30 a.m.** **Board Member Training – Disciplinary Guidelines**
  (All Members)

- **10:00 a.m. – 4:00 p.m.** **Full Board Meeting**
  (All Members)

MEDICAL BOARD OF CALIFORNIA

QUARTERLY BOARD MEETING AGENDA

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

Courtyard by Marriott – Cal Expo
Golden State Room A & B
1782 Tribute Road
Sacramento, CA 95815
916-929-7900 (directions only)

Thursday July 18, 2013
1:00 p.m. – 5:30 p.m.
(or until the conclusion of Business)

Friday, July 19, 2013
10:00 a.m. – 4:30 p.m.
(or until the conclusion of Business)

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

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

ORDER OF ITEMS IS SUBJECT TO CHANGE.

Thursday, July 18, 2013

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

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

3. Approval of Minutes from the June 4, 2013 Meeting – All Members

4. Presentation on Covered California – Jeffrey Rideout, M.D., Senior Medical Advisor, Covered California

5. Discussion and Consideration of Proposed Regulations to Implement Senate Bill 1441 relating to Substance Abusing Licensees – Mr. Heppler / Ms. Dobbs

6. Discussion and Consideration of Teleconferencing Options for Medical Board Meetings – Ms. Schipske / Ms. Kirchmeyer / Mr. Heppler

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

8. President's Report – Dr. Levine
   A. Committee Appointments

9. Interim Executive Director's Report – Ms. Kirchmeyer
   A. Update on Staffing and Administration
   B. Budget Overview
   C. BreEZe Update
   D. Sunset Review Update

10. Report on History of Business and Profession Code section 2220.7 (Gag Clause) – Ms. Kirchmeyer / Ms. Threadgill

11. Update on Health Professions Education Foundation – Ms. Yaroslavsky / Dr. Diego

12. Update on Federation of State Medical Boards – Dr. Levine and Ms. Kirchmeyer

13. Update on Physician Assistant Board – Mr. Schunke

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

RECESS

Friday, July 19, 2013

15. 10:00 a.m. Call to Order/Roll Call

16. 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)]

17. Update on Education & Wellness Committee; Consideration of Committee Recommendations – Ms. Yaroslavsky

18. Discussion and Consideration of Queensland/Ochsner Medical School Application for Recognition – Mr. Worden / Dr. Nuovo

19. Update on Activities of the Board of Pharmacy – Ms. Herold / Ms. Sodergren

20. Update/Follow Up from Joint Forum to Promote Appropriate Prescribing and Dispensing – Ms. Kirchmeyer and Ms. Herold / Ms. Sodergren

21. Update on Prescribing Task Force – Ms. Yaroslavsky / Dr. Bishop

22. Update and Discussion on the Strike Force for Prescribing Violations – Ms. Threadgill / Ms. Sweet
    A. Short Term Plan
    B. Long Term Plan

23. Legislation/Regulations – Ms. Simoes
    A. 2013 Legislation
    B. Status of Regulatory Actions

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

25. Update on Outpatient Surgery Settings Program
    A. Update from Outpatient Surgery Settings Task Force; Consideration and Possible Action – Dr. Gnanadev/Dr. Salomonson
    B. Web site and Program Update – Mr. Worden

26. Review and Consideration of Request for Approval as an Accrediting Agency; Healthcare Facilities Accreditation Program – Mr. Worden

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

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

29. Election of Officers

30. Agenda Items for October 24-25, 2013 Meeting in Riverside

31. Adjournment

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

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

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

The mission of the Medical Board of California is to protect healthcare consumers through the proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act, and to promote access to quality medical care through the Board's licensing and regulatory functions.

MEDICAL BOARD OF CALIFORNIA
QUARTERLY BOARD MEETING

Hilton Sacramento Arden West
Folsom Room
2200 Harvard Blvd.
Sacramento, CA 95815

Tuesday June 4, 2013

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 called the meeting of the Medical Board of California (Board) to order on June 4, 2013 at 10:13 am. A quorum was present and due notice was provided to all interested parties.

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

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

Staff Present:
Susan Cady, Staff Services Manager, Central Complaint Unit
Ramona Carrasco, Central Complaint Unit Manager
Dianne Dobbs, Department of Consumer Affairs, Legal Counsel
Kathryn Hayes, Licensing Program Manager
Rashya Henderson, Investigator
Kurt Heppler, Staff Counsel
Cassandra Hockenson, Public Information Officer
Teri Hunley, Business Services Office Manager
Diane Ingram, Information Systems Branch Manager
Kimberly Kirchmeyer, Deputy Director
Mark Loomis, Investigator

Armando Melendez, Business Services Analyst
Cindi Oseto, Licensing Program Manager
Regina Rao, Business Services Analyst
Paulette Romero, Central Complaint Unit Manager
David Ruswinkle, Associate Governmental Program Analyst, Enforcement
Kevin Schunke, Licensing Outreach Manager
Jennifer Simoes, Chief of Legislation
Laura Sweet, Deputy Chief, Enforcement
Renee Threadgill, Chief of Enforcement
Lisa Toof, Administrative Assistant II
See Vang, Business Services Analyst
Kerrie Webb, Legal Counsel
Curt Worden, Chief of Licensing

Members of the Audience:
G.V. Ayers, Consultant, Senate Business, Professions, and Economic Development Committee
Gloria Castro, Senior Assistant Attorney General, Attorney General's Office
Don Chang, Department of Consumer Affairs, Legal Office
Yvonne Choong, California Medical Association
Zennie Coughlin, Kaiser Permanente
Julie D'Angelo Fellmeth, Center for Public Interest Law
Hank Dempsey, Chief Consultant, Assembly Business, Professions, and Consumer Protection Committee
Bryce Docherty, California Ambulatory Surgery Association
Karen Ehrlich, L.M., Midwifery Advisory Council
Reichel Everhart, Department of Consumer Affairs
Faith Gibson, Licensed Midwife
Sarah Huchel, Consultant, Assembly Business, Professions, and Consumer Protection Committee
Dorothea Johnson, Department of Consumer Affairs, Legal Office
Tina Minasian, Consumers Union Safe Patient Project
Jeff Sears, Department of Consumer Affairs, Human Resources Office
Taryn Smith, Senate Office of Research
Dave Thornton

Agenda Item 2 Introduction and Swearing In of New Board Member; Mr. Phil Tagami

Dr. Levine introduced Mr. Tagami. She announced that he was appointed by the Governor in May of this year and presented his background in both public and private sector. Dr. Levine then welcomed Mr. Tagami as a Board Member and officially swore him in.

Dr. Levine requested that Lisa Toof note for the minutes that Mr. Serrano Sewell had arrived.

Agenda Item 3 Public Comments on Items not on the Agenda

Ms. Yvonne Choong, California Medical Association (CMA) spoke in regards to discussion that took place at the February Joint Forum to Promote Appropriate Prescribing and Dispensing that was co-

sponsored by the Board and the Board of Pharmacy in regards to corresponding responsibility on the part of pharmacists and the need for pharmacists to
verify prescriptions before dispensing medication. CMA, while working with the California Pharmacists Association, has identified some confusion among members regarding the definition of appropriate corresponding responsibility and how it is being exercised.

The CMA found that there are a lack of guidelines and standardization about the appropriate amount of information needed by the pharmacist in order to verify the legitimacy of the prescription. Some of the physicians have received requests for extended portions of the medical records, MRI's, etc. Some pharmacists have wanted to look at the medical records and collaborate with the physicians regarding the diagnosis before dispensing the medication. This has caused some disruption in patient care and in some cases threats of enforcement action against physicians for failure to comply.

CMA and the California Pharmacists Association are requesting a presentation which would include a presentation by the Board of Pharmacy and a discussion on this issue at the next Board Meeting.

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

A few edits, typographical in nature, were requested by the Members. Dr. Levine asked for a motion to approve the minutes with the edits discussed. Ms. Yaroslavsky made a motion; s/Ms. Diego. Mr. Tagami abstained. Motion Carried.

Agenda Item 5 Closed Session

Dr. Levine announced that the Board Members received an email from the Executive Director, Linda Whitney advising the Board and Ms. Kirchmeyer of her intention to retire effective June 1, 2013, which she did. Dr. Levine stated that the only outstanding matter to be considered in closed session is the appointment of an Acting Executive Director and that once the Board takes an action on this matter, the meeting will return into open session and announce the results of the closed session.

Dr. Levine announced that the Board was now in closed session and asked everyone who was not part of closed session to please leave the room.

The open meeting ended at 10:25 am and went into closed session. Closed session adjourned at 12:10 pm. Dr. Levine announced a Lunch Break and requested that open session reconvene at 12:35 pm.

Dr. Levine reconvened the meeting of the Board in open session at 12:45 pm.

Agenda Item 6 Announcement of Actions Taken in Closed Session

Dr. Levine stated she was pleased to announce that the Members of the Board unanimously voted to ask Kimberly Kirchmeyer to serve as Interim Executive Director as a search process is completed for a permanent replacement for the position. Dr. Levine stated that the Board Members had the opportunity to have a conversation with Ms. Kirchmeyer and the Board expressed their confidence in Ms. Kirchmeyer's ability to lead the Board staff and to work with the Board to set out a vision. Additionally, the Board Members requested Ms. Kirchmeyer help the Board begin to do the important

work that lays ahead in the next months and years to ensure that not only is the Board committed to consumer protection but that the fact of that is known and trusted by members of the public.

Agenda item 7 **Discussion of Procedures for the Selection of a New Executive Director, depending on the action of Agenda Item 5**

Dr. Levine introduced Mr. Jeffrey Sears from the Department of Consumer Affairs (DCA) and stated that he will discuss the procedures for the selection of a new Executive Director.

Mr. Sears thanked the Board for allowing him the opportunity to be there and stated that the DCA shares the Board's confidence in Ms. Kirchmeyer's abilities. He mentioned that DCA has worked with Ms. Kirchmeyer for many years and looks forward to working with her for many more.

Mr. Sears presented the Board Members with a summary sheet of the typical process that the DCA uses for selecting a new Executive Director.

Mr. Sears stated that the first step in the process is for the Board to appoint a Selection Committee (Committee) which can be done either by appointment or by volunteers. The Committee would then work with the DCA office of Human Resources throughout the process. Components of the selection process are an evaluation of the duty statement for the position and updating revisions, if necessary, determination of the recruitment methodology, and approval of the recruitment bulletin.

Mr. Sears stated that it would also be the responsibility of the Committee to review applications and resumes when they come in and determine which meet the criteria that the Committee establishes for the screening of the initial applications. The Committee can then either interview their top candidates or they can forward those top candidates to the Board for a full Board interview in the future. Typically, the Committee will do an initial interview before forwarding the top candidates to the Board for consideration.

Much of the staff work is done by DCA Human Resources staff, however it is a significant responsibility and workload for the Selection Committee. He suggested to the Members who wish to volunteer, to please think about that workload since the pace that this process moves forward depends on how fast the Selection Committee can take on their components of this process including conducting initial interviews, scheduling screening criteria, and actual screening of the applications. Dr. Levine then asked for Board Member volunteers to sit on the Selection Committee for the recruitment of the new Executive Director.

Dr. GnanaDev and Mr. Tagami both volunteered. Dr. Levine thanked them both as well as Mr. Sears.

Agenda Item 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

Ms. Simoes stated that this is the bill that would require coroners 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. At the last board meeting, the Board voted to change its position on SB 62 from Support if Amended, to Support due to the amendments taken. A support letter went out on May 8th to Senator Price and the Senate Appropriations Committee. This bill was heard in Senate Business, Professions, and Economic Development Committee on April 29, 2013, and she testified in Support of SB 62. This bill was put on the suspense file due to the fiscal impact identified. However, this bill passed out of Senate Appropriations. (7-0) on May 23, 2013, and passed out of the Senate (39-0) on May 28, 2013. This bill is now in the Assembly. The next step will be for it to be heard in the Assembly Business, Professions, and Consumer Protection Committee, however, a hearing date has not yet been set for this bill. Staff will continue to work with the author's office, Assembly Business and Professions Committee and interested parties on this bill.

Dr. Levine asked if there had been any amendments subsequent to the bill since the last Board Meeting. Ms. Simoes stated that there had not been any changes.

Use of CURES Data – Ms. Threadgill and Ms. Cady

Dr. Levine invited Laura Sweet to make the CURES presentation.

Dr. Levine stated that the Medical Board has a large stake in the functionality and accessibility of the CURES program, California's prescription drug monitoring program. It is currently in a situation where its funding will expire June 30, 2013. Ms. Sweet stated that she believes there is pending legislation that will address this issue.

Dr. Levine stated that is a critical piece of the Board's work and also a critical piece of the work flow of prescribers and dispensers in the State.

Ms. Sweet gave a report on CURES, starting with a brief background about CURES and how the investigation utilizes the CURES. CURES stands for Controlled Substance Utilization Review and Evaluation System and is currently administered by the Department of Justice (DOJ). It originated from the triplicate prescription program that was created in 1940. Currently CURES collects schedules II, III and IV prescription information on a weekly basis via an electronic data system and allows preregistered practioners, pharmacists, and law enforcement officers access to it on an instantaneous basis 24 hours a day. She discussed the CURES Patient Activity Report, the information it identifies, and the benefits of this report to the prescribers and the patients. Ms. Sweet's report also included the steps the field investigators use for investigations. She included several examples of Prescriber Prescription History and what the history reports include. She stated that the CURES report cannot be relied upon on its own basis for demonstrating the State's burden of "good cause". The Investigator must procure all of the individual prescriptions to ensure the CURES report is accurate to be certain the Board has the accurate evidence, which is a very time consuming process.

Ms. Yaroslavsky asked if as part of the refinement of the CURES program, would it be helpful for the Board staff to have some kind of methodology to pull out of CURES certain identifying criteria for a patient as well as for physicians.

Ms. Sweet responded that it would be helpful but it is not an option at this time, but with the proper funding, data extracting could definitely be an option.

Dr. GnanaDev asked, if a patient comes to him, what kind of information can he obtain from CURES.

Ms. Sweet responded saying if a physician is signed up for the Patient Activity Report, he can query that patient, request that patient's activity report and it would let him know who is prescribing to this patient, what they are receiving of the scheduled medications and where those medications are being prescribed.

Ms. Sweet stated that it is a very useful tool for prescribing physicians, but it is not as accurate as staff would like it to be.

Dr. GnanaDev stated that he has had some emergency room doctors come to him and complain stating that they cannot sign up for CURES database.

Ms. Sweet responded that issue is due to a lack of funding for the program.

Ms. Yaroslavsky asked if there should be a law in place that says that any physician that is allowed to prescribe schedule II, III or IV drugs has to be a participant in the CURES program.

Dr. Levine responded saying that once CURES is updated, that would be the time to look at requirements about the mandatory use of CURES and that currently 12 percent of physicians and about 8 percent of pharmacists in the state are signed up for CURES.

Ms. Sweet finished her presentation by discussing the pain management guidelines, the subject interview, and the expert reviewer decision options.

Dr. Levine asked if the DOJ has a way to monitor the extent to which pharmacies are submitting, on a weekly basis, the reports they are supposed to be submitting.

Ms. Sweet responded that she is not able to answer that question, but would find out and get back to her.

Mr. Tagami stated that he appreciates the data coming in and would like to know if Ms. Sweet has a recommendation for the Board, looking at specifically what direction the Board should take.

Ms. Sweet responded that staff believes a task force or staffing similar to what the Board has for the Operation Safe Medicine unit, which is a unit dedicated to unlicensed activity, would be the best approach since these are time consuming cases. This would extract these cases from current investigator caseloads, which would improve time frames.

Mr. Tagami responded stating that the next question is how to differentiate from what the professionals who do this every day are requesting by way of tools and suggestions. Those recommendations would need to be accompanied with costs, at what other permission and/or communications are required to make it effective and how much time is needed to implement it. Ultimately it is looking to perfect a case that a judge will then support, that can be acted upon to bring closure and enforcement. That is a piece of this that needs to come into focus and that from that specifically what the "ask" of the Board is by way of permissions as it relates to funding and process to make sure that a new program is implemented. In addition, the Board needs to know if the funding sources are readily available or able to be re-directed, what the implementation time is, and what the checkup is to make sure this new direction and program has the impact that was intended.

Dr. Diego asked how a physician would know he/she was deviating from the Pain Management Guidelines, and does the Board post that information on the Web site.

Ms. Sweet stated that and article regarding the guidelines has been in the Newsletter at least three times and they are posted on the Web site.

Dr. Levine stated that there are two sets of guidelines, one is the pain management guidelines and the second is the appropriate prescribing guidelines for opioids. At the last Enforcement Committee meeting the Committee had asked that a task force be convened to include interested parties to look at possible needed revisions to these guidelines. Dr. Bishop and Ms. Yaroslavsky had agreed to co-chair that task force. CMA had also offered resources. There are a lot of changes in opioid prescribing and this is a perfect time to actually relook at it.

Ms. Yaroslavsky suggested that staff give a timeframe that they will bring back to the Task Force members when this is going to roll out.

Dr. Low suggested the Board create within enforcement a unit dedicated to addressing the problem of overprescribing and CURES review would be a part of that unit. The Board should have the resources since it is dedicating a certain number of investigators towards those efforts anyway, so there is no reason not to create a focused unit within enforcement looking at overprescribing and addressing those problems.

Dr. Levine asked Ms. Sweet if that was feasible.

Ms. Sweet responded that at the current time, she does not believe it is feasible as the Board does not have enough staff at this point in time.

Dr. Levine asked Ms. Sweet to work with staff to see what it would take to create a dedicated unit in terms of resources, training, expense, etc. within the investigative unit in enforcement to actually address the problem. A revamped CURES where the Board could have confidence in the data would be part of that with hopes that will be in process soon.

Ms. Sweet stated that DOJ manages the CURES database and that staff has no access to make program changes, etc.

Dr. Levine recommended collaboration with DOJ to achieve this goal.

Dr. GnanaDev stated he felt this is an important issue, not just on the enforcement side, but on the prevention side and made a motion that staff present at the next board meeting what it will take to create a special investigative unit on the prescription drug overdose and how staff can work with other agencies on the CURES database availability, signing up, etc.

Mr. Tagami requested expanding the request to include a work plan, a budget, a schedule, a list of other stakeholders that need to be engaged by way of what recommendations and steps they see or need and also taking a look at suggestions and recommendations from other states by way of best practices and find out if there have been any similar programmatic changes or reforms done to address these specific issues. Then as that becomes concurrent and the program is going forward, then have staff come back to the Board with a status update and discuss how to go about inviting stakeholders in to communicate with the Board.

Mr. Heppler stated that this type of request made to the staff by the Board can take place without a motion since the Members are directly guiding the Board's own staff to present a comprehensive report and to have it ready for consideration by the Board at the next available opportunity.

Mr. Tagami then requested that this be agendized for action at a future meeting so that the Board can then affirm and adopt steps that would be concrete associated with action and time.

Dr. Low stated that the Board has to be very realistic in what it alone can do quickly and effectively and what its obligation are to the public. He believes that the Board should not be bogged down by trying to get everybody else involved and thinks the Board should look specifically at what the Board's roll is in terms of trying to deal with this particular problem of overprescribing. He feels that if this plan becomes too encompassing, it will be difficult to get something done quickly.

Ms. Yaroslavsky suggested that the opportunity for the task force to meet prior to the next Board Meeting with staff's involvement and engagement would be a good vehicle to start this conversation moving forward. She recommended there be an interim meeting either before or after the July meeting.

Cost/Ramifications of Senate Bill 304 (Price) – Proposal to Transfer all Investigative Staff from the Medical Board to Department of Justice – Ms. Kirchmeyer and Ms. Threadgill

Ms. Kirchmeyer began her report with a detailed explanation of the costs of SB 304.

The Board is projecting the costs of this transfer to be approximately $1.3 million dollars. These costs are related to the reclassification of the investigators into DOJ classifications. These costs only include salaries, not benefits.

The first fund condition in the materials included future costs for the CURES system as proposed in a current budget bill, the Board approved increase in expert reviewer pay, anticipated BreEZe costs, a proposal for a Northern Operation Safe Medicine unit, and other additional enforcement staff. The

proposed future costs have not been approved, but are going through the review process. It is important to know this impact is based upon projected figures.

The second shows the same fund condition with a projected $2 million dollar reversion this year, which could occur due to vacant positions and other savings the Board is projecting. At the July Board Meeting staff will have a more accurate picture of the actual reversion.

Ms. Kirchmeyer stated staff has discussed this transition with the DOJ and believes they have identified which positions would be transferred to the DOJ, which ones would stay with the Board, and which ones are uncertain at this time.

Ms. Kirchmeyer proceeded through each ramifications. She stated that the following are items that staff believes are ramifications that will occur:

- The funding for the investigator 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 is 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 that 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 appropriate action was taken, i.e. closure of case or filing of administrative action. More discussion is necessary as to what this individual would do and their review authority.
- The Investigators would be provided increased authority in Penal Code section 830.1, which will allow them to work more efficiently on their cases, specifically prescribing practices and sexual misconduct cases.

Ms. Kirchmeyer stated there are some uncertain ramifications. These include:

- The disbursement of the Office of Standards and Training Unit as 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.
- 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 DCA's Division of Investigation (DOI). Note: Board of Podiatric Medicine utilizes the vertical enforcement model.

- What would occur when the Board hits the financial threshold for the hours that could be paid to the Attorney General's office from that line item. Would the Board have to halt 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 and the cost of those new positions.

Ms. Kirchmeyer stated that this could not logistically happen by January 1, 2014 as that is only three months after the bill is signed and all of these items would need to be discussed with the DOJ and the other healing arts boards.

Board staff also gathered information from other states and from the Federation of State Medical Boards. Of the 12 State Boards that responded, nine use their own in-house investigators. Staff provided the Board with the information from the FSMB indicating which boards have authority over disciplinary investigations.

Lastly, staff provided the Board with a copy of the pros and cons that were identified at the last meeting. Staff has not identified any other pros or cons to add to this list, but have provided these ramifications for the Board in order to take a position on this portion of SB 304.

Dr. Low feels that the investigators are like policeman and detectives, and the Attorney General's Office (AG) is like the District Attorney's Office. They are separate and for a good reason. If the Board moves the investigators into the AG's Office, he is concerned that the cases will not get the same degree of scrutiny that the Board gets when they are separate. The concept of investigating complaints is better done by the Medical Board. Other than making things happen more efficiently, he does not see much benefit since the main goal is still public protection and what is best for the public. He questions if it is best to move it under one entity.

Mr. Serrano Sewell agreed with Dr. Low and believes that if this should work out, there needs to be a very clear Memorandum of Understanding (MOU) between the two agencies that memorializes what is in law, etc. The large public policy question is the loss of public oversight. The Board has jurisdiction over its investigators and through that establishes priorities. Should this very important function be turned over to another independently elected office, the oversight from this Board will end. The AG's office will have to be brought into the discussion and that office would have to decide independently how they want to interact with the public.

Ms. Yaroslavsky expressed her concerns about how the Board is are going to hold accountable another public entity. She added that if the Board could hold another public entity accountable, why can the Board not fix the timelines today.

Dr. GnanaDev feels that putting them in a separate entity that is independently elected without the Board having much control does not make sense to him.

Dr. Bishop believes that the drastic action being taken is due to the unresponsiveness of the Board to the concerns of the Legislature. The Board has to show a will to make some changes to do what is right to protect the public. He agrees with the Legislature that the Board has not done a good job at

protecting the public. He thinks that if the Board can come up with a way to demonstrate to the public and the Legislature that it can improve, the investigators should be kept with the Board, and if not, the Board will be forced to have the investigators transferred..

Mr. Tagami stated that from listening to the Members and Staff speak about this issue, that the Board has been wrestling with this issue for some time and believes that this issue should be approached with a beginner's mind. The possibilities are eminent and only the expert sees the limitations. He is seeing that the Board has a good closure rate on complaints and cases. The question before the Board is how are the different parts of the Government going to evolve to deal with new circumstances and behaviors that are coming from the public and in some cases out of practicing physicians. He feels finding the best practices is important and needs to be understood. Working as a team internally is an important part of the solution. He stated that he would be a supporter of keeping the investigative unit with the Board for several reasons. He thinks there are unintended consequences with the division. The steps to address these new concerns that have been evolving and coming to light by the Legislature, the public and the media are all things that can be addressed in a very constructive, responsible way by the Board. He feels that the steps to address the issues have been initiated and believes this is the time to come together and collaborate. He believes there has to be two tracks. There has to be an immediate set of actions demonstrating the seriousness to get this moving, but at the same time the Board needs to look for that outreach, work with the Legislative staff, communicate with the Legislature, the Governor's Office and with the public to address concerns. Mend fences if they need to be mended and move forward in a lasting and sustainable way.

Public comment was heard on this agenda item:

Dave Thornton, prior Medical Board Executive Director, gave a brief background on himself and where he is coming from on this issue. He started doing investigations for the Board in 1975. In 2000, he was promoted to the Board's Chief of Enforcement and held that position for about 3.5 years. In 2004 he was appointed as Executive Director and retired from that position in 2007. The issue of transferring investigators dates back to 2005 with SB 231 (Figueroa). That was the Board's sunset bill. The Board had unanimously voted to approve the transfer of the investigative staff back then. At the last minute, the transfer was pulled out of the bill, but what was not pulled out was the transfer of authority for the investigations where the Board no longer had authority. That authority had been transferred to DOJ. When that transfer of authority happened, DOJ had no investigators at that time. The Board has always had a retention problem and transferring the investigators to DOJ would solve the problem of retention with the investigative staff at DOJ as the salary differential is considerable. He believes the Board would not lose control of the investigative staff as the Board will still control which cases go over to the DOJ, still have control of cases where an accusation is filed, and still have control as a Board over decisions that come to the Board such as stipulated and proposed decisions.

Dr. GnanaDev suggested that the Board should pay its investigators the same salary as the DOJ pays its.

Mr. Thornton reminded the Board that the request has to go through the Department of Personnel Administration (DPA) and they have always been reluctant to upgrade one set of investigator's salary. DPA feels if it gives the salary adjustment to one set of investigators, it would have to give it to all.

Ms. Yaroslavsky questioned why the DOJ can pay their investigators more than other State agencies. Mr. Thornton stated that the DOJ has a "Special Agent" classification that most other agencies do not have, and the salary level had been set for those in that classification.

Dr. Low believes that the Board should do whatever is necessary to be able to adjust the salaries for its Investigators rather than move them to DOJ.

Mr. Tagami asked if staff has statistics on turnover rate of investigators.

Ms. Threadgill stated that staff has done multiple studies with retention having been the focus over many years and can get those statistics for him.

Ms. Threadgill stated that over the last 8 years, their unit had 20 transfers and 20 retirements which is almost half of the entire unit.

Mr. Tagami requested a report on the average tenure of the Board's investigators and how it aligns with other law enforcement. He stated this information would be relevant for decision making.

Public Comment was heard for this agenda item:

Julie D'Angelo Fellmeth, Administrative Director for the Center of Public Interest Law and former Medical Board Enforcement Monitor from 2003 – 2005, stated that CPIL strongly supports the revision in SB 304 to transfer the Board's Investigators to the AG's Office, specifically into its Health Quality Enforcement (HQE) section which has specialized in cases against physicians for over 20 years. She provided several letters of support from Board Members in 2004.

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

Mr. Heppler stated that at the last Board Meeting the Board had asked staff to commence the rulemaking process to implement the SB 1441 Uniform Standards. He reported that he and Ms. Dobbs have had some preliminary discussions about how best to accomplish that. He stated that staff will bring language to the July Board Meeting for the Board's consideration. If it meets the Board's approval, the Board could then set the matter for public hearing. That hearing could take place at the October Board Meeting, at which time the Board would consider public and written comment taken during the open comment period. If the language meets the Board's satisfaction, then the Board could close the comment period and prepare the Statement of Reasons without any adverse comment. The Board would then transmit the final regulatory package to the required various control agencies, including the Office of Administrative Law (OAL) for ultimate approval of the regulation.

b. <u>Consumer Protection Enforcement Initiative (CPEI) Positions: Position Description and Plan to fill Non-Sworn Investigator Positions and Timeline – Ms. Kirchmeyer and Ms. Threadgill</u>

Ms. Kirchmeyer gave a very brief background on the CPEI positions. She stated that at the Executive Committee Meeting on January 31, 2013, a presentation was made on the CPEI positions. She stated the Board has the handout in their current packet that was provided at that meeting.

This document described the history of these positions, explained why these positions had not been filled, and explained that these positions were eliminated due to the 5% salary savings drill or Budget Letter 12-03. The Board was notified it could reestablish these positions in its blanket and at the January Meeting staff provided a proposal for reclassifying these positions. However, after that meeting, staff was notified that those positions could no longer be reclassified.

Upon this information staff went back and revived and reviewed the Board's original plan when the positions were established in July and October of 2010 and developed a plan to establish a unit for these positions.

Ms. Kirchmeyer briefly described that these positions are not in the Governor's budget. Looking at the Salaries and Wages section of the Governor's budget for FY 2013/2014, it shows the Board has 281.4 Medical Board positions. 10.3 of those are temporary positions leaving the Board with 271.1 full time permanent positions. This number does not include the CPEI positions because, again, these positions were eliminated, which is why these positions are not counted in the Board's vacancy rate.

The Board can fill these positions as long as it ensures that it maintains an overall salary savings of approximately $941,000 each year. This amount equates to about a 5% vacancy rate.

As long as the Board maintains these vacancies and this amount, it can fill these positions. The Board needs to remain very cognizant of this and ensure it does not expend its budget.

Ms. Kirchmeyer asked Ms. Threadgill to continue with report.

Ms. Threadgill reported that Board staff has proposed to establish a Complaint Investigation Unit staffed with six (6) non-sworn Special Investigator positions and one Supervising Special Investigator I position within the Enforcement Program. The Board staff has identified a number of case types that can be investigated and referred for prosecution without the use of a sworn investigator. Staff 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 complaints based upon information from the accreditation agencies.

Not all enforcement activities or investigative duties require the use of sworn 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, among other non-sworn duties. Having non-sworn investigators allows sworn investigators to perform investigative tasks requiring peace officer status such as 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 sworn 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.

Ms. Kirchmeyer briefly went over the time frame showing that on June 3, 2013, staff submitted packages for these positions to the DCA and since these are new positions they have to go through the complete approval process to the DCA Human Resources Office as well as DPA for approval. That is a lengthy process to get through, but once approval is complete, staff will start advertising for those positions and filling those positions at that time.

Public Comment was heard on this agenda item:

Ms. Tina Minasian, on her own behalf stated she does not agree with the way the non-sworn and sworn investigators duties and salaries are set. She would like this issue to be agendized for discussion at a future Board Meeting.

c. <u>Senate Bill 100 (Price) Chapter 645, Statutes of 2011: Task Force on Outpatient Surgery Settings – Dr. GnanaDev.</u>

Dr. GnanaDev announced that the Task Force had not met yet, but will be meeting before the next Board Meeting in July. The Task Force will be looking at the Outpatient Surgery Settings standards to see if they need to be amended and if the task force will need to establish new laws or regulations, etc.

<u>Web site – Mr. Worden</u>

Mr. Worden reported that the accreditation agencies have been providing additional information regarding the outpatient surgery settings that are accredited pursuant to Health and Safety Code Section 1248 and 1248.1 and staff has been updating that information on the Board's Web site. Mr. Worden stated that the Board Meeting packet contained a printout of the Board's outpatient surgery setting webpage that staff have been working on to provide additional information to consumers. The specific additions include the following links:

- Outpatient Surgery Setting FAQs
- Outpatient Setting Complaint Overview/Process

- Consumer Complaint Form
- Consumer Complaint Form (Spanish)
- Types of Settings Not Required on List
- CMS - Acronyms
- CMS - Glossary
- CMS - Approved Accreditation Organization Contact Information
- CMS – Accrediting Organization Complaint Contacts

In addition, the Board has requested the accreditation agencies to provide information regarding outpatient surgery settings that have been certified as meeting CMS requirements even though these type of settings are exempt in statute from being accredited and reported. These settings in the near future will be identified by a box on the Web site as CMS.

This information is being provided as a courtesy to California consumers to help them determine if an outpatient surgery setting may be CMS certified. CMS certified settings are exempt from providing any information to the Board and therefore, these listings on the Board's Web site will not have all of the information that is required for an outpatient surgery setting that requires accreditation pursuant to Health & Safety Code sections 1248 - 1248.2.

Staff is also working on providing the inspection reports on each accredited setting's listing in the next few months.

Ms. Serrano Sewell asked if the renewal of the accreditation agencies had been completed, and if not, when the Board expected those applications to be submitted.

Mr. Worden responded that the accreditation agencies had already submitted all of the renewal forms and documentation, however staff has not reviewed them yet.

Mr. Serrano Sewell stated that it appeared from the last meeting that there are differences in the standards across the accreditation agencies. He stated that one agency said it would only accredit outpatient surgery settings in which the physician performing that procedure had the same authority to perform that surgery at an acute care hospital and was certified in that area of practice, but not all accrediting agencies had this as a requirement. Mr. Serrano Sewell stated that maybe the Board should suspend the renewal process, or allow an interim approval for the existing applicants, with the understanding that the Board would exercise its rulemaking authority and promulgate new standards based upon what the Board expects of the accrediting agencies. For example, new standards could be to set a number of unannounced visits/inspections, etc. He stated the Board should take this opportunity and give some serious thought to promulgating new laws or regulations at this time.

Mr. Worden stated that the Outpatient Surgery Setting Task force made up of Dr. Gnanadev and Dr. Salmonson will be looking at the standards to identify any that need to be brought to the Board for possible regulations or statute changes. Mr. Worden added that after the changes go through the regulatory process that would be something the accrediting agencies would have to abide by once the regulations become effective.

Mr. Serrano Sewell asked if there was a way to ensure the accreditation agencies complied with any new requirements before going through the renewal process. Otherwise it will be three years before the entity would have to comply with the new regulations. Mr. Serrano Sewell requested that Mr. Heppler respond from a legal perspective.

Mr. Heppler stated that it seemed the Board wanted to suspend the renewal process, or defer it, with the understanding that there may be some upcoming regulatory developments that would put the subsequent renewal on a higher standard. He stated this is difficult because the renewal and licensing realm is a right. The Board can continue to renew the accreditation agency, and if it falls short of what the standard is then the Board can take administrative disciplinary action and stop that renewal cycle by taking the approval away. So it is not impossible, but it is unusual.

From a public policy perspective, by deferring the renewal, the accreditation agency may be deficient in some regard that the Board will not find because it deferred the renewal for 12 months. He recommended the Board consider that the standards in H&S Code section 1248.15, are minimum standards. The Board may want to consider changing those standards and doing it in an expedited manner.

After discussion, the members decided to continue the accreditation agencies' renewal process and move forward through the Outpatient Surgery Setting Task Force to develop any necessary new laws or regulations.

Complaint Process – Ms. Threadgill and Ms. Cady

Ms. Threadgill explained that the concerns about procedures being performed under anesthesia in an outpatient surgery setting is not a new complaint issue for the Board. Staff has been reviewing complaints regarding outpatient surgery settings for at least 13 years, since Business and Professions Code (B&P) section 2216 was added to the Medical Practice Act.

When evaluating complaints about procedures performed in outpatient surgery settings, staff much first determine whether the setting is one that would fall under the Board's purview and would require accreditation. If the setting is certified to participate in MediCare or is a federally operated facility or a facility operating on a tribal reservation, the setting would be exempt from the requirement to be accredited. If not the Enforcement Program staff would confer with Licensing staff to identify whether the facility is accredited through one of the four approved accreditation agencies.

The next issue that must be considered is identifying whether the procedure was performed with a level of anesthesia that had the probability of placing a patient at risk. It can be difficult to determine if the combination of drugs administered to a patient meets this criteria without input from a medical expert. If the combination of drugs being used does not meet the level of "general" anesthesia, the outpatient surgery setting does not require accreditation.

Ms. Threadgill reported that it is common for issues related to an outpatient surgery setting to be identified through a complaint filed about the quality of care a physician provided. Once the patient's medical records are obtained, staff confirms whether the level of anesthesia was such that would have required the setting be accredited and then verifies if the setting is licensed, exempt, or accredited. If

the setting is not accredited, the complaint is then referred for further investigation, regardless of whether the care and treatment were appropriate.

Ms. Cady referred the Board Members to a chart in their packet that outlined the Board's responsibility in responding to complaints received about the outpatient surgery settings. The Health and Safety Code requires that the accrediting agency perform either an inspection or investigation in response to a complaint forwarded by the Board and provides timeframes for responding back to the Board when the investigation or inspection is complete.
Ms. Cady then referred to another chart that outlined how the Board responds to complaints received specifically naming the outpatient surgery setting. The first step in the process is to determine whether the setting is accredited or not. If the setting is accredited, the complaint will be referred to the accrediting agency for inspection. When the inspection report is received in Licensing, the findings are reviewed to identify if any deficiencies were noted in areas related to patient safety. If so, the inspection report is referred to the Complaint Unit for a formal investigation.

If the setting is not accredited, the complaint is initiated and initially reviewed by the Complaint unit. If the allegations indicate that procedures are being performed under general anesthesia, the complaint will be referred for investigation. A case would also be initiated on the physician who is alleged to have performed the procedure in a setting without accreditation as it could represent a violation of B&P Code section 2216.

Dr. Levine asked about the status and outcome of the California Department of Public Health (CDPH) letter that Ms. Whitney had sent to them back in December 2012 that CDPH responded to in April, 2013. She asked if there has been an MOU signed.

Ms. Kirchmeyer responded by saying there has not been an MOU signed and that staff is in the process of setting up a meeting in the near future with CDPH to get this issue resolved and will have an update for the Board at the July meeting.

Dr. Bishop stated that the Board has to be concerned, not just about whether the outpatient surgery setting is accredited or not, but that an actual trained anesthesiologist is performing these surgeries, as each individual surgery, person, and situation varies.

Public Comment was heard on this agenda item:

Tina Minasian speaking on behalf of Consumers Union, stated her concerns regarding physician-owned outpatient surgery settings and urged the Board to apply rigorous oversight to outpatient surgery settings and their accrediting agencies.

Accreditation Standards – Mr. Worden and Mr. Heppler

Mr. Heppler stated that this agenda item was covered in the prior discussion, and asked the Board if it would like to go over it in more detail or wait until the next Board Meeting where staff would have more information to share since the Task Force will have met by then.

Dr. Levine suggested that the Board wait until the July Board Meeting for further details and also reminded staff that the Board had requested a side-by-side chart of the different standards used by the accrediting agencies.

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

Dr. Levine stated there were two issues that arose through the Sunset Review. One is interim suspension orders (ISO) and the other is disciplinary guidelines. The disciplinary guidelines are intended to create the ability for the Board and the Administrative Law Judges (ALJ) to evaluate the facts and circumstances of a case and to make judgments about the appropriate discipline. Dr. Levine believes the Board is hampered by the current mechanism and format of reporting on discipline and the way it is tracked. It is not capturing, in an extractable way, the rational for deviation. There needs to be a process for capturing that information that can be documented over time and the basis for deviation from the guidelines.

In regards to the ISOs, questions were raised about the number of times it is sought out and why, in some situations, the Board is not successful at getting an ISO. There is pending legislation in SB 304, which contains an extension of the time between an ISO being granted and the time to file an accusation. One of the reasons there is hesitation on the part of the AG's Office is the uncertainty that an accusation can be filed within the 15 day timeframe that is the current statute.

Dr. Levine reported that the Board has approved training for the ALJs on the topic of ISOs to be put on by the Office of Administrative Hearings (OAH). That training is scheduled to take place on June 28, 2013. This training will re-familiarize them with the process, the circumstances, and why the Board will be asking for ISOs.

There will also be a training this summer for ALJs on the Board's disciplinary guidelines through the OAH. The ALJs, in the process of making decisions, need to explain the rationale for either using the guidelines or deviating from them and clearly documenting the reason for the deviation.

Dr. Low requested that the AG's Office adapt a more standardized form in its letters to the Members of Panels A and B. He recommended it use the same format for all offices so that the Members receive the same kinds of information, background, etc. It should state whether or not it is consistent with the disciplinary guidelines and if not, why. In addition, for the stipulations, he would like Board staff to put a note to the Panel Members about the deviation so that it is easy to locate when reviewing cases.

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

Dr. Low requested that the Board discuss taking a position on Utilization Review complaints.

Dr. Bishop requested having the California Department of Health Care Services give a presentation to the Board on ways to assist new physicians, coming out of residency, avoid being involved in fraud schemes.

Mr. Tagami would like to have the Board's legal staff clarify what is listed on the agenda that can be an action item. He would also like to see the enforcement issues that were discussed in detail today be agendized for the next meeting for possible action.

Ms. Webb responded to Mr. Tagami's comment on clarifying the agenda by stating that items where action is intended should be identified as an action item clearly on the agenda as opposed to being shown as an update.

Dr. Levine would also like the carry over items from the April Meeting be agendized for the next meeting, including a staff report on follow up to the Joint Forum, an update on the Board of Pharmacy activities, a report on teleconference options, and a report on the gag clause.

Agenda Item 10 Adjournment

Dr. Levine adjourned the meeting at 3:50 pm.

_____ _____
Sharon Levine, M.D., President Date

_____ _____
Silvia Diego, M.D., Secretary Date

_____ _____
Kimberly Kirchmeyer, Interim Executive Director Date

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

Biography

Agenda Item # 4

Jeffrey Rideout, M.D., M.A., FACP
Senior Medical Advisor, Covered California (the California Health Insurance Exchange)

Dr. Rideout is currently the Senior Medical Advisor for Covered California, the state of California's Health Insurance Exchange. In this role, Dr. Rideout is responsible for clinical quality, network management, delivery system reform and clinical and network analytics related to the estimated 3-4 million eligible Californians that will seek insurance coverage through the Exchange beginning in October of 2013. Cited by President Obama as a prime example of how the Affordable Care Act is working, Covered California will be the largest and one of the most active exchanges in the nation and has already created a new market for individual insurance coverage in the state of California.

Previously Dr. Rideout has served in a number of corporate leadership roles, including SVP and Chief Medical Officer for The TriZetto Group, where he led TriZetto's strategy around development and delivery of a comprehensive suite of products and services that enable payers, providers and employers to improve the cost and quality of care, including support for new "accountable care" business models. Dr. Rideout was previously the global leader of the healthcare division for Cisco Systems Internet Business Solutions Group and Cisco's Chief Medical Officer. Dr. Rideout has also served as Chief Medical Officer and SVP for Blue Shield of California and head of Quality Management for Blue Cross of California/WellPoint.

Dr. Rideout serves on numerous industry boards, including the Pacific Business Group on Health and the Integrated Healthcare Association. He previously served as a member of the National Advisory Council for the Robert Wood Johnson/IHI Pursuing Perfection grant program, and also served as a member of the American Health Information Community (AHIC's) Chronic Care Workgroup for the US Department of Health and Human Services under HHS Secretary Michael Leavitt. Dr. Rideout has also supported numerous venture backed companies and venture capital firms in board, advisory and management roles.

Dr. Rideout is a volunteer physician and a Board of Directors member for Medical Teams International, an international medical relief organization. He is also on the board of Contra Costa Interfaith Housing, which provides permanent housing to low income families in the Contra Costa County in California. Dr. Rideout is also a faculty member at the University of California, San Francisco, Stanford University and the UC Berkeley Haas School of Business, teaching on topics related to healthcare technology, services and venture investing.

Dr. Rideout is a board certified internist, completing his residency training at University of California, San Francisco, and is a Fellow of the American College of Physicians. He received his medical degree from Harvard Medical School and his undergraduate degree from Stanford University. He also holds a master's degree in Philosophy, Politics, and Economics from Oxford University where he studied as a Rhodes Scholar.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: July 1, 2013
ATTENTION: Board Members
SUBJECT: Implementation of SB 1441 – Proposed Regulatory Language
STAFF CONTACT: Kurt Heppler

REQUESTED ACTION:
After review and discussion of the attached regulatory language, in conjunction with the SB 1441 Uniform Standards Regarding Substance-Abusing Healing Arts Licensees, direct Board staff to begin the regulatory process and set these regulations for a hearing at the October Board Meeting.

BACKGROUND AND ANALYSIS:
Senate Bill 1441 (Ridley-Thomas, Chapter 548, Statutes of 2008) created the Substance Abuse Coordination Committee (SACC) and required the SACC, by January 1, 2010, to formulate uniform and specific standards in specified areas that each healing arts board shall use in dealing with substance-abusing licensees, whether or not a board chooses to have a formal diversion program. The SACC drafted and adopted the **attached** SB 1441 Uniform Standards Regarding Substance-Abusing Healing Arts Licensees (Standards) based upon this directive. These Standards were finalized in April 2011. Upon adoption of these Standards, each healing arts board was requested to review its regulations and disciplinary guidelines to ensure compliance with these Standards.

The Medical Board of California (Board) had already begun the process of updating its disciplinary guidelines when the Standards were finalized. These revisions to the disciplinary guidelines were submitted by the Board to the Office of Administrative Law in December 2011 and became effective in January 2012. The Board staff also reviewed the Standards and made changes to its policies and procedures based upon the language of the Standards. However, there are some items in the Standards that still need to be placed in the Board's regulations.

In reviewing the Standards, Board staff has determined that it would be more appropriate to place the Standards into specific regulatory language rather than place them in the disciplinary guidelines and incorporate them by reference. Therefore, the Board staff is recommending an amendment to the current regulatory section and also the addition of a completely new section that will encompass all of the language from the Standards pertinent to the Board (see **attached** language).

The language in the additional section will implement Standards 1 – 12. Standards 13 – 15 specifically discuss a "private-sector vendor" that "provides diversion services". Therefore, the Board has not included language for these Standards, as the Board does not have a vendor nor does the Board provide diversion services. Standard 16 requires the Board to gather specific data pertaining to substance-abusing licensees. This language would not be placed in regulation; however, the Board has worked with the lab performing testing for the Board's probationers and has requested this information. In addition, the Department of Consumer Affair's new BreEZe system, once implemented, may be used to assist in the gathering of this information.

The Board should move forward with setting a regulatory hearing at the October Board Meeting in order to completely implement all of the Standards.

PROPOSED REGULATIONS FOR IMPLEMENTATION OF UNIFORM STANDARDS REGARDING SUBSTANCE-ABUSING HEALING ARTS LICENSEES (SB 1441)

Article 4
Disciplinary Guidelines and Uniform Standards for Substance-Abusing Licensees

1. Section 1361 of Title 16 of the California Code of Regulations is amended to read:

Section 1361. Disciplinary Guidelines and Exceptions for Uniform Standards Related to Substance-Abusing Licensees.

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

(b) Notwithstanding subsection (a), the Board shall use the uniform standards for substance-abusing licensees as provided in Section 1361.5, without deviation, for each individual determined to be a substance-abusing licensee.

(c) Nothing in this section or section 1361.5 shall be construed as a limitation on the Board's authority to seek an interim suspension order against a licensee pursuant to section 11529 of the Government Code.

2. Section 1361.5 is added to Title 16 of the California Code of Regulations to read:

1361.5. Uniform Standards for Substance-Abusing Licensees.

(a) If the licensee is to be disciplined, for unprofessional conduct involving the use of illegal drugs, the abuse of drugs and/or alcohol or both, the licensee shall be presumed to be a substance-abusing licensee for purposes of section 315 of the Code. The terms and conditions specified in subsection (c) shall be used in any probationary order of the Board affecting that licensee.

(b) Nothing in this section shall prohibit the Board from imposing additional terms or conditions of probation that are specific to a particular case or that are derived from the Board's disciplinary guidelines referenced in Section 1361 in any order that the Board determines would provide greater public protection or enhance the rehabilitation of the licensee.

(c) The following probationary terms and conditions shall be used without deviation in the case of a substance-abusing licensee:

(1) Notice of Employment Information. If a licensee whose license is on probation has an employer, the licensee shall provide to the Board the names, physical addresses, mailing addresses, and telephone numbers of all employers and supervisors and shall give specific, written consent for the Board and his or her employers and supervisors to communicate regarding the licensee's work status, performance, and monitoring.

(2) Clinical Diagnostic Evaluations and Reports.
(A) Whenever a licensee on probation due to a substance abuse problem is ordered to undergo a clinical diagnostic evaluation, the evaluator shall be a licensed physician and surgeon who holds a valid, unrestricted license to conduct clinical diagnostic evaluations, has three (3) years' experience in providing evaluations of physicians and surgeons with substance abuse disorders, and is approved by the Board. The evaluation shall be conducted in accordance with acceptable professional standards for conducting substance abuse clinical diagnostic evaluations. The evaluator shall not have a current or former financial, personal, or business relationship with the licensee within the last five (5) years. The evaluator shall provide an objective, unbiased, and independent evaluation. The cost of an evaluation shall be borne by the licensee.
(B) For a licensee who undergoes a clinical diagnostic evaluation, the Board shall order the licensee to cease practice during the clinical diagnostic evaluation pending the results of the clinical diagnostic evaluation and review by the Board.
(C) While awaiting the results of the clinical diagnostic evaluation, the licensee shall be randomly drug tested at least two (2) times per week.
(D) The clinical diagnostic evaluation report shall set forth, in the evaluator's opinion, whether the licensee has a substance abuse problem, whether the licensee is a threat to himself or herself or others, and recommendations for substance abuse treatment, practice restrictions, or other recommendations related to the licensee's rehabilitation and safe practice. If the evaluator determines during the evaluation process that a licensee is a threat to himself or herself or others, the evaluator shall notify the Board within 24 hours of such a determination. In determining whether the licensee is safe to return to either part-time or full-time practice and what restrictions or recommendations should be imposed, including participation in an inpatient or outpatient treatment program, the evaluator shall consider the following factors:
(i) License type, licensee's history, documented length of sobriety, scope and pattern of substance abuse, treatment history, medical history, current medical condition, nature, duration and severity of substance abuse problem, and whether the licensee is a threat to himself or herself or others.
(E) For all evaluations, a final written report shall be provided to the Board no later than ten (10) days from the date the evaluator is assigned the matter, unless the evaluator requests additional information to complete the evaluation, not to exceed 30 days.
(F) The Board shall review the clinical diagnostic evaluation report to determine whether the licensee is safe to return to either part-time or full-time practice and what restrictions or recommendations shall be imposed on the licensee based on the recommendations made by the evaluator.

(3) Worksite Monitor Requirements and Responsibilities.
(A) If the Board determines that a worksite monitor is necessary for a particular licensee, the licensee shall, within 30 calendar days of the effective date of that determination, submit to the Board or its designee for prior approval the names of a worksite monitor(s). The worksite

monitor shall meet the following criteria to be approved by the Board:
(i) The worksite monitor shall not have a current or former financial, personal, or familial relationship with the licensee, or other relationship that could reasonably be expected to compromise the ability of the monitor to render impartial and unbiased reports to the Board. If it is impractical for anyone but the licensee's employer to serve as the worksite monitor, this requirement may be waived by the Board; however, under no circumstances shall a licensee's worksite monitor be an employee or supervisee of the licensee.
(ii) The worksite monitor's license scope of practice shall include the scope of practice of the licensee who is being monitored or be another physician and surgeon if no monitor with like scope of practice is available.
(iii) The worksite monitor shall have an active unrestricted license with no disciplinary action within the last five (5) years.
(B) The worksite monitor shall sign an affirmation that he or she has reviewed the terms and conditions of the licensee's disciplinary order and agrees to monitor the licensee as set forth by the Board.
(C) The worksite monitor shall adhere to the following required methods of monitoring the licensee:
(i) Have face-to-face contact with the licensee in the work environment on as frequent a basis as determined by the Board but not less than once per week.
(ii) Interview other staff in the office regarding the licensee's behavior, if requested by the Board.
(iii) Review the licensee's work attendance.
(D) The worksite monitor shall verbally report any suspected substance abuse to the Board and the licensee's employer within one (1) business day of occurrence. If the suspected substance abuse does not occur during the Board's normal business hours, the verbal report shall be made to the Board within one (1) hour of the next business day. A written report that includes the date, time, and location of the suspected abuse, the licensee's actions and any other information deemed important by the worksite monitor shall be submitted to the Board within 48 hours of the verbal report.
(E) The worksite monitor shall complete and submit a written report monthly or as directed by the Board. The report shall include: the licensee's name; license number; the worksite monitor's name and signature; worksite monitor's license number; worksite location(s); the dates licensee had face-to-face contact with monitor; worksite staff interviewed, if applicable; attendance report; any change in behavior and/or personal habits; any indicators that can lead to suspected substance abuse.
(F) The licensee shall execute agreements with the approved worksite monitor(s) and the Board authorizing the Board and worksite monitor to exchange information.
(G) If the monitor resigns or is no longer available, licensee shall, within 5 calendar days of such resignation or unavailability, submit to the Board the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If licensee fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, licensee 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. Licensee shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

(4) Group Support Meetings.
(A) The Board may require a licensee to participate in group support meetings. The Board may impose participation in group support meetings following such recommendation by the evaluator or in a clinical diagnosis report.
(B) When determining the frequency of group support meetings to be attended, the Board or the evaluator shall give consideration to the licensee's history, the documented length of sobriety, time that has elapsed since substance use, the recommendation of the clinical evaluator, the scope and pattern of use, the licensee's treatment history, and the nature, duration, and severity of substance abuse.
(C) The facilitator of a group support meeting shall conform to the following requirements:
(i) He or she shall have a minimum of three (3) years' experience in the treatment and rehabilitation of substance abuse, and shall be licensed or certified by the state or nationally certified organizations.
(ii) He or she shall not have a current or former financial, personal, or business relationship with the licensee within the last five (5) years.
(iii) He or she shall provide to the Board a signed document showing the licensee's name, the group name, the date and location of the meeting, the licensee's attendance, and the licensee's level of participation and progress.
(iv) He or she shall report a licensee's unexcused absence to the Board within 24 hours.

(5) Biological Fluid Testing. The Board shall require biological fluid testing of substance-abusing licensees.
(A) For the purposes of this subsection, biological fluid testing means the acquisition and chemical analysis of a licensee's urine, blood, breath, or hair.
(B) The following standards shall apply to a licensee ordered to undergo biological fluid testing**:**
(i) The licensee shall be tested a minimum of 52-104 times per year for the first year of probation and at any time ordered by the Board. After the first year of probation, licensees who are practicing shall be randomly drug tested at least 36-104 times per year, and at any time as directed by the Board.
(1) The Board may revise the frequency specified in section (i) upon a determination that the licensee is not currently employed in a health care field, the licensee suffers from a substance use or abuse disorder, or other circumstances in which a revision of the testing frequency would not impair public protection. In no case may the testing frequency be reduced below twenty-four (24) times per calendar year.
(ii) Drug testing may be required on any day, including weekends and holidays.
(iii) The scheduling of testing shall be done on a random basis, preferably by a computer program, except when testing on a specific date is ordered by the Board.
(iv) Licensees shall be required to make daily contact with the Board to ascertain if testing is required.
(v) Licensees shall submit to all random and specifically ordered biological fluid tests.
(vi) The cost of biological fluid testing shall be borne by the licensee.
(vii) Licensees may elect to have the tests performed by an entity under contract with the Board or by another entity, provided that the entity meets all the following standards:
(1) Its specimen collectors must either be certified by the Drug and Alcohol Testing Industry Association or have completed the training required to serve as a collector for the United States Department of Transportation.

(2) It conforms to the current United States Department of Transportation Guidelines for Specimen Collection
(3) Its testing locations comply with the Urine Specimen Collection Guidelines published by the United States Department of Transportation without regard to the type of test administered.
(4) The collection of testing specimens shall be observed.
(5) Its laboratories shall be certified and accredited by the U.S. Department of Health and Human Services.
(6) Its collection sites submit a specimen to a laboratory within one (1) business day of receipt and all specimens collected shall be subjected to chain of custody procedures. The entity shall process and analyze the specimen and provide legally defensible test results to the Board within seven (7) days of receipt of the specimen.

(6) Results of Biological Fluid Tests.
(A) If the results of a biological fluid test indicates that a licensee has used, consumed, ingested or administered to himself or herself a prohibited substance, the Board shall order the licensee to cease practice and instruct the licensee to leave any place of employment where he or she is practicing medicine or providing medical services. The Board shall also immediately notify all the licensee's employers that the licensee may not provide medical services or practice medicine while the cease practice order is in effect.
(B) After the issuance of a cease practice order, the Board shall determine whether the test is in fact evidence of prohibited substance use by consulting with the specimen collector and the laboratory, communicating with the licensee, his or her treating physician(s), other health care provider, or group facilitator, as applicable.
(C) If no prohibited substance use exists, the Board shall immediately lift the cease practice order.
(D) For the purposes of this section, "prohibited substance" means an illegal or unlawful drug, a lawful drug not prescribed or ordered by an appropriately licensed health care provider for use by the licensee and approved by the Board, alcohol, or other substance.

(7) Actions by Licensees and Consequences Thereof.
(A) A licensee who does any of the following shall be deemed to have committed a major violation of his or her probation:
(i) Fails to undergo a required clinical diagnostic evaluation;
(ii) Commits multiple minor violations of probation conditions and terms;
(iii) Treats a patient or patients while under the influence of drugs or alcohol;
(iv) Commits any drug or alcohol offense that is a violation of state or federal law or any regulation adopted thereto;
(v) Fails to undergo biological testing when ordered;
(vi) Uses, consumes, ingests, or administers to himself or herself a prohibited substance;
(vii) Knowingly uses, makes, alters or possesses any object or product in such a way as to defraud a biological fluid test designed to detect the presence of a prohibited substance.
(B) If a licensee commits one or more major violation, the Board may take the following actions:
(i) Issue an immediate cease practice order.
(ii) Order the licensee to undergo a clinical diagnostic evaluation at the expense of the licensee. Any order issued by the Board pursuant to this subsection may state that the licensee must test negative for at least a month of continuous drug testing before being allowed to resume practice.

(iii) Increase the frequency of biological fluid testing.
(C) A licensee who does any of the following shall be deemed to have committed a minor violation of his or her probation:
(i) Failure to submit required documentation to the Board in a timely manner;
(ii) Unexcused absence at required meetings;
(iii) Failure to contact a worksite monitor as required;
(iv) Failure to comply with another term or condition of his or her probation that does not impair public safety.
(D) If a licensee commits one or more minor violations, the Board may take the following actions:
(i) Issue a cease practice order;
(ii) Issue a citation and fine.
(iii) Order the licensee to undergo a clinical diagnostic evaluation at the expense of the licensee.
(E) Nothing in this section shall be considered a limitation on the Board's authority to revoke the probation of a licensee who has violated a term or condition of that probation.

(8) Request to Return to Full or Partial Practice.
(A) Before determining whether to authorize the return to practice after the issuance of a cease practice order or after the imposition of practice restrictions following a clinical diagnostic evaluation, the Board in conjunction with the evaluator shall ensure that the licensee meets the following criteria:
(i) A demonstration of sustained compliance with his or her current treatment or recovery program, as applicable.
(ii) A demonstration of the capability to practice medicine safely as evidenced by current worksite monitor reports, evaluations conducted by licensed health care practitioners, and any other information relating to the licensee's substance abuse and recovery therefrom.
(iii) Negative drug screening reports for at least six (6) months, two (2) positive worksite monitor reports, and complete compliance with other terms and conditions of probation.

Uniform Standards Regarding Substance-Abusing Healing Arts Licensees

Senate Bill 1441 (Ridley-Thomas)

Implementation by
Department of Consumer Affairs,
Substance Abuse Coordination Committee

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DEPARTMENT OF CONSUMER AFFAIRS

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Table of Contents

Uniform Standard #1 4
Uniform Standard #2 6
Uniform Standard #3 7
Uniform Standard #4 8
Uniform Standard #5 12
Uniform Standard #6 13
Uniform Standard #7 14
Uniform Standard #8 16
Uniform Standard #9 17
Uniform Standard #10 18
Uniform Standard #11 20
Uniform Standard #12 21
Uniform Standard #13 22
Uniform Standard #14 26
Uniform Standard #15 27
Uniform Standard #16 28

#1 SENATE BILL 1441 REQUIREMENT

Specific requirements for a clinical diagnostic evaluation of the licensee, including, but not limited to, required qualifications for the providers evaluating the licensee.

#1 Uniform Standard

If a healing arts board orders a licensee who is either in a diversion program or whose license is on probation due to a substance abuse problem to undergo a clinical diagnosis evaluation, the following applies:

1. The clinical diagnostic evaluation shall be conducted by a licensed practitioner who:

    - holds a valid, unrestricted license, which includes scope of practice to conduct a clinical diagnostic evaluation;

    - has three (3) years experience in providing evaluations of health professionals with substance abuse disorders; and,

    - is approved by the board.

2. The clinical diagnostic evaluation shall be conducted in accordance with acceptable professional standards for conducting substance abuse clinical diagnostic evaluations.

3. The clinical diagnostic evaluation report shall:

    - set forth, in the evaluator's opinion, whether the licensee has a substance abuse problem;

    - set forth, in the evaluator's opinion, whether the licensee is a threat to himself/herself or others; and,

    - set forth, in the evaluator's opinion, recommendations for substance abuse treatment, practice restrictions, or other recommendations related to the licensee's rehabilitation and safe practice.

The evaluator shall not have a financial relationship, personal relationship, or business relationship with the licensee within the last five years. The evaluator shall provide an objective, unbiased, and independent evaluation.

If the evaluator determines during the evaluation process that a licensee is a threat to himself/herself or others, the evaluator shall notify the board within 24 hours of such a determination.

For all evaluations, a final written report shall be provided to the board no later than ten (10) days from the date the evaluator is assigned the matter unless the evaluator requests additional information to complete the evaluation, not to exceed 30 days.

#2 SENATE BILL 1441 REQUIREMENT

Specific requirements for the temporary removal of the licensee from practice, in order to enable the licensee to undergo the clinical diagnostic evaluation described in subdivision (a) and any treatment recommended by the evaluator described in subdivision (a) and approved by the board, and specific criteria that the licensee must meet before being permitted to return to practice on a full-time or part-time basis.

#2 Uniform Standard

The following practice restrictions apply to each licensee who undergoes a clinical diagnostic evaluation:

1. The Board shall order the licensee to cease practice during the clinical diagnostic evaluation pending the results of the clinical diagnostic evaluation and review by the diversion program/board staff.

2. While awaiting the results of the clinical diagnostic evaluation required in Uniform Standard #1, the licensee shall be randomly drug tested at least two (2) times per week.

After reviewing the results of the clinical diagnostic evaluation, and the criteria below, a diversion or probation manager shall determine, whether or not the licensee is safe to return to either part-time or fulltime practice. However, no licensee shall be returned to practice until he or she has at least 30 days of negative drug tests.

- the license type;
- the licensee's history;
- the documented length of sobriety/time that has elapsed since substance use
- the scope and pattern of use;
- the treatment history;
- the licensee's medical history and current medical condition;
- the nature, duration and severity of substance abuse, and
- whether the licensee is a threat to himself/herself or the public.

#3 SENATE BILL 1441 REQUIREMENT

Specific requirements that govern the ability of the licensing board to communicate with the licensee's employer about the licensee's status or condition.

#3 Uniform Standard

If the licensee who is either in a board diversion program or whose license is on probation has an employer, the licensee shall provide to the board the names, physical addresses, mailing addresses, and telephone numbers of all employers and supervisors and shall give specific, written consent that the licensee authorizes the board and the employers and supervisors to communicate regarding the licensee's work status, performance, and monitoring.

#4 SENATE BILL 1441 REQUIREMENT

Standards governing all aspects of required testing, including, but not limited to, frequency of testing, randomnicity, method of notice to the licensee, number of hours between the provision of notice and the test, standards for specimen collectors, procedures used by specimen collectors, the permissible locations of testing, whether the collection process must be observed by the collector, backup testing requirements when the licensee is on vacation or otherwise unavailable for local testing, requirements for the laboratory that analyzes the specimens, and the required maximum timeframe from the test to the receipt of the result of the test.

#4 Uniform Standard

The following standards shall govern all aspects of testing required to determine abstention from alcohol and drugs for any person whose license is placed on probation or in a diversion program due to substance use:

TESTING FREQUENCY SCHEDULE

A board may order a licensee to drug test at any time. Additionally, each licensee shall be tested RANDOMLY in accordance with the schedule below:

Level	**Segments of Probation/Diversion**	Minimum Range of Number of Random Tests
I	Year 1	52-104 per year
II*	Year 2+	36-104 per year

*The minimum range of 36-104 tests identified in level II, is for the second year of probation or diversion, and each year thereafter, up to five (5) years. Thereafter, administration of one (1) time per month if there have been no positive drug tests in the previous five (5) consecutive years of probation or diversion.

Nothing precludes a board from increasing the number of random tests for any reason. Any board who finds or has suspicion that a licensee has committed a violation of a board's testing program or who has committed a Major Violation, as identified in Uniform Standard 10, may reestablish the testing cycle by placing that licensee at the beginning of level I, in addition to any other disciplinary action that may be pursued.

EXCEPTIONS TO TESTING FREQUENCY SCHEDULE

I. PREVIOUS TESTING/SOBRIETY
   In cases where a board has evidence that a licensee has participated in a treatment or monitoring program requiring random testing, prior to being subject to testing by the board, the board may give consideration to that testing in altering the testing

frequency schedule so that it is equivalent to this standard.

II. VIOLATION(S) OUTSIDE OF EMPLOYMENT
An individual whose license is placed on probation for a single conviction or incident or two convictions or incidents, spanning greater than seven years from each other, where those violations did not occur at work or while on the licensee's way to work, where alcohol or drugs were a contributing factor, may bypass level I and participate in level II of the testing frequency schedule.

III. NOT EMPLOYED IN HEALTH CARE FIELD
A board may reduce testing frequency to a minimum of 12 times per year for any person who is not practicing OR working in any health care field. If a reduced testing frequency schedule is established for this reason, and if a licensee wants to return to practice or work in a health care field, the licensee shall notify and secure the approval of the licensee's board. Prior to returning to any health care employment, the licensee shall be subject to level I testing frequency for at least 60 days. At such time the person returns to employment (in a health care field), if the licensee has not previously met the level I frequency standard, the licensee shall be subject to completing a full year at level I of the testing frequency schedule, otherwise level II testing shall be in effect.

IV. TOLLING
A board may postpone all testing for any person whose probation or diversion is placed in a tolling status if the overall length of the probationary or diversion period is also tolled. A licensee shall notify the board upon the licensee's return to California and shall be subject to testing as provided in this standard. If the licensee returns to employment in a health care field, and has not previously met the level I frequency standard, the licensee shall be subject to completing a full year at level I of the testing frequency schedule, otherwise level II testing shall be in effect.

V. SUBSTANCE USE DISORDER NOT DIAGNOSED
In cases where no current substance use disorder diagnosis is made, a lesser period of monitoring and toxicology screening may be adopted by the board, but not to be less than 24 times per year.

OTHER DRUG STANDARDS

Drug testing may be required on any day, including weekends and holidays.

The scheduling of drug tests shall be done on a random basis, preferably by a computer program, so that a licensee can make no reasonable assumption of when he/she will be tested again. Boards should be prepared to report data to support back-to-back testing as well as, numerous different intervals of testing.

Licensees shall be required to make daily contact to determine if drug testing is required.

Licensees shall be drug tested on the date of notification as directed by the board.

Specimen collectors must either be certified by the Drug and Alcohol Testing Industry Association or have completed the training required to serve as a collector for the U.S. Department of Transportation.

Specimen collectors shall adhere to the current U.S. Department of Transportation Specimen Collection Guidelines.

Testing locations shall comply with the Urine Specimen Collection Guidelines published by the U.S. Department of Transportation, regardless of the type of test administered.

Collection of specimens shall be observed.

Prior to vacation or absence, alternative drug testing location(s) must be approved by the board.

Laboratories shall be certified and accredited by the U.S. Department of Health and Human Services.

A collection site must submit a specimen to the laboratory within one (1) business day of receipt. A chain of custody shall be used on all specimens. The laboratory shall process results and provide legally defensible test results within seven (7) days of receipt of the specimen. The appropriate board will be notified of non-negative test results within one (1) business day and will be notified of negative test results within seven (7) business days.

A board may use other testing methods in place of, or to supplement biological fluid testing, if the alternate testing method is appropriate.

PETITIONS FOR REINSTATEMENT

Nothing herein shall limit a board's authority to reduce or eliminate the standards specified herein pursuant to a petition for reinstatement or reduction of penalty filed pursuant to Government Code section 11522 or statutes applicable to the board that contains different provisions for reinstatement or reduction of penalty.

OUTCOMES AND AMENDMENTS

For purposes of measuring outcomes and effectiveness, each board shall collect and report historical and post implementation data as follows:

Historical Data - Two Years Prior to Implementation of Standard

Each board should collect the following historical data (as available), for a period of two years, prior to implementation of this standard, for each person subject to testing for banned substances, who has 1) tested positive for a banned substance, 2) failed to

appear or call in, for testing on more than three occasions, 3) failed to pay testing costs, or 4) a person who has given a dilute or invalid specimen.

Post Implementation Data- Three Years

Each board should collect the following data annually, for a period of three years, for every probationer and diversion participant subject to testing for banned substances, following the implementation of this standard.

Data Collection

The data to be collected shall be reported to the Department of Consumer Affairs and the Legislature, upon request, and shall include, but may not be limited to:

Probationer/Diversion Participant Unique Identifier
License Type
Probation/Diversion Effective Date
General Range of Testing Frequency by/for Each Probationer/Diversion Participant
Dates Testing Requested
Dates Tested
Identify the Entity that Performed Each Test
Dates Tested Positive
Dates Contractor (if applicable) was informed of Positive Test
Dates Board was informed of Positive Test
Dates of Questionable Tests (e.g. dilute, high levels)
Date Contractor Notified Board of Questionable Test
Identify Substances Detected or Questionably Detected
Dates Failed to Appear
Date Contractor Notified Board of Failed to Appear
Dates Failed to Call In for Testing
Date Contractor Notified Board of Failed to Call In for Testing
Dates Failed to Pay for Testing
Date(s) Removed/Suspended from Practice (identify which)
Final Outcome and Effective Date (if applicable)

#5 SENATE BILL 1441 REQUIREMENT

Standards governing all aspects of group meeting attendance requirements, including, but not limited to, required qualifications for group meeting facilitators, frequency of required meeting attendance, and methods of documenting and reporting attendance or nonattendance by licensees.

#5 Uniform Standard

If a board requires a licensee to participate in group support meetings, the following shall apply:

When determining the frequency of required group meeting attendance, the board shall give consideration to the following:

- the licensee's history;
- the documented length of sobriety/time that has elapsed since substance use;
- the recommendation of the clinical evaluator;
- the scope and pattern of use;
- the licensee's treatment history; and,
- the nature, duration, and severity of substance abuse.

Group Meeting Facilitator Qualifications and Requirements:

1. The meeting facilitator must have a minimum of three (3) years experience in the treatment and rehabilitation of substance abuse, and shall be licensed or certified by the state or other nationally certified organizations.

2. The meeting facilitator must not have a financial relationship, personal relationship, or business relationship with the licensee within the last year.

3. The group meeting facilitator shall provide to the board a signed document showing the licensee's name, the group name, the date and location of the meeting, the licensee's attendance, and the licensee's level of participation and progress.

4. The facilitator shall report any unexcused absence within 24 hours**.**

#6 SENATE BILL 1441 REQUIREMENT

Standards used in determining whether inpatient, outpatient, or other type of treatment is necessary.

#6 Uniform Standard

In determining whether inpatient, outpatient, or other type of treatment is necessary, the board shall consider the following criteria:

- recommendation of the clinical diagnostic evaluation pursuant to Uniform Standard #1;
- license type;
- licensee's history;
- documented length of sobriety/time that has elapsed since substance abuse;
- scope and pattern of substance use;
- licensee's treatment history;
- licensee's medical history and current medical condition;
- nature, duration, and severity of substance abuse, and
- threat to himself/herself or the public.

#7 SENATE BILL 1441 REQUIREMENT

Worksite monitoring requirements and standards, including, but not limited to, required qualifications of worksite monitors, required methods of monitoring by worksite monitors, and required reporting by worksite monitors.

#7 Uniform Standard

A board may require the use of worksite monitors. If a board determines that a worksite monitor is necessary for a particular licensee, the worksite monitor shall meet the following requirements to be considered for approval by the board.

1. The worksite monitor shall not have financial, personal, or familial relationship with the licensee, or other relationship that could reasonably be expected to compromise the ability of the monitor to render impartial and unbiased reports to the board. If it is impractical for anyone but the licensee's employer to serve as the worksite monitor, this requirement may be waived by the board; however, under no circumstances shall a licensee's worksite monitor be an employee of the licensee.

2. The worksite monitor's license scope of practice shall include the scope of practice of the licensee that is being monitored, be another health care professional if no monitor with like practice is available, or, as approved by the board, be a person in a position of authority who is capable of monitoring the licensee at work.

3. If the worksite monitor is a licensed healthcare professional he or she shall have an active unrestricted license, with no disciplinary action within the last five (5) years.

4. The worksite monitor shall sign an affirmation that he or she has reviewed the terms and conditions of the licensee's disciplinary order and/or contract and agrees to monitor the licensee as set forth by the board.

5. The worksite monitor must adhere to the following required methods of monitoring the licensee:

    a) Have face-to-face contact with the licensee in the work environment on a frequent basis as determined by the board, at least once per week.

    b) Interview other staff in the office regarding the licensee's behavior, if applicable.

    c) Review the licensee's work attendance.

Reporting by the worksite monitor to the board shall be as follows:

1. Any suspected substance abuse must be verbally reported to the board and the licensee's employer within one (1) business day of occurrence. If occurrence is not during the board's normal business hours the verbal report must be within one (1) hour of the next business day. A written report shall be submitted to the board within 48 hours of occurrence.

2. The worksite monitor shall complete and submit a written report monthly or as directed by the board. The report shall include:

   - the licensee's name;
   - license number;
   - worksite monitor's name and signature;
   - worksite monitor's license number;
   - worksite location(s);
   - dates licensee had face-to-face contact with monitor;
   - staff interviewed, if applicable;
   - attendance report;
   - any change in behavior and/or personal habits;
   - any indicators that can lead to suspected substance abuse.

The licensee shall complete the required consent forms and sign an agreement with the worksite monitor and the board to allow the board to communicate with the worksite monitor.

#8 SENATE BILL 1441 REQUIREMENT

Procedures to be followed when a licensee tests positive for a banned substance.

#8 Uniform Standard

When a licensee tests positive for a banned substance:

1. The board shall order the licensee to cease practice;

2. The board shall contact the licensee and instruct the licensee to leave work; and

3. The board shall notify the licensee's employer, if any, and worksite monitor, if any, that the licensee may not work.

Thereafter, the board should determine whether the positive drug test is in fact evidence of prohibited use. If so, proceed to Standard #9. If not, the board shall immediately lift the cease practice order.

In determining whether the positive test is evidence of prohibited use, the board should, as applicable:

1. Consult the specimen collector and the laboratory;

2. Communicate with the licensee and/or any physician who is treating the licensee; and

3. Communicate with any treatment provider, including group facilitator/s.

#9 SENATE BILL 1441 REQUIREMENT

Procedures to be followed when a licensee is confirmed to have ingested a banned substance.

#9 Uniform Standard

When a board confirms that a positive drug test is evidence of use of a prohibited substance, the licensee has committed a major violation, as defined in Uniform Standard #10 and the board shall impose the consequences set forth in Uniform Standard #10.

#10 SENATE BILL 1441 REQUIREMENT

Specific consequences for major and minor violations. In particular, the committee shall consider the use of a "deferred prosecution" stipulation described in Section 1000 of the Penal Code, in which the licensee admits to self-abuse of drugs or alcohol and surrenders his or her license. That agreement is deferred by the agency until or unless licensee commits a major violation, in which case it is revived and license is surrendered.

#10 Uniform Standard

Major Violations include, but are not limited to:

1. Failure to complete a board-ordered program;
2. Failure to undergo a required clinical diagnostic evaluation;
3. Multiple minor violations;
4. Treating patients while under the influence of drugs/alcohol;
5. Any drug/alcohol related act which would constitute a violation of the practice act or state/federal laws;
6. Failure to obtain biological testing for substance abuse;
7. Testing positive and confirmation for substance abuse pursuant to Uniform Standard #9;
8. Knowingly using, making, altering or possessing any object or product in such a way as to defraud a drug test designed to detect the presence of alcohol or a controlled substance.

Consequences for a major violation include, but are not limited to:

1. Licensee will be ordered to cease practice.
   a) the licensee must undergo a new clinical diagnostic evaluation, and
   b) the licensee must test negative for at least a month of continuous drug testing before being allowed to go back to work.
2. Termination of a contract/agreement.
3. Referral for disciplinary action, such as suspension, revocation, or other action as determined by the board.

Minor Violations include, but are not limited to:

1. Untimely receipt of required documentation;
2. Unexcused non-attendance at group meetings;
3. Failure to contact a monitor when required;
4. Any other violations that do not present an immediate threat to the violator or to the public.

Consequences for minor violations include, but are not limited to**:**

1. Removal from practice;
2. Practice limitations;
3. Required supervision;
4. Increased documentation;
5. Issuance of citation and fine or a warning notice;
6. Required re-evaluation/testing;
7. Other action as determined by the board.

#11 SENATE BILL 1441 REQUIREMENT

Criteria that a licensee must meet in order to petition for return to practice on a full time basis.

#11 Uniform Standard

"Petition" as used in this standard is an informal request as opposed to a "Petition for Modification" under the Administrative Procedure Act.

The licensee shall meet the following criteria before submitting a request (petition) to return to full time practice:

1. Demonstrated sustained compliance with current recovery program.

2. Demonstrated the ability to practice safely as evidenced by current work site reports, evaluations, and any other information relating to the licensee's substance abuse.

3. Negative drug screening reports for at least six (6) months, two (2) positive worksite monitor reports, and complete compliance with other terms and conditions of the program.

#12 SENATE BILL 1441 REQUIREMENT

Criteria that a licensee must meet in order to petition for reinstatement of a full and unrestricted license.

#12 Uniform Standard

"Petition for Reinstatement" as used in this standard is an informal request (petition) as opposed to a "Petition for Reinstatement" under the Administrative Procedure Act.

The licensee must meet the following criteria to request (petition) for a full and unrestricted license.

1. Demonstrated sustained compliance with the terms of the disciplinary order, if applicable.

2. Demonstrated successful completion of recovery program, if required.

3. Demonstrated a consistent and sustained participation in activities that promote and support their recovery including, but not limited to, ongoing support meetings, therapy, counseling, relapse prevention plan, and community activities.

4. Demonstrated that he or she is able to practice safely.

5. Continuous sobriety for three (3) to five (5) years.

#13 SENATE BILL 1441 REQUIREMENT

If a board uses a private-sector vendor that provides diversion services, (1) standards for immediate reporting by the vendor to the board of any and all noncompliance with process for providers or contractors that provide diversion services, including, but not limited to, specimen collectors, group meeting facilitators, and worksite monitors; (3) standards requiring the vendor to disapprove and discontinue the use of providers or contractors that fail to provide effective or timely diversion services; and (4) standards for a licensee's termination from the program and referral to enforcement.

#13 Uniform Standard

1. A vendor must report to the board any major violation, as defined in Uniform Standard #10, within one (1) business day. A vendor must report to the board any minor violation, as defined in Uniform Standard #10, within five (5) business days.

2. A vendor's approval process for providers or contractors that provide diversion services, including, but not limited to, specimen collectors, group meeting facilitators, and worksite monitors is as follows:

   (a) Specimen Collectors:

   (1) The provider or subcontractor shall possess all the materials, equipment, and technical expertise necessary in order to test every licensee for which he or she is responsible on any day of the week.

   (2) The provider or subcontractor shall be able to scientifically test for urine, blood, and hair specimens for the detection of alcohol, illegal, and controlled substances.

   (3) The provider or subcontractor must provide collection sites that are located in areas throughout California.

   (4) The provider or subcontractor must have an automated 24-hour toll-free telephone system and/or a secure on-line computer database that allows the participant to check in daily for drug testing.

   (5) The provider or subcontractor must have or be subcontracted with operating collection sites that are engaged in the business of collecting urine, blood, and hair follicle specimens for the testing of drugs and alcohol within the State of California.

   (6) The provider or subcontractor must have a secure, HIPAA compliant, website or computer system to allow staff access to drug test results and compliance reporting information that is available 24 hours a day.

(7) The provider or subcontractor shall employ or contract with toxicologists that are licensed physicians and have knowledge of substance abuse disorders and the appropriate medical training to interpret and evaluate laboratory drug test results, medical histories, and any other information relevant to biomedical information.

(8) A toxicology screen will not be considered negative if a positive result is obtained while practicing, even if the practitioner holds a valid prescription for the substance.

(9) Must undergo training as specified in Uniform Standard #4 (6).

(b) Group Meeting Facilitators:

A group meeting facilitator for any support group meeting:

(1) must have a minimum of three (3) years experience in the treatment and rehabilitation of substance abuse;

(2) must be licensed or certified by the state or other nationally certified organization;

(3) must not have a financial relationship, personal relationship, or business relationship with the licensee within the last year;

(4) shall report any unexcused absence within 24 hours to the board, and,

(5) shall provide to the board a signed document showing the licensee's name, the group name, the date and location of the meeting, the licensee's attendance, and the licensee's level of participation and progress.

(c) Work Site Monitors:

The worksite monitor must meet the following qualifications:

(1) Shall not have financial, personal, or familial relationship with the licensee, or other relationship that could reasonably be expected to compromise the ability of the monitor to render impartial and unbiased reports to the board. If it is impractical for anyone but the licensee's employer to serve as the worksite monitor, this requirement may be waived by the board; however, under no circumstances shall a licensee's worksite monitor be an employee of the licensee.

(2) The monitor's licensure scope of practice shall include the scope of practice of the licensee that is being monitored, be another health care professional if no

monitor with like practice is available, or, as approved by the board, be a person in a position of authority who is capable of monitoring the licensee at work.

(3) Shall have an active unrestricted license, with no disciplinary action within the last five (5) years.

(4) Shall sign an affirmation that he or she has reviewed the terms and conditions of the licensee's disciplinary order and/or contract and agrees to monitor the licensee as set forth by the board.

2. The worksite monitor must adhere to the following required methods of monitoring the licensee:

   a) Have face-to-face contact with the licensee in the work environment on a frequent basis as determined by the board, at least once per week.

   b) Interview other staff in the office regarding the licensee's behavior, if applicable.

   c) Review the licensee's work attendance.

3. Any suspected substance abuse must be verbally reported to the contractor, the board, and the licensee's employer within one (1) business day of occurrence. If occurrence is not during the board's normal business hours the verbal report must be within one (1) hour of the next business day. A written report shall be submitted to the board within 48 hours of occurrence.

4. The worksite monitor shall complete and submit a written report monthly or as directed by the board. The report shall include:

   - the licensee's name;
   - license number;
   - worksite monitor's name and signature;
   - worksite monitor's license number;
   - worksite location(s);
   - dates licensee had face-to-face contact with monitor;
   - staff interviewed, if applicable;
   - attendance report;
   - any change in behavior and/or personal habits;

- any indicators that can lead to suspected substance abuse.

(d) Treatment Providers

Treatment facility staff and services must have:

(1) Licensure and/or accreditation by appropriate regulatory agencies;

(2) Sufficient resources available to adequately evaluate the physical and mental needs of the client, provide for safe detoxification, and manage any medical emergency;

(3) Professional staff who are competent and experienced members of the clinical staff;

(4) Treatment planning involving a multidisciplinary approach and specific aftercare plans;

(5) Means to provide treatment/progress documentation to the provider.

(e) General Vendor Requirements

The vendor shall disapprove and discontinue the use of providers or contractors that fail to provide effective or timely diversion services as follows:

(1) The vendor is fully responsible for the acts and omissions of its subcontractors and of persons either directly or indirectly employed by any of them. No subcontract shall relieve the vendor of its responsibilities and obligations. All state policies, guidelines, and requirements apply to all subcontractors.

(2) If a subcontractor fails to provide effective or timely services as listed above, but not limited to any other subcontracted services, the vendor will terminate services of said contractor within 30 business days of notification of failure to provide adequate services.

(3) The vendor shall notify the appropriate board within five (5) business days of termination of said subcontractor.

#14 SENATE BILL 1441 REQUIREMENT

If a board uses a private-sector vendor that provides diversion services, the extent to which licensee participation in that program shall be kept confidential from the public.

#14 Uniform Standard

The board shall disclose the following information to the public for licensees who are participating in a board monitoring/diversion program regardless of whether the licensee is a self-referral or a board referral. However, the disclosure shall not contain information that the restrictions are a result of the licensee's participation in a diversion program.

- Licensee's name;
- Whether the licensee's practice is restricted, or the license is on inactive status;
- A detailed description of any restriction imposed.

#15 SENATE BILL 1441 REQUIREMENT

If a board uses a private-sector vendor that provides diversion services, a schedule for external independent audits of the vendor's performance in adhering to the standards adopted by the committee.

#15 Uniform Standard

1. If a board uses a private-sector vendor to provide monitoring services for its licensees, an external independent audit must be conducted at least once every three (3) years by a qualified, independent reviewer or review team from outside the department with no real or apparent conflict of interest with the vendor providing the monitoring services. In addition, the reviewer shall not be a part of or under the control of the board. The independent reviewer or review team must consist of individuals who are competent in the professional practice of internal auditing and assessment processes and qualified to perform audits of monitoring programs.

2. The audit must assess the vendor's performance in adhering to the uniform standards established by the board. The reviewer must provide a report of their findings to the board by June 30 of each three (3) year cycle. The report shall identify any material inadequacies, deficiencies, irregularities, or other non-compliance with the terms of the vendor's monitoring services that would interfere with the board's mandate of public protection.

3. The board and the department shall respond to the findings in the audit report.

#16 SENATE BILL 1441 Requirement

Measurable criteria and standards to determine whether each board's method of dealing with substance-abusing licensees protects patients from harm and is effective in assisting its licensees in recovering from substance abuse in the long term.

#16 Uniform Standard

Each board shall report the following information on a yearly basis to the Department of Consumer Affairs and the Legislature as it relates to licensees with substance abuse problems who are either in a board probation and/or diversion program.

- Number of intakes into a diversion program
- Number of probationers whose conduct was related to a substance abuse problem
- Number of referrals for treatment programs
- Number of relapses (break in sobriety)
- Number of cease practice orders/license in-activations
- Number of suspensions
- Number terminated from program for noncompliance
- Number of successful completions based on uniform standards
- Number of major violations; nature of violation and action taken
- Number of licensees who successfully returned to practice
- Number of patients harmed while in diversion

The above information shall be further broken down for each licensing category, specific substance abuse problem (i.e. cocaine, alcohol, Demerol etc.), whether the licensee is in a diversion program and/or probation program.

If the data indicates that licensees in specific licensing categories or with specific substance abuse problems have either a higher or lower probability of success, that information shall be taken into account when determining the success of a program. It may also be used to determine the risk factor when a board is determining whether a license should be revoked or placed on probation.

The board shall use the following criteria to determine if its program protects patients from harm and is effective in assisting its licensees in recovering from substance abuse in the long term.

- At least 100 percent of licensees who either entered a diversion program or whose license was placed on probation as a result of a substance abuse problem successfully completed either the program or the probation, or had their license to practice revoked or surrendered on a timely basis based on noncompliance of those programs.

- At least 75 percent of licensees who successfully completed a diversion program or probation did not have any substantiated complaints related to substance abuse for at least five (5) years after completion.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: July 11, 2013
ATTENTION: Board Members
SUBJECT: Teleconferencing of Board Meetings
STAFF CONTACT: Kimberly Kirchmeyer, Deputy Director

RECOMMENDED ACTION:

Review the information provided and determine the feasibility of providing teleconferencing for statewide public participation.

BACKGROUND AND ANALYSIS:

The Board has been asked to teleconference future meetings to permit public participation from individuals who cannot attend. 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. In response, staff was directed to research the feasibility of this request and provide the information back to the Members for their consideration. The objectives of the Board are to encourage public participation and transact its business efficiently.

At the April 26, 2013 Board Meeting, staff provided a memo to the Members with alternatives that would allow more individuals to participate in the Board's meetings. The Members believed that more discussion needed to occur on these proposals and asked Ms. Schipske to work with Board staff to identify methods that may meet the needs of the public and the Board.

After further review, and following a discussion with Ms. Schipske, staff believes that the following options would enable meaningful participation by members of the public who cannot attend the meeting, while permitting the transaction of Board business within the time allocated for the meeting.

Options for Teleconferencing:

1) Provide a telephone number for anyone to call in and provide comments. Presumably, individuals would watch the meeting via webcast and, when appropriate, could call in and provide comment on the item(s) of interest to them. The Board would have to provide a staff member who would use a laptop and be the moderator. 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 moderator would notify the Board President/Committee Chair that a comment is pending. At the appropriate time, the callers would provide their comments. The callers would need to be limited to specified minutes per comment per agenda item (example two minutes).

   The issue with this option is the time that could be incurred to hear from all the individuals at the meeting and on the telephone. However, the Board does have the authority pursuant to Government Code section 11125.7 to limit by regulation the length of time afforded for public comment. For example, for comments on "Items not on the Agenda" the Board could state that it is going to allow 20 minutes maximum for individuals at the meeting and 20 minutes maximum for callers on the conference line. The Board would state that each speaker (whether in person or on

the telephone) would be given two minutes to provide his/her comments and at the end of the comment, the Board would then move to the next speaker. At the end of the 20 minutes, the public comment period would end.

The Board could also provide a time limit on specific agenda items. For example, at the end of a discussion, the Board would open it up to comments from the public and would state that it would allow 10 minutes for individuals at the meeting and 10 minutes for individuals on the telephone. Again, the speaker would be provided with a certain time limit (two minutes) that would be adhered to and then the Board would move to the next speaker, until the 10 minute limit was exhausted.

Please note that limiting the time allocated for public comment on any agenda item is a change from the Board's current practice of apportioning time per speaker. Under current Board practice, each commenter gets to speak but his or he time is limited.

This option involves setting two limits: a limit on the total time for public comment on an item **and** a limit on the time per speaker. So, if there were a large number of speakers or callers on an issue, and a small amount of time was allocated, speakers may be limited to a minute or less of comment. This option may be problematic as callers may not be able to speak if the time allocated has elapsed.

2) Provide an email account whereby an individual watching the webcast could submit written comments or questions to a staff member, who would monitor and read the comments or questions to the Board at the appropriate time. The same limits as above could be instituted, including limiting the reading of the item to two minutes and allowing comment for 10 or 20 minutes. However, this option does not permit persons to call in to a meeting.

In reviewing these options, legal counsel has stated the Board may choose to put the time limits in regulation. This will allow the Board to set specific requirements and also allow the public to have input through the regulatory process. If the Board institutes the time limit requirements equally for those present at the meeting and for those joining remotely, regulations may not be necessary, but again are recommended.

Whatever option is chosen, the Board would need to strictly impose the time limits on all speakers. If the Board states at the beginning of a meeting that each speaker is allowed two minutes, the Board must consistently limit each speaker. Consistency will be the key to implementing this process.

The Board would need implementation time, including development and testing, in order to initiate either of these options. The Board may need to pilot the selected teleconferencing option at a Committee or other meeting before implementing on a full-scale basis. In addition, the Board would need to ensure that it has the appropriate connections at the hotels for the technology necessary to implement these options. The cost for either option would be minimal, but would require a staff person to monitor the phone/computer.

Standing Committees, Task Forces & Councils
of the Medical Board of California
June 2013

Committee	*Members*
Executive Committee	**Sharon Levine, M.D., President** Gerrie Schipske, R.N.P., J.D., Vice President Silvia Diego, M.D., Secretary Reginald Low, M.D. Janet Salomonson, M.D. Barbara Yaroslavsky, Past President
Licensing Committee	**Janet Salomonson, M.D., Chair** Michael Bishop, M.D. Silvia Diego, M.D. Gerrie Schipske, R.N.P., J.D. Denise Pines
Enforcement Committee	**Reginald Low, M.D., Chair** Dev GnanaDev, M.D. Sharon Levine, M.D. Gerrie Schipske, R.N.P., J.D. David Serrano Sewell Barbara Yaroslavsky
Application Review Committee	**Gerrie Schipske, R.N.P., J.D., Chair** Silvia Diego, M.D. Reginald Low, M.D.
Special Faculty Permit Review Committee	**Reginald Low, M.D., Chair** Wadie Najm, M.D. Clarence Braddock, M.D. Neal Cohen, M.D. (UCSF) Daniel Giang, M.D. (LLU) John A. Heydt, M.D. (UCR) James Nuovo, M.D. (UCD) Neil Parker, M.D. (UCLA) Andrew Ries, M.D. (UCSD) Frank Sinatra, M.D. (USC) Barbara Yaroslavsky
Special Programs Committee	**Chair (Vacant)**
Access to Care Committee/Cultural & Linguistic Competency Committee ********** **Subcommittee Members**	**Vacant, Chair** Barbara Yaroslavsky ********** David Hayes-Bautista, Ph.D. Sergio Aguilar-Gaxiola, M.D., Ph.D

Education & Wellness Committee	**Barbara Yaroslavsky, Chair** Silvia Diego, M.D. Sharon Levine, M.D. Janet Salomonson, M.D. Gerrie Schipske, R.N.P., J.D. ********** Daniel Giang, M.D. William Norcross, M.D. Laurie Gregg, M.D. Gary Nye, M.D.
Committee on Physician Supervisory Responsibilities	**Gerrie Schipske, R.N.P., J.D. Chair** Suzanne Kilmer, M.D. Christopher Barnard, M.D. . James Newman, M.D Michael Bishop, M.D. Paul Phinney, M.D. Jack Bruner, M.D. Harrison Robbins, M.D. Beth Grivett, P.A. Janet Salomonson, M.D.
Midwifery Advisory Council	**Carrie Sparrevohn, L.M., Chair** James Byrne, M.D. Karen Ehrlich, L.M. Monique Webster Barbara Yaroslavsky
Panel A	**Barbara Yaroslavsky, Chair** Janet Salomonson, M.D., Vice Chair Michael Bishop, M.D. Silvia Diego, M.D. David Serrano Sewell, J.D. Felix Yip, M.D.
Panel B	**Reginald Low, M.D., Chair** Dev GnanaDev, M.D. Sharon Levine, M.D. Denise Pines Gerrie Schipske, R.N.P., J.D. Phil Tagami
Budget Subcommittee	Barbara Yaroslavsky
Full Board Evaluation Subcommittee	Janet Salomonson, M.D.
Legislation Subcommittee	Sharon Levine, M.D.
Strategic Plan Subcommittee	Sharon Levine, M.D. Barbara Yaroslavsky

Members of Executive Committee include: President, Vice President, Secretary, Immediate Past President, and one other member appointed by the President. (*note: there should be at least one public member within group of five members)

Revised: June 2013

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

FY 2012-13 Governor's Budget	ACTUAL 2011-12	CURRENT YEAR 2012-13	BY 2013-14	BY+1 2014-15	BY+2 2015-16
BEGINNING BALANCE	$ 30,246	$ 24,613	$ 20,835	$ 15,395	$ 7,249
Prior Year Adjustment	$ 752	$ -	$ -	$ -	$ -
Adjusted Beginning Balance	$ 30,998	$ 24,613	$ 20,835	$ 15,395	$ 7,249
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	$ 36	$ 63
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	$ 52,499	$ 52,526
Transfers:					
GENERAL FUND LOAN*	$ (9,000)				
TOTALS, REVENUES AND TRANSFERS	$ 43,857	$ 52,513	$ 52,523	$ 52,499	$ 52,526
TOTAL RESOURCES	$ 74,855	$ 77,126	$ 73,358	$ 67,894	$ 59,775
EXPENDITURES					
Disbursements:					
0840 State Controller (State Operations)	$ 58	$ 67		$ -	$ -
8880 FSCU (State Operations)	$ 2	$ 302	$ 259		
FISCAL	$ 126	$			
1110 Program Expenditures (State Operations)	$ 50,056	$ 55,922 **	$ 55,673	$ 56,810	$ 57,853
2013-2014 and 2014-15 Approved Costs					
BreEZe Costs			$ 1,183		
CURES			$ 848	$ 790	
Anticipated Future Costs					
BreEZe Costs					
Expert Review Rate Increase				$ 467	$ 467
Anticipated BreEZe Cost				$ 1,300	$ 1,300
Northern Operation Safe Medicine				$ 697	$ 568
Enforcement Enhancements				$ 581	$ 489
Totals, Disbursements	$ 50,242	$ 56,291	$ 57,963	$ 60,645	$ 60,677
FUND BALANCE					
Reserve for economic uncertainties	$ 24,613	$ 20,835	$ 15,395	$ 7,249	$ (902)
Months in Reserve	5.2	4.3	3.0	1.4	-0.2

NOTES:

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

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

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

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

7/2/2013

Medical Board of California
FY 12/13
Budget Expenditure Report
(As of MAY 31, 2013)
(92% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENSES/ ENCUMB	PERCENT OF BUDGET EXP/ENCUMB	UNENCUMB BALANCE
PERSONAL SERVICES				
Salary & Wages				
(Staff & Exec Director)	15,268,382	13,252,820	86.8	2,015,562
Board Members	31,500	59,884	190.1	(28,384)
Phy Fitness Incentive Pay	29,623	28,440	96.0	1,183
Temp Help	1,137,513	1,392,347	122.4	(254,834)
Overtime	12,143	43,900	361.5	(31,757)
Staff Benefits	7,775,513	6,430,380	82.7	1,345,133
Salary Savings	0			0
TOTALS, PERS SERVICES	24,254,674	21,207,771	87.4	3,046,903
OPERATING EXP & EQUIP				
General Expense	608,071	550,299	90.5	57,772
Fingerprint Reports	333,448	279,215	83.7	54,233
Minor Equipment	132,300	58,687	44.4	73,613
Printing	685,755	211,352	30.8	474,403
Communications	372,190	203,205	54.6	168,985
Postage	282,511	166,866	59.1	115,645
Insurance	41,053	17,295	42.1	23,758
Travel In-State	401,298	293,814	73.2	107,484
Travel Out-of-State	7,000	3,021	43.2	3,979
Training	78,895	89,825	113.9	(10,930)
Facilities Operation (Rent)	2,702,140	2,276,640	84.3	425,500
Consult/Prof Services	1,606,594	1,934,801	120.4	(328,207)
Departmental Prorata	4,540,957	4,542,584	100.0	(1,627)
Interagency Services	5,142	0	0.0	5,142
Consolidated Data Center	650,230	553,347	85.1	96,883
Data Processing	129,492	87,730	67.7	41,762
Central Admin Svcs (Statewide Prorata)	2,348,960	2,348,960	100.0	0
Attorney General Services	13,347,280	10,873,393	81.5	2,473,887
Office of Administrative Hearings	1,525,080	1,004,632	65.9	520,448
Evidence/Witness	1,893,439	1,759,037	92.9	134,402
Court Reporter Services	225,000	213,133	94.7	11,867
Major Equipment	652,000	644,886	98.9	7,114
Other Items of Expense	81	66,290	81,839.5	(66,209)
Vehicle Operations	261,925	265,353	101.3	(3,428)
Court-ordered Payments	0	22,486		(22,486)
Board of Control Claim	0	1,435		(1,435)
TOTALS, OE&E	32,830,841	28,468,286	86.7	4,362,555
TOTALS, EXPENDITURES	57,085,515	49,676,057	87.0	7,409,458
Scheduled Reimbursements	(384,000)	(327,273)	85.2	(56,727)
Distributed Costs	(780,000)	(537,305)	68.9	(242,695)
NET TOTAL, EXPENDITURES	55,921,516	48,811,479	87.3	7,110,036
Unscheduled Reimbursements		(1,422,459)		
		47,389,020		

Budget Expenditure Report.xls
Date: June 28, 2013

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
BUDGET REPORT
JULY 1, 2012 to MAY 31, 2013

	FY 12/13 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	2,476,739	2,236,294	current
Staff Benefits	1,216,790	1,043,875	current
TOTAL PERSONAL SERVICES	3,693,529	3,280,169	
OPERATING EXPENSES & EQUIPMENT			
General Expense	58,184	17,923	1-2
Fingerprint Reports*	333,448	277,235	1-2
Printing	61,000	34,251	1-2
Communications	52,246	20,204	1-2
Postage	125,000	97,625	1-2
Travel In-State	14,758	2,540	1-2
Training	8,500	1,478	1-2
Facilities Operation	226,000	226,215	current
Consult/Professional Services	1,225,873	1,670,230	1-2
Departmental Services	519,486	444,106	current
Interagency Services	587	0	current
Data Processing	4,000	8,665	1-2
Statewide Pro Rata	268,016	268,017	current
Attorney General	190,000	93,120	current
Evidence/Witness Fees	7,500	0	1-2
Court Reporter Services	250	0	1-2
Other Items of Expense	0	36	1-2
Major Equipment	26,000	16,580	1-2
Minor Equipment	0	0	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	3,120,848	3,178,225	
SCHEDULED REIMBURSEMENTS	(384,000)	(327,273)	
DISTRIBUTED COSTS	(31,130)	(23,348)	
TOTAL BUDGET/EXPENDITURES	**6,399,247**	**6,107,773**	

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

6/28/2013

MEDICAL BOARD OF CALIFORNIA
ENFORCEMENT PROGRAM
BUDGET REPORT
JULY 1, 2012-MAY 31, 2013

	FY 12/13 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	9,884,363	8,781,776	current
Staff Benefits	4,545,798	3,735,890	current
TOTAL PERSONAL SERVICES	14,430,161	12,517,666	
OPERATING EXPENSE & EQUIPMENT			
General Expense/Fingerprint Reports	389,307	371,199	1-2
Printing	300,255	93,067	1-2
Communications	222,358	136,532	1-2
Postage	69,500	64,177	1-2
Insurance	38,235	14,890	current
Travel In-State	242,018	213,872	1-2
Travel Out-State	7,000	3,086	1-2
Training	31,000	52,479	1-2
Facililties Operations	2,064,940	1,656,553	current
Consultant/Professional Services	300,000	251,949	1-2
Departmental Services	3,191,838	3,386,362	current
Interagency Services	3,613	0	1-2
Data Processing	18,000	22,725	1-2
Statewide Pro Rata	1,650,379	1,650,379	current
Attorney General 1/	13,157,280	10,780,273	current
OAH	1,525,080	1,004,632	1
Evidence/Witness Fees	1,820,939	1,669,616	1-2
Court Reporter Services	224,750	213,133	1-2
Major Equipment	147,000	436,916	1-2
Other Items of Expense (Law Enf. Materials/Lab, etc.)	81	63,987	1-2
Vehicle Operations	210,925	224,360	1-2
Minor Equipment	0	23,797	1-2
Court-Ordered Payments	0	23,922	current
TOTAL OPERATING EXPENSES & EQUIPMENT	25,614,498	22,357,907	
DISTRIBUTED COSTS	(744,053)	(510,346)	
TOTAL BUDGET/EXPENDITURES	**39,300,606**	**34,365,227**	
Unscheduled Reimbursements		(72,445)	
		34,292,782	

1/See next page for monthly billing detail

MEDICAL BOARD OF CALIFORNIA
ATTORNEY GENERAL EXPENDITURES - FY 12/13
DOJ AGENCY CODE 003573 - ENFORCEMENT (6303)
page 1 of 2

		Number of Hours	Rate	Amount
July	Attorney Services	5,386.75	170.00	915,747.50
	Paralegal Services	206.00	120.00	24,720.00
	Auditor/Analyst Services	110.00	99.00	10,890.00
	Cost of Suit			0.00
				951,357.50
August	Attorney Services	6,056.00	170.00	1,029,520.00
	Paralegal Services	215.00	120.00	25,800.00
	Auditor/Analyst Services	79.50	99.00	7,870.50
	Cost of Suit			264.00
				1,063,454.50
September	Attorney Services	5,132.25	170.00	872,482.50
	Paralegal Services	201.50	120.00	24,180.00
	Auditor/Analyst Services	76.00	99.00	7,524.00
	Cost of Suit			726.58
				904,913.08
October	Attorney Services	6,249.75	170.00	1,062,457.50
	Paralegal Services	242.00	120.00	29,040.00
	Auditor/Analyst Services	97.00	99.00	9,603.00
	Cost of Suit			315.00
				1,101,415.50
November	Attorney Services	5,098.25	170.00	866,702.50
	Paralegal Services	169.00	120.00	20,280.00
	Auditor/Analyst	121.50	99.00	12,028.50
	Cost of Suit			2,238.45
				901,249.45
December	Attorney Services	4,833.75	170.00	821,737.50
	Paralegal Services	230.50	120.00	27,660.00
	Auditor/Analyst	82.00	99.00	8,118.00
	Cost of Suit			1,946.95
				859,462.45
			Total July-Dec =	**5,781,852.48**
			FY 12/13 Budget =	**13,157,280.00**

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

January				
	Attorney Services	5,992.50	170.00	1,018,725.00
	Paralegal Services	243.00	120.00	29,160.00
	Auditor/Analyst	122.00	99.00	12,078.00
	Cost of Suit			3,346.42
				1,063,309.42
February				
	Attorney Services	5,024.75	170.00	854,207.50
	Paralegal Services	273.50	120.00	32,820.00
	Auditor/Analyst	110.00	99.00	10,890.00
	Cost of Suit			430.17
				898,347.67
March				
	Attorney Services	5,649.00	170.00	960,330.00
	Paralegal Services	171.50	120.00	20,580.00
	Auditor/Analyst Services	106.25	99.00	10,518.75
	Cost of Suit			3,471.00
				994,899.75
April				
	Attorney Services	5,669.00	170.00	963,730.00
	Paralegal Services	276.75	120.00	33,210.00
	Auditor/Analyst Services	140.50	99.00	13,909.50
	Cost of Suit			2,592.69
				1,013,442.19
May				
	Attorney Services	5,761.50	170.00	979,455.00
	Paralegal Services	278.50	120.00	33,420.00
	Auditor/Analyst Services	151.00	99.00	14,949.00
	Cost of Suit			598.00
				1,028,422.00
June				
	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst Services	0.00	99.00	0.00
	Cost of Suit			
				0.00

Revised 06/28/2013

FYTD Total =	**10,780,273.51**
FY 12/13 Budget =	**13,157,280.00**

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

	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	FYTD Total
Invest Cost Recovery	3,981	971	871	846	996	2,177	896	3,550	896	896	1,100	1,146	18,326
Criminal Cost Recovery	0	0	0	0	0	0	0	0	0	0	0	0	0
Probation Monitoring	43,697	74,202	31,474	35,029	120,104	157,971	332,595	170,590	72,520	94,712	71,738	47,283	1,251,913
Exam	2,475	3,730	1,750	9,456	4,031	1,158	1,237	2,621	1,400	4,235	2,500	627	35,219
Cite/Fine	5,500	9,000	10,075	4,000	2,600	5,700	5,000	2,896	1,950	5,650	950	200	53,521
MONTHLY TOTAL	55,653	87,903	44,170	49,331	127,731	167,006	339,728	179,656	76,766	105,493	76,288	49,255	1,358,980
FYTD TOTAL	55,653	143,557	187,727	237,058	364,788	531,794	871,522	1,051,178	1,127,944	1,233,436	1,309,725	1,358,980	

	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	FYTD Total
Invest Cost Recovery	300	350	300	100	50	3,932	40,589	50	10,281	0	0	0	55,952
Criminal Cost Recovery	0	0	150	0	50	250	605	504	1,055	754	14,147	2,558	20,073
Probation Monitoring	42,542	41,848	44,639	105,369	96,368	109,993	343,253	222,925	83,025	97,287	59,217	34,113	1,280,578
Exam	1,639	777	2,481	627	1,692	2,552	977	1,106	6,495	1,831	6,024	2,224	28,424
Cite/Fine	200	4,350	800	10,650	3,250	6,400	8,650	7,002	3,450	7,825	3,075	3,800	59,452
MONTHLY TOTAL	44,681	47,325	48,370	116,745	101,409	123,127	394,074	231,587	104,307	107,698	82,462	42,695	1,444,479
FYTD TOTAL	44,681	92,005	140,375	257,120	358,530	481,657	875,730	1,107,317	1,211,624	1,319,322	1,401,784	1,444,479	

	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	FYTD Total
Invest Cost Recovery	250	300	650	2,349	750	700	4,527	600	2,595	6,888	600		20,209
Criminal Cost Recovery	1,409	705	619	5,136	964	10,914	2,411	1,198	676	489	39,422		63,943
Probation Monitoring	38,879	47,871	26,432	65,999	45,648	146,950	434,545	319,499	52,448	55,458	29,123		1,262,852
Exam	1,848	3,456	6,563	2,666	5,212	975	3,074	1,625	4,725	12,262	138		42,543
Cite/Fine	2,800	1,900	4,750	6,268	8,586	12,300	8,700	4,059	3,850	1,650	3,100		57,963
MONTHLY TOTAL	45,186	54,232	39,014	82,418	61,160	171,839	453,257	326,981	64,294	76,747	72,382	0	1,447,510
FYTD TOTAL	45,186	99,418	138,432	220,850	282,010	453,849	907,106	1,234,087	1,298,381	1,375,128	1,447,510	1,447,510	

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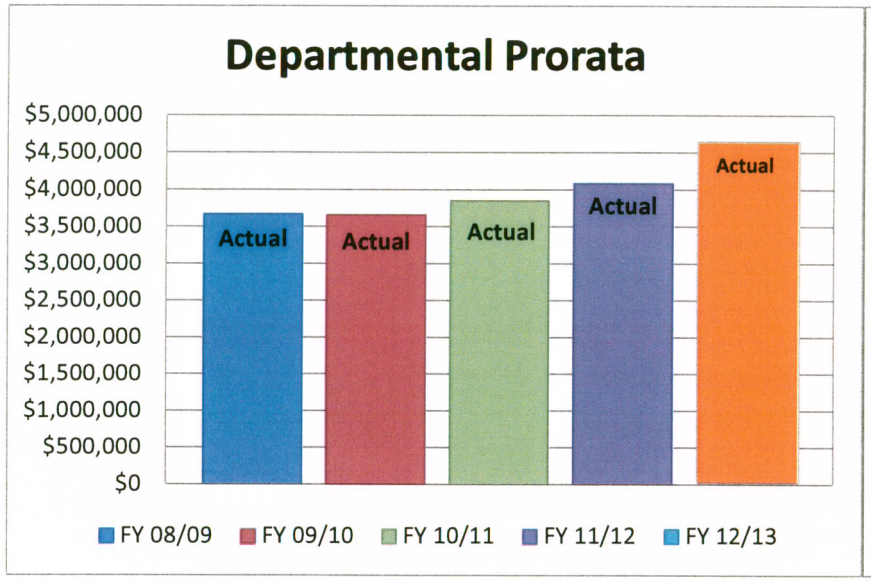
MEDICAL BOARD OF CALIFORNIA BUDGET OVERVIEW BY BOARD COMPONENT

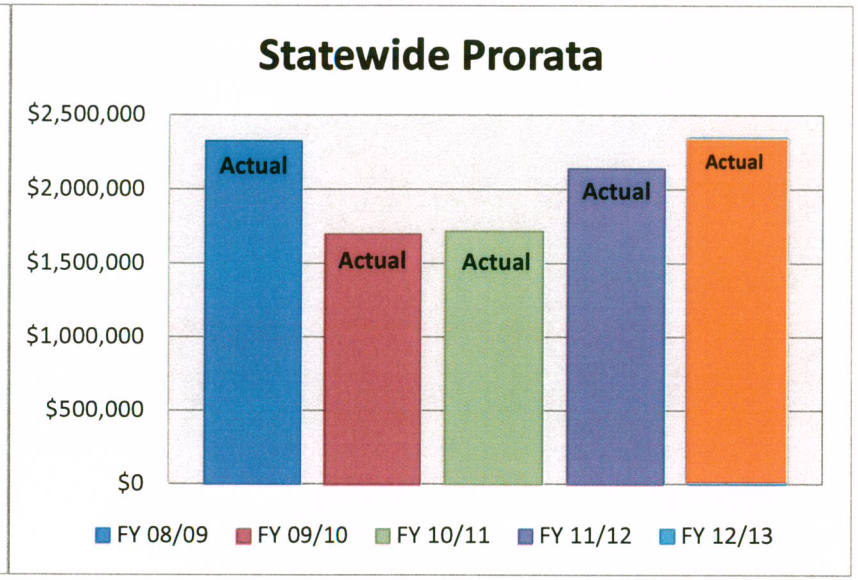
	EXEC	ENFORCE	OPERATION SAFE MEDICINE	LICENSING	ADMIN SERVICES	INFO SYSTEMS	PROBATION MONITORING	BOARD TOTAL
FY 09/10								
$ Budgeted	2,030,000	36,539,000	567,000	4,262,000	1,558,000	2,953,000	1,589,000	49,498,000
$ Spent *	2,920,000	34,130,000	494,000	4,772,000	1,547,000	2,728,000	500,000	47,091,000 *
Positions Authorized	8.8	146.6	6.0	45.5	15.0	16.0	25.0	262.9
FY 10/11								
$ Budgeted	1,944,000	37,720,000	577,000	5,045,000	1,688,000	3,118,000	1,735,000	51,827,000
$ Spent *	1,771,000	34,420,000	651,000	5,061,000	1,564,000	2,948,000	487,000	46,902,000 *
Positions Authorized	8.8	165.0	6.0	52.3	15.0	17.0	25.0	289.1
FY 11/12								
$ Budgeted	1,885,220	40,510,088		5,336,015	1,585,554	3,069,028	2,013,445	54,399,350
$ Spent*	1,775,576	33,754,208		4,745,127	1,543,636	2,810,667	503,487	45,132,701 *
Positions Authorized	8.8	164.1		53.3	15.0	17.0	25.0	283.2
FY 12/13								
$ Budgeted	2,132,008	39,300,606	525,515	6,399,247	1,570,587	3,754,162	2,239,391	55,921,516
$ Spent thru 05/31*	1,461,933	34,292,782	591,024	6,107,773	1,565,289	2,723,888	646,331	47,389,020 *
Positions Authorized	8.8	147.0	6.0	53.3	14.0	17.0	25.0	271.1

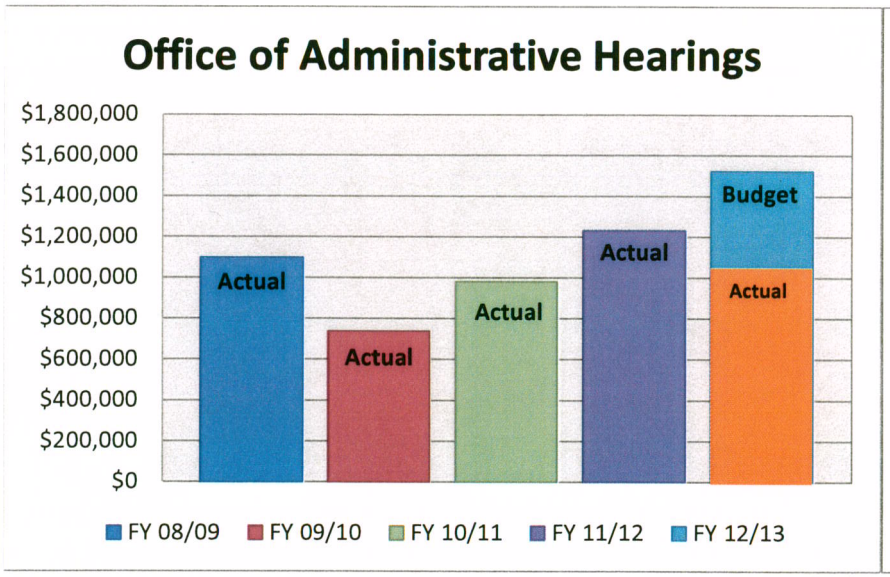
* net expenditures (includes unscheduled reimbursements)

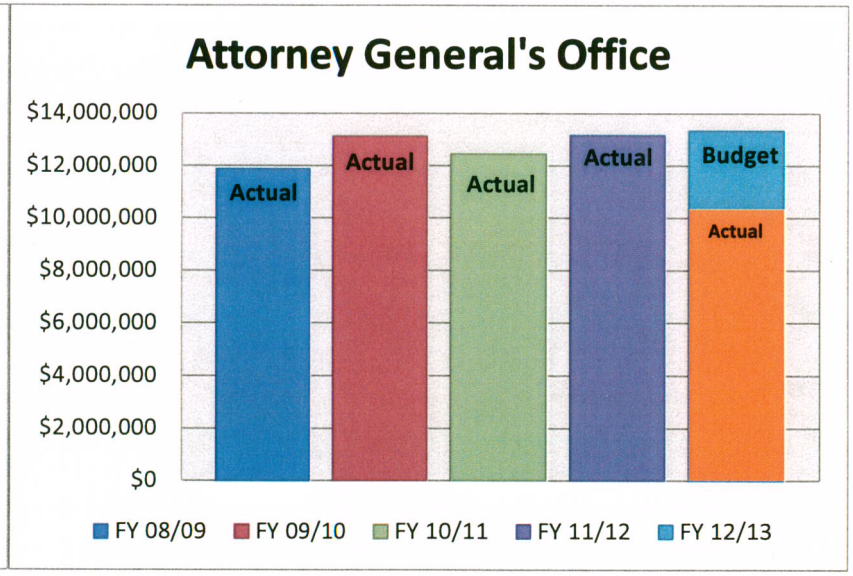
6/28/2013
Budget Overview by Program.xls

Strategic Plan Objective 5.3
External Agencies' Spending









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

NAMES	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APRIL	MAY	JUNE	YTD
DR. BISHOP - Per diem	$1,100.00	$ 400.00	$ 600.00	$ 600.00	$ 600.00	$ 400.00	$ 600.00	$ 300.00	$ 500.00				$ 5,100.00
Travel	$ 904.66		$ 517.90	$ 88.64			$ 866.32						$ 2,377.52
	$2,004.66	$ 400.00	$1,117.90	$ 688.64	$ 600.00	$ 400.00	$1,466.32	$ 300.00	$ 500.00	$ -	$ -	$ -	**$ 7,477.52**
DR. CARREON - Per diem	$1,700.00												$ 1,700.00
Travel													$ -
	$1,700.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 1,700.00**
DR. DIEGO - Per diem	$1,300.00	$ 800.00	$ 600.00	$ 1,800.00	$ 1,400.00	$ 1,100.00	$1,500.00	$ 800.00	$1,000.00	$1,100.00			$11,400.00
Travel	$ 244.80	$ 94.35		$ 619.76			$ 501.75	$ 320.35					$ 1,781.01
	$1,544.80	$ 894.35	$ 600.00	.	$ 1,400.00	$ 1,100.00	$2,001.75	$1,120.35	$1,000.00	$1,100.00	$ -	$ -	**$ 13,181.01**
DR. DURUISSEAU - Per diem	$1,100.00												$ 1,100.00
Travel	$ 126.56												$ 126.56
	$1,226.56	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 1,226.56**
DR GNANADEV - Per diem	$1,200.00	$ 900.00	$ 700.00		$ 700.00	$ 600.00	$ 900.00	$ 600.00	$ 700.00				$ 6,300.00
Travel	$ 601.02		$ -		$ -	$ -	$ 903.11						$ 1,504.13
	$1,801.02	$ 900.00	$ 700.00	$ -	$ 700.00	$ 600.00	$1,803.11	$ 600.00	$ 700.00	$ -	$ -	$ -	**$ 7,804.13**
DR. LEVINE - Per diem	$ -												$ -
Travel	$ 413.90		$ 285.72	$ 359.62		$ 243.82	$ 57.30	$ 325.71		$ 605.66			$ 2,291.73
	$ 413.90	$ -	$ 285.72	$ 359.62	$ -	$ 243.82	$ 57.30	$ 325.71	$ -	$ 605.66	$ -	$ -	**$ 2,291.73**
DR. LOW - Per diem													$ -
Travel													$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
MS. PINES - Per diem			$1,100.00	$ 1,700.00	$ 1,600.00	$ 1,700.00	$1,800.00	$1,500.00	$1,700.00	$1,700.00	$1,500.00		$14,300.00
Travel			$ 171.68	$ 365.64	$ 446.49		$ 269.24			$ 55.82			$ 1,308.87
	$ -	$ -	$1,271.68	$ 2,065.64	$ 2,046.49	$ 1,700.00	$2,069.24	$1,500.00	$1,700.00	$1,755.82	$1,500.00	$ -	**$ 15,608.87**
DR. SALOMONSON - Per diem	$ 400.00		$ 200.00	$ 500.00			$ 200.00	$ 500.00					$ 1,800.00
Travel	$ 742.92		$ 462.73	$ 515.94			$ 894.25	$ 687.68					$ 3,303.52
	$1,142.92	$ -	$ 662.73	$ 1,015.94	$ -	$ -	$1,094.25	$1,187.68	$ -	$ -	$ -	$ -	**$ 5,103.52**
MS.SCHIPSKE - Per diem	$1,200.00	$ 400.00	$ 600.00	$ 1,300.00	$ 700.00	$ 900.00	$ 700.00	$ 500.00	$1,100.00	$1,600.00	$1,200.00		$10,200.00
Travel	$ 523.85			$ 498.39									$ 1,022.24
	$1,723.85	$ 400.00	$ 600.00	$ 1,798.39	$ 700.00	$ 900.00	$ 700.00	$ 500.00	$1,100.00	$1,600.00	$1,200.00	$ -	**$ 11,222.24**
MR. SERRANO SWELL- Per diem			$ 600.00	$ 600.00		$ 600.00	$ 700.00	$ 800.00	$ 700.00	$ 700.00	$ 700.00		$ 5,400.00
			$ 257.30	$ 774.36						$ 618.72			$ 1,650.38
	$ -	$ -	$ 857.30	$ 1,374.36	$ -	$ 600.00	$ 700.00	$ 800.00	$ 700.00	$1,318.72	$ 700.00	$ -	**$ 7,050.38**
MS. YAROSLAVSKY - Per diem	$1,600.00	$1,300.00	$ 900.00	$ 1,200.00	$ 1,000.00	$ 1,200.00	$ 300.00	$ 400.00					$ 7,900.00
Travel	$ 688.35	$ 883.88	$ 454.51	$ 581.44	$ 510.70		$ 872.40		$1,398.35	$ 364.38			$ 5,754.01
	$2,288.35	$2,183.88	$1,354.51	$ 1,781.44	$ 1,510.70	$ 1,200.00	$1,172.40	$ 400.00	$1,398.35	$ 364.38	$ -	$ -	**$ 13,654.01**
MS. YIP - Per diem													$ -
Travel													$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**

As of: 6/27/2013

TOTAL PER DIEM	$65,200.00
TOTAL TRAVEL	$21,119.97
TOTAL	**$ 86,319.97**

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	July 2, 2013
ATTENTION:	Members, Medical Board
SUBJECT:	Summary of the Gag Clause for Physicians
STAFF CONTACT:	Kim Kirchmeyer, Interim Executive Director and Renee Threadgill, Chief of Enforcement

History of Gag Clause Legislation:

2003/04 – Assembly Member Correa introduced AB 320. This bill would prohibit a licensee, or an entity acting on behalf of a licensee, which licensee is regulated by the Department of Consumer Affairs or various boards, bureaus, or programs from including, or permitting to be included, a provision in an agreement to settle a civil dispute that prohibits the other party in that dispute from contacting, filing a complaint with, or cooperating with the department, board, bureau, or program or that requires the other party to withdraw a complaint from the department, board, bureau, or program. A licensee in violation of these provisions would be subject to disciplinary action by the board, bureau, or program. This bill passed out of the legislature but was vetoed by the Governor.

2005 - Assembly Member Negrete McLeod introduced AB 446. This bill would prohibit a licensee who is regulated by the Department of Consumer Affairs or various boards, bureaus, or programs, or an entity or person acting as an authorized agent of a licensee, from including or permitting to be included a provision in an agreement to settle a civil dispute that prohibits the other party in that dispute from contacting, filing a complaint with, or cooperating with the department, board, bureau, or program, or that requires the other party to withdraw a complaint from the department, board, bureau, or program. A licensee in violation of these provisions would be subject to disciplinary action by the board, bureau, or program. The bill would also prohibit a board, bureau, or program from requiring its licensees in a disciplinary action that is based on a complaint or report that has been settled in a civil action to pay additional moneys to the benefit of any plaintiff in the civil action. This bill passed out of the legislature but was vetoed by the Governor.

2006 – Assembly Member Negrete McLeod introduced AB 2260, sponsored by the Medical Board of California. This bill addressed revisions to the special programs (B&P 2111, 2113, 2168) and the gag clause, as follows. This bill would prohibit a physician and surgeon from including certain provisions in an agreement to settle a civil dispute arising from his or her practice that interferes with communications, as specified, between the board and another party to the dispute. The bill would make the violation of this requirement subject to disciplinary action by the board. This bill was signed into law on September 28, 2006, effective on January 1, 2007.

Business and Professions Code section 2220.7 (commonly referred to as prohibition against gag clause or confidentiality agreement) provides:

> "(a) A physician and surgeon shall not include or permit to be included any of the following provision in an agreement to settle a civil dispute arising from his or her practice, whether the agreement is made before or after filing the action:
> (1) A provision that prohibits another party to the dispute from contacting or cooperating
> with the board.
> (2) A provision that prohibits another party to the dispute from filing a complaint with the board.
> (3) A provision that requires another party to the dispute to withdraw a complaint he or she has filed with the board.
> (b) A provision described in subdivision (a) is void as against public policy.
> (c) A physician and surgeon who violates this section is subject to disciplinary action by the board."

Since this law was enacted the Board has taken several actions against licensees.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	July 2, 2013
ATTENTION:	Medical Board of California
SUBJECT:	Recognition of International Medical School University of Queensland Ochsner Clinical School Program Request to Authorize Site Inspection
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing

REQUESTED ACTION AND RECOMMENDATION:

1. Determine if the admission process at the University of Queensland Ochsner Clinical School Program (UQO), which does not include a student interview as part of the evaluation for admission and criminal background checks are only done as part of the student visa application, is equivalent to those utilized by US and Canadian medical schools as required by the California Code of Regulations, Title 16, Division 13, Section 1314.1 (b)(8).

2. If the Board determines that the UQO's's admission process is sufficient to meet the standards set in regulation:

    a. Authorize a site team to conduct a site inspection of the University of Queensland School of Medicine in Australia and/or several representative teaching hospitals in the Ochsner Health System in southeast Louisiana where students in the Ochsner Clinical Program receive clinical training.

    b. Approve the composition of the site team, which usually includes at least one Board Executive staff member, one legal counsel, one Board member and a Medical Consultant.

    c. Delegate to staff the determination of the hospital training site or sites to be reviewed.

    d. Approve staff to move forward with an out-of-state travel request for the teaching hospital sites and an out-of-country travel request for the medical school site visit.

BACKGROUND AND ANALYSIS:

The University of Queensland School of Medicine, located in Brisbane, Australia, was founded in 1936 to train physicians to practice medicine primarily in Australia. It is the largest medical school in Australia and is currently recognized by the Board. Students graduate with the MBBS degree, which is the equivalent of the M.D. degree in the United States. Geographically, the

school extends throughout Queensland with major sites in Brisbane, the outer metropolitan areas, and a number of rural and remote area facilities throughout the rest of Queensland.

In 2008, the school adopted a "clinical school model" with the School of Medicine organized around 11 clinical schools (there were 10 clinical schools at the time the Self-Assessment Report was submitted) where students conduct their clinical training. Nine of the clinical schools are located in Australia and the remaining two are offshore clinical schools located in New Orleans, Louisiana, and in Brunei, SE Asia. The Brunei and Ochsner (New Orleans) clinical schools are designed for international students who will return to their own country to practice medicine upon graduation. Australian students are not eligible to apply to the offshore clinical school programs. Under the clinical school model, students study two years of basic sciences at the University of Queensland School of Medicine in Brisbane, Australia and then complete two years of clinical training at one of the clinical school sites. The Australian Medical Council has reviewed and approved each of the eleven clinical programs. The University of Queensland is not seeking the Board's recognition of the Brunei Clinical School Program at this time.

The Ochsner Clinical School Program in Louisiana is conducted in partnership with the Ochsner Health System which includes eight hospitals throughout southeast Louisiana, primarily in New Orleans and Baton Rouge. Ochsner has full institutional accreditation from the Accreditation Council for Graduate Medical Education (ACGME) as does its 27 Graduate Medical Education programs through the respective Residency Review Committees. The Ochsner Health System is also formally affiliated with both Louisiana State University School of Medicine and Tulane University School of Medicine. The UQO admits one class of students each year, with the academic year running from January to late November. The first class of students was admitted in January 2009 with an enrollment of 12 students. The UQO is aiming for a total enrollment of 480 students (120 students admitted into the program each year).

As a medical school program whose primary purpose is to educate non-citizens to practice medicine outside Australia, UQO meets the criteria for the Board's review pursuant to Section 1314.1(a)(2) of Title 16, California Code of Regulations. In January 2012, UQO officials submitted a Self Assessment Report to commence the Board's review process. Medical Consultant James Nuovo, M.D., has been reviewing the school's application. Dr. Nuovo and medical school officials have exchanged written information over the past year. On May 10, 2013, Dr. Nuovo and staff met with Dr. William Pinsky, Chief Academic Officer at Ochsner and Head of the UQO to discuss several issues concerning the administration of the school's educational program.

In his attached memorandum dated May 1, 2013, Dr. James Nuovo presented the results of his review of written documentation submitted by University of Queensland officials. Dr. Nuovo is recommending that the Board determine if the UQO's admission process is equivalent to those utilized by US and Canadian schools and, if deemed equivalent, proceed to the site inspection phase of the medical school review process.

During the site inspection, Dr. Nuovo, along with a Board staff representative, legal counsel and one Board member, will tour the school's campus in Australia; interview UQO

Executives/Administrators, faculty and students; and/or also tour several representative U.S. hospitals where UQO students complete clinical rotations during their third and fourth years and meet with students and Ochsner Executive/Administrators and faculty. The Board has previously conducted site inspections to multiple medical schools, primarily in the Caribbean region. Site inspections have proved invaluable to the Board in confirming the resources documented in the Self Assessment Report, determining whether the curriculum satisfies the minimum requirements of law and in evaluating the effectiveness of the program to graduate physicians who will be able to safely practice medicine in California.

Staff is requesting the Board members review Dr. Nuovo's report and determine whether to conduct site inspections to UQO's campus in Australia and to a representative sample of clinical training sites in southeast Louisiana. If the Board approves this request, staff will begin the process of arranging a site inspection. The Board will also need to approve the composition of the site team. Staff will work with UQO officials to determine the most compatible dates for the inspection and develop the team's itinerary. After these arrangements are finalized, staff will submit the request for out-of-statel/out-of-country travel approval to the Governor's Office. Following the site inspection, the team members will prepare a comprehensive report for the Board's review. The team's report will present the team's findings and will recommend that the Board either disapprove or grant recognition to the UQO.

Alternatively, if the Board requires further information regarding the school's educational resources before it reaches a decision regarding site inspections, staff will request UQO officials to submit the information for the Board's review during a future meeting.

FISCAL CONSIDERATIONS:

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

Representative(s) from the UQO are planning on being available during the meeting to answer any questions you may have concerning the school's educational program.

If you have any questions concerning this memorandum, please telephone me at (916) 263-2389.

May 1, 2013

To: Linda Whitney
Executive Director
Medical Board of California

From: Jim Nuovo, MD
Professor & Associate Dean of Graduate Medical Education
UC Davis School of Medicine

Re: Evaluation of the University of Queensland Ochsner Clinical School Program

Background

The Medical Board of California (Board) requested a review of the materials provided by the University of Queensland Ochsner (UQO) Clinical School Program. These were submitted in pursuit of a request for the recognition of the UQO Clinical School Program by the Board to enable their students and graduates to participate in clinical clerkships, to enter graduate medical education programs in California, and to become eligible for licensure to practice medicine in California.

This report is based on my review of the documents initially provided to the Board and from a response by the School to additional questions posed after review of the Self-Assessment Report.

The goal of this review was to determine if the medical education received in this program meets the requirements of current California statutes and regulations for recognition by the Medical Board of California.

Recommendations

The documents that have been provided are insufficient to determine whether the UQO Clinical School Program is in substantial compliance with the requirements of Business and Professions Code Sections 2089 and 2089.5 and California Code of Regulations, Title 16, Division 13, Section 1314.1.

In order to determine whether the UQO Clinical School Program is in substantial compliance with the aforementioned statutes and regulations, I recommend that the Board consider a site visit.

However, before the Board considers a site visit, I feel that the concern regarding the admissions process, as described below, be addressed.

Review

The University of Queensland (UQ) School of Medicine

The University of Queensland's School of Medicine was founded in 1936. It has worked to establish itself as "Australia's Global Medical School." As an indication of these efforts, the School notes that there are "over 450 staff who work across 31 sites over three continents." As of 2011, there were 1770 students studying in the MBBS program.

Once fully implemented, the UQO Clinical School Program would add 480 students to the School's complement.

The School has a defined mission statement which includes its "Vision, Purpose, Core Values and Strategic Priorities." It's Core Values include: Social Commitment, Inspiring Passion, Collective Pursuit of Excellence, Integrity and Professionalism, Valuing Our Social Community, and Innovation."

Its Strategic Priorities include: "Learning, Discovery, Engagement, Globalisation, and Operational Excellence."

The Self-Assessment Report provides a statement of the "Broad Expectations for the Education of Students." These are presented as "three aims of the UQ MBBS curriculum with seven goals and 35 outcomes, which align with the School of Medicine's Vision, Purpose and Values as well as the Australian Medical Council's Attributes of a Medical Graduate."

The Ochsner Health System

The Ochsner Health System (OHS) is a not-for-profit healthcare provider based in southeast Louisiana. OHS was founded in 1942. The OHS hospitals include: Ochsner Baptist Medical Center, Ochsner Medical Center – Kenner, Ochsner Hospital – Elmwood, Ochsner Medical Center – West Bank, Ochsner Medical Center – Baton Rouge, Ochsner St. Anne General Hospital, Ochsner Medical Center, and Ochsner Medical Center – Northshore.

The OHS "Mission and Vision Statement" is included in the Self-Assessment Report and states: "Ochsner will be a global medical and academic leader who will save and change lives. We will shape the future of healthcare through our integrated health system, fuelled by the passion and strength of our diversified team of physicians and employees."

The University of Queensland Ochsner (UQO) Clinical School Program

The UQO Clinical School Program opened in January 2009 with an enrollment of 12 students. The first class of UQO students graduated from the program in September 2012. The goal of the UQO Clinical School Program is for a total enrollment of 480 students.

Students admitted to this program will study two years of Basic Sciences at UQ in Australia. They will then spend two years completing their core and elective clinical rotations at OHS in New Orleans and/or Baton Rouge, Louisiana.

Upon successful completion of the curriculum, the UQO students are eligible for ECFMG certification and receive the MBBS degree.

UQ has 10 different "clinical schools" within its school of medicine where students complete their clinical rotations. Two of these schools are offshore; UQO and the Brunei Clinical School, which is a partnership between UQ and the University Brunei Darusslam in Brunei. UQ is not seeking recognition of the Brunei Clinical School.

The following is a detailed assessment of the School based on the aforementioned statutes and regulations and on the School's response to the Self-Assessment Report and the additional concerns posed by this reviewer.

Business and Professions Code Sections 2089

Section 2089 requires the medical curriculum to extend over four years or 32 months of actual instruction. UQO is a four year program in which the first two years (called Phase 1) are primarily pre-clinical and completed in Australia. The third and fourth years (called Phase 2) are structured as 10 Core Clinical Rotations and are completed in the OHS. These Core Clinical Rotations include: Medicine, Surgery, Mental Health, General Practice, Medicine in Society, Obstetrics and Gynecology, Pediatrics and Child Health, Medical Specialties, Surgical Specialties, and Electives.

The total number of hours of all courses required to complete the MBBS degree program is 5,740. This complies with the 4,000 hour minimum requirement in Section 2089.

UQO has an expected attendance of 100% for all curricular elements of Phase 1 and Phase 2. Students are required to sign in for all educational sessions and this is monitored in an attendance log folder. Students must account for all absences and there is a process to address those who are not in compliance.

The School does not allow transfer into the MBBS program for students enrolled at other medical schools.

The School's curriculum includes all of the courses listed in Section 2089 (b). The information provided in the Self-Assessment Report indicates that the goals, objectives and course content meet the educational requirements.

The School meets the medical curriculum requirement for instruction in pain management and end-of-life care as listed in Section 2089 (c).

Business and Professions Code Sections 2089.5

The documents provided by UQO indicate that the instruction in the clinical courses meets or exceeds the minimum requirements in Section 2089.5. For example, Section 2089.5 requires a minimum of 72 weeks of clinical coursework. UQO requires 82 weeks of clinical coursework.

Students complete the core clinical rotations required in Section 2089.5 at OHS hospitals. The information provided by the School indicates that they are in compliance with item (d); specifically, that the sites provided for these core clinical rotations are performed in hospitals that meet one of the stated requirements.

OHS has a long track record of providing training in both undergraduate and graduate medical education. OHS is the sponsoring institution for 27 ACGME accredited training programs with over 300 residents and fellows.

OHS currently provides 600 student-months of clerkship training for third and fourth year medical students from Tulane and the Louisiana State University School of Medicine. Therefore, the UQO program represents a substantial increase in the number of student months offered within their system. As noted above, the projected full complement of students will require accommodation of 240 students at a time in Phase 2 of the curriculum. Additional information will need to be acquired during a site visit to assess the educational and administrative capacity of OHS to meet this educational load.

The School indicates that there is a head of the department for all required courses. For the preclinical sciences, the instructors have full-time faculty appointments and appropriate credentials. For the clinical training, the faculty at OHS have appropriate credentials for the training of the students.

California Code of Regulations, Title 16, Division 13, Section 1314.1

The Self-Assessment Report states that UQ is one of Australia's "premier learning and research institutions." UQ is a founding member of the "national Group of Eight, an alliance of research-strong universities." The School of Medicine is the largest School within the Faculty of Health Sciences at UQ, and one of the largest Schools within the University with 461 FTE staff and 2700 unpaid Academic Title Holders. The Schools programs are delivered across three of UQ's campuses (Herston, St. Lucia, and Ipswich), and through 10 Clinical Schools; two of which are offshore (OHS and Brunei).

The School of Medicine has an "Office of the Medical Dean" which includes the Deputy Head of the School (with oversight of the Clinical Schools); an "Office of Teaching and Learning" which is responsible for quality assurance in teaching, learning and assessment; and an "Office of Research."

The organization and governance of the UQO "matches that of the other Clinical Schools within the School of Medicine." UQO has the "same structures, functions, and responsibilities as the onshore Clinical Schools. All Clinical School Heads report to the Deputy Head of the School." UQ acknowledges the challenges it faces in operating the offshore clinical schools due to the geographic separation and describes a plan to ensure effective communication. The effectiveness of the UQO Program to meet this challenge will need to be assessed during the site visit.

UQ provided a description of the facilities and faculty for each preclinical course. There is a sufficient description of the credentials of the faculty to indicate that they are appropriately qualified to teach their specific curricular content. It is unclear whether the School has sufficient resources to manage the proposed increase in the complement of students for the UQO Program and this will need to be assessed during the site visit.

UQ has published standards governing admission requirements. There is a description of the admissions criteria, student selection and promotion. However, the information provided is not of sufficient detail to determine whether the School has an effective process of assessment of

these admissions requirements; specifically, that the School has a comprehensive method of review of students' performance and this is reflected in modifications to the admissions policies and procedures.

UQ states that it has "an admissions process, not a selection process." There are admission guidelines which include: "a completed key degree" with a GPA equivalent of 2.67, an MCAT with a minimum score of 8/8/M/8 – "(Students who do not meet the minimum MCAT requirement but have no less than a score of 7 and nor more than one 7 in their MCAT will be assessed on a case-by-case basis)," English language proficiency "(this requirement is met if the applicant graduated from an institution where the instruction and assessment was in English."

Further, "an interview will not be part of the selection process. A consultation with a school of medicine representative will be provided to all eligible students, either in person or by telephone. This consultation is designed to assist students with the decision to study medicine at UQ. It will not affect the student's offer of a place in the program."

Students who are interested in applying to the MBBS program are directed to a website led by International Pathways Incorporated at http://www.mededpath.org.

Finally, it is stated that "our practice is that if students meet our criteria then we make an offer."

Criminal background checks are done as part of the student visa application; however, it is unclear whether the stated criteria will be acceptable to the Board.

Based on the documents provided, I do not feel the School meets the entrance requirements of the California Code of Regulations, Title 16, Division 13, Section 1314.1 (8); specifically, that "its admitted students generally meet entrance requirements equivalent to those utilized by Us>s and Canadian medical schools, including an appropriate background check." This issue should be resolved before consideration of a site visit.

There are defined promotion standards for each phase of training. The capacity of the UQO to have well defined roles will need to be assessed as part of the site visit.

The School does not accept transfers from other medical schools.

The School presented information on its financial resources. The School appears to have sufficient financial resources to carry out its stated mission.

The School indicates that it is compliant with the requirement to permanently retain student transcripts.

Final Comments

The concerns listed above are not necessarily inclusive of all concerns and it is possible that additional concerns may need to be addressed while on site or by subsequent documents.

Thank you for the opportunity to review the materials from UQ and the UQO Program.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: July 2, 2013
ATTENTION: Board Members
SUBJECT: Prescribing Task Force
STAFF CONTACT: Renee Threadgill

REQUESTED ACTION:
This report is intended to provide an update to the Members on the activities of the Prescribing Task Force. No action is needed at this time.

BACKGROUND AND ANALYSIS:
At the April 24-25, 2013 Board Meeting the Members approved the establishment of a Prescribing Task Force in order to address the serious problem of prescription drug abuse. Ms. Yaroslavsky and Mike Bishop, M.D. were appointed to the Task Force.

On July 2, 2013, the Task Force Board Members met with Staff to discuss and establish the mission, vision, and objective of the Task Force. The Members adopted a mission and vision statement and developed objectives for the Task Force.

Mission Statement
The Task Force will identify ways to proactively approach and find solutions to the epidemic of prescription drug overdoses through education, prevention, best practices, communication, and outreach by engaging all stakeholders in this endeavor.

Vision
To significantly reduce prescription drug overdoses.

Objectives
- *Identify appropriate patient information that can be shared/discussed between the prescriber and the pharmacist*
- *Identify best practices for prescribing*
  - *Revisit the current Pain Management Guidelines*
  - *Educate prescribers on best practices for prescribing and the public on diversion, disposal and additional information regarding overprescribing and addiction*
  - *Define an outreach plan to provide information to all stakeholders*
- *Review the Board's policy on experts for overprescribing cases*

The first meeting of the Task Force will be an all-day meeting held in September, 2013 in Sacramento. The Task Force meeting will be a working meeting with all invited interested parties providing input toward the objectives of the Task Force based upon their areas of expertise/perspective. The interested parties will include individual prescribers from all specialties and dispensers from all types of facilities/settings, but also representatives from:
Attorney General's Office
District Attorney's Offices
County Sheriff's Offices
Other Healing Arts Boards (Pharmacy, Registered Nursing, Physician Assistants, Dental, etc.)
Drug Enforcement Administration
Consumer and Advocate Groups

All Prescriber Associations (California Medical Association, California Nursing Association, etc.)
California Pharmacist Association
Specialty Boards
Kaiser
California Hospital Association
Media
Schools (including medical, pharmacy, dental, etc.[all prescribers/dispensers])
Teaching physicians/pharmacists
Department of Insurance
Insurance Companies
Senate and Assembly Committees (B&P, Health)

Several meetings may be required in order to meet all of the objectives of the Task Force. The Task Force Board Members have identified the first two objective on the above list as its first priorities. The Task Force will also be asking all interested parties to articulate problems from their perspectives. As these problems are brought forward, they will be added to the objectives list and the working group will establish solutions that can then be shared with the prescribing and dispensing communities.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: July 1, 2013
ATTENTION: Board Members
SUBJECT: Prescribing Strike Force
STAFF CONTACT: Laura Sweet

REQUESTED ACTION:

Direct staff to prepare a Budget Change Proposal in order to justify the creation of two teams to investigate prescribing violations, one in northern and one in southern California.

STAFF RECOMMENDATION:

Recommend a Budget Change Proposal be prepared for Fiscal Year 2015-2016 in order to establish two units dedicated to the investigation of overprescribing by physicians in the state of California. Requested positions include two (2) Supervising Investigator I positions, twelve (12) investigator positions, two (2) staff services analyst positions, and two (2) office technicians.

BACKGROUND AND ANALYSIS:

During 2010, there were over 38,000 unintentional drug overdose deaths in the United States; over 22,000 attributable to prescription drugs. Drug-induced deaths became the leading cause of injury-related deaths, beating out motor vehicle accidents. Studies show that prescription drugs are the gateway drug to heroin use. The economic impact is also devastating.

During 2011, 6.1 million Americans reported current non-medical use of prescription drugs. One in five people using drugs for the first time in 2011 began by using a prescription drug non-medically. Of the 38,329 drug overdose deaths in 2010, approximately 22,100 involved prescription drugs of which, 16,651 involved opioid pain killers (versus 4183 for cocaine and 3038 for heroin).

Investigating allegations of inappropriate prescribing is time consuming. Due to the harrowing consequences of an unscrupulous practitioner, as described above, investigations must be undertaken quickly. Most overprescribing allegations involve a minimum of five patients. The Board investigator will be required to contact and interview each patient or their next-of-kin and ancillary witnesses; will visit each pharmacy the patient patronized, which often exceeds ten or fifteen pharmacies; obtain every prescription that has been filled (which may exceed 500 physical prescriptions); will procure medical records for each patient via a release, subpoena or search warrant (from the subject physician and any subsequent or prior treating physicians); etc. There are numerous other additional tasks involved in the investigation of a prescribing case, but this provides a glimpse into the complexity and volume of most overprescribing investigations.

Currently, there are 161 overprescribing investigations pending in the field. This figure does not include any proactive investigative work. This figure alone, divided by 12 investigators, would equal a caseload of 13 cases per investigator, which is slightly high for the complexity of these types of cases but is immensely superior to the current situation where each investigator has between 20-29 cases, including the complicated prescribing cases. Were the Board to factor proactive case investigation work into the equation, the overprescribing caseload would likely reach 200 cases at any given point in time, for an average caseload of 16.6 cases per investigator.

FISCAL CONSIDERATIONS:

Title	***Monthly****	***Yearly****
Investigator x 12	$74,328	$891,936
Supervising Investigator I x 2	$13,604	$163,248
Office Technician x 2	$6,528	$78,336
Staff Services Analyst x 2	$8,892	$106,704
Total per Year	$103,352	$1,240,224

* This does not include benefits nor equipment

IMPLEMENTATION PLAN:

- Summer 2013 – Spring 2014: Obtain statistics including number of cases, time necessary to conduct these types of investigations, location of the complaints, etc. from the current cases being performed by re-directed staff.
- Summer 2013 – Spring 2014: Obtain information from other entities, including other state medical boards, other law enforcement agencies, etc., on best practices for these types of cases.
- Spring 2014 – Summer 2014: Draft Budget Change Proposal with information gathered from the re-directed staff working in a specialized unit. Submit Budget Change Proposal to the Department of Consumer Affairs to initiate the review process.
- Summer 2014 – Winter 2015: Budget Change Proposal continues through the review process and if approved goes into the Governor's Budget on January 10, 2014.
- Winter 2015 – July 2015: Budget Change Proposal goes through legislative hearings and becomes effective July 1, if approved.
- July 2015: Board begins recruitment to fill positions
- Fall 2015 – Winter 2016: Board trains new investigators

PREVIOUS MBC AND/OR COMMITTEE ACTION:

The Board has currently re-directed existing resources to attempt to address the most serious overprescribing cases in the Enforcement Program's caseload. The Enforcement Program needs additional resources to continue to make progress with reducing case aging and performing targeted investigations on overprescribing cases.

2013 LEGISLATION

Agenda Item 23A

LEGISLATIVE PACKET

MEDICAL BOARD OF CALIFORNIA
FULL BOARD MEETING

JULY 18-19, 2013

MEDICAL BOARD OF CALIFORNIA - 2013 TRACKER LIST
July 10, 2013

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 27	Medina	UC Riverside Medical School: Funding	Senate 3rd Reading	Support – Ltr. Sent 6/19/13	7/3/13
AB 154	Atkins	Healing Arts: Reproductive Health Care	Sen. Approps	Neutral	6/24/13
AB 186	Maienschein	Professions & Vocations: Military Spouses: Temporary Licenses	Sen. B&P	Support (amends taken) – Ltr. Sent 6/27/13	6/24/13
AB 496	Gordon	Task Force: LGBT Cultural Competency	Sen. Approps	Support – Ltr. Sent 6/19/13	6/25/13
AB 512	Rendon	Sponsored Health Care Events: Sunset Extension	Assembly - Enrollment	Support – Ltr. Sent 6/19	Intro.
AB 565	Salas	California Physician Corps Program	Sen. Approps	Support – Ltr. Sent 6/6/13	7/2/13
AB 589	Fox	Underrepresented Medical Specialties	Asm. Health	2-year Bill	Intro.
AB 635	Ammiano	Drug Overdose Treatment: Liability	Sen. 3rd Reading	Support – Ltr. Sent 5/8/13	6/24/13
AB 809	Logue	Healing Arts: Telehealth	Sen. Health	Support – Ltr. Sent 6/21/13	6/25/13
AB 831	Bloom	Drug Overdoses	Held in Approps.	Support – Ltr. Sent 5/8/13 – 2-year Bill	4/3/13
AB 860	Perea	Medical School Scholarships	Held in Approps.	Support – Ltr. Sent 5/8/13 – 2-year Bill	4/8/13
AB 916	Eggman	Healing Arts: False or Misleading Advertising	Sen. B&P	Support – Ltr. Sent 5/23/13	Intro.
AB 1000	Wieckowski	Physical Therapists: Direct Access to Services	Sen. Approps	Need Board to review again - amended	6/24/13
AB 1003	Maienschein	Professional Corporations: Healing Arts Practitioners	Asm. B&P	2-year bill – merged into AB 1000	4/1/13
AB 1176	Bocanegra & Bonta	Medical Residency Training Program Grants	Held in Approps.	Support – Ltr. Sent 5/8/13 – 2-year Bill	4/23/13

Orange – For Discussion, Green – Positions Taken, Pink – Chaptered, Blue – Spot or 2-year Bill

MEDICAL BOARD OF CALIFORNIA - 2013 TRACKER LIST
July 10, 2013

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 1182	Brown	Medically Underserved Areas	Assembly	SPOT	Intro.
AB 1269	Gray	Medicine: Special Faculty Permit	Asm. B&P	SPOT	Intro.
AB 1278	Hueso	Integrative Cancer Treatment	Now SB 117		SB 117
AB 1288	Perez, V.	Medical Board of California: Licensing Application	Assembly - Concurrence	Neutral	6/6/13
AB 1308	Bonilla	Midwifery	Sen. 2nd Reading	Support if Amended – Ltr. Sent 6/6/13	7/9/13
ACR 40	Perez	Donate Life California Day	Chaptered, #19	Support	4/8/13
SB 20	Hernandez	Health Care: Workforce Training	Asm. Approps	Support – Ltr. Sent 6/19/13	2/14/13
SB 21	Roth	UC Riverside Medical School: Funding	Asm. Higher Ed.	Support – Ltr. Sent 5/8/13	6/26/13
SB 62	Price	Coroners: Reporting Requirements: Prescription Drug Use	Asm. Approps	Support – Ltr. Sent 5/8/13	6/27/13
SB 117	Hueso	Integrative Cancer Treatment	Sen. B&P	Neutral – 2-year Bill	4/30/13
SB 304	Price	Healing Arts: Sunset Bill	Asm. B&P	Support if Amended – Ltr. Sent 5/22/13	4/24/13
SB 305	Price	Healing Arts: Boards	Asm. Approps	Support – Ltr. Sent 6/19/13	6/19/13
SB 352	Pavley	Medical Assistants: Supervision	Asm. 3rd Reading	Support (amends taken) – Ltr. Sent 6/21/13	6/19/13
SB 410	Yee	Anesthesiologist Assistants	Senate	2-year Bill	4/30/13
SB 491	Hernandez	Nurse Practitioners	Asm. B&P	Oppose – Ltr. Sent 5/8/13	5/21/13
SB 492	Hernandez	Optometrist Practice: Licensure	Asm. B&P	Neutral, Reco: OUA	5/8/13

Orange – For Discussion, Green – Positions Taken, Pink – Chaptered, Blue – Spot or 2-year Bill

MEDICAL BOARD OF CALIFORNIA - 2013 TRACKER LIST
July 10, 2013

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
SB 493	Hernandez	Pharmacy Practice	Asm. B&P	Support (amends taken)– Ltr. Sent 5/29/13	5/28/13
SB 670	Steinberg	Physicians and Surgeons: Drug Prescribing Privileges	Asm. B&P	Support if Amended – Ltr. Sent 5/8/13	5/24/13
SB 701	Emmerson	Hospital-Affiliated Outpatient Settings	Sen. B&P	2-year Bill	Intro.
SB 796	Nielsen	Medicine: Physicians and Surgeons	Senate	SPOT	Intro.
SB 809	DeSaulnier	Controlled Substances: Reporting: CURES	Asm. B&P	Support in Concept – Ltr. Sent 6/21/13	6/26/13
SCR 8	DeSaulnier	Prescription Drug Abuse Awareness Month	Chaptered, #26	Support – Ltr. Sent 2/7/13	4/18/13

Orange – For Discussion, Green – Positions Taken, Pink – Chaptered, Blue – Spot or 2-year Bill

AB 27

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 27 and SB 21
Author: Medina and Roth
Bill Date: July 3 and June 26, 2013, Amended
Subject: UC Riverside Medical School: Funding
Sponsor: Author and the California Medical Association
Position: Support

STATUS OF BILL:

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

DESCRIPTION OF CURRENT LEGISLATION:

These bills contain 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 (UC), Riverside. Both bills contain urgency clauses, which mean that the bills would take effect immediately once signed into law. SB 21 would 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 AB 27 and SB 21 were amended to add findings and declarations and to require the moneys appropriated to only be used for funding the UC Riverside School of Medicine, not for other purposes or to supplant other funding. The amendments would require the UC Riverside School of Medicine to develop a program to identify eligible medical residents and to assist those residents to apply for physician retention programs, including the Steven M. Thompson Medical School Scholarship Program (STMSSP).

AB 27 and SB 21 were amended to remove the appropriation language as the Higher Education Trailer Bill, AB 94, was amended to include a $15,000,000 appropriation allocated to UC Riverside School of Medicine. Both bills reference AB 94 and the appropriation.

ANALYSIS:

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

In July 2008, the UC Board of Regents officially approved the proposed establishment of an independent four-year School of Medicine at UC Riverside, intended to serve the medically underserved

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

The purpose of these bills is to provide funding from the General Fund in order to establish a more viable funding source for the UC Riverside School of Medicine. AB 27 and SB 21 no longer include an appropriation, but refer to AB 94, which includes the appropriation for UC Riverside School of Medicine. Both bills specify that funds provided shall be available for planning and startup costs associated with academic programs to be offered at the UC Riverside School of Medicine, including: Academic planning activities, support of academic program offerings, and faculty recruitment; the acquisition of instructional materials and equipment; and ongoing operating support for faculty, staff, and other annual operating expenses for the UC Riverside School of Medicine. Both bills were also amended to add findings and declarations and to require the moneys appropriated to only be used for funding the UC Riverside School of Medicine, not for other purposes or to supplant other funding. The amendments would also require the UC Riverside School of Medicine to develop a program to identify eligible medical residents and to assist those residents to apply for physician retention programs, including the STMSSP.

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

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

These bills will help to increase access to care and help the Inland Empire area of California to prepare and be ready for implementation of the Affordable Care Act; the Board has taken a support position on these bills.

FISCAL: None to the Board

SUPPORT: SB 21 - California Medical Association (Sponsor); American College of Emergency Physicians; Bourns, Gordon Bourns, CEO; California Association of Physician Groups; California Podiatric Medical Association; California Primary Care Association; City of Murieta; Enterprise Media and the Press-Enterprise; Inland Empire Economic Partnership; Insurance Commissioner Dave Jones; Kaiser Permanente; Mayor Rusty Bailey, City of Riverside; Medical Board of California; Riverside County Superintendent of Schools; Southwest California Legislative Council; Southwest Riverside County Association of Realtors; University of California; University of California Riverside Alumni Association; and Western Riverside Council of Governments

AB 27 – California Primary Care Association; California Podiatric Medical Association; Medical Board of California; and Riverside County Superintendent of Schools

OPPOSITION: None on file

AMENDED IN SENATE JULY 3, 2013

AMENDED IN ASSEMBLY MAY 24, 2013

AMENDED IN ASSEMBLY MARCH 21, 2013

AMENDED IN ASSEMBLY MARCH 13, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 27

Introduced by Assembly Member Medina
(Principal coauthor: Senator Roth)
(Coauthor: Assembly Member Linder)

December 3, 2012

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

LEGISLATIVE COUNSEL'S DIGEST

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

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

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

(b) California lags substantially in the number of medical school seats per capita, having just 17.3 seats per 100,000 persons, compared to the United States average of 31.4 seats per 100,000 persons, according to statistics published by the Association of American Medical Colleges.

(c) According to the California HealthCare Foundation, 72 percent of California's 58 counties have an undersupply of primary care physicians, with primary care physicians making up just 34 percent of California's physician workforce.

(d) The University of California, Riverside, (UCR) has had a longstanding two-year medical education program and its independent four-year school of medicine has received preliminary accreditation from the Liaison Committee on Medical Education, the nationally recognized accrediting body for medical education programs leading to M.D. degrees in the United States and Canada. When this new four-year medical school opens in August 2013, it will become the first new public medical school in California in more than 40 years.

(e) This community-based medical school with a public mission to expand and diversify the region's physician workforce and to improve the health of people living in inland southern California has made a commitment to underserved patient populations.

(f) There are two principal determinants of where a physician practices: (1) where he or she grew up, and (2) where he or she completes residency training following medical school graduation.

(g) The UCR medical school has strategies to capitalize on both of these factors. Among these strategies are all of the following: (1) developing student pipeline programs that inspire more young people in the region to pursue careers in medicine and other allied health professions and to recruit them to the UCR medical school; (2) utilizing a holistic review of medical school applicants that takes into account diverse life experiences in addition to their academic performance; (3) teaching a curriculum that emphasizes key competencies for primary care medicine, including wellness and prevention, evidence-based medicine, and chronic disease management; (4) creating new residency training programs in primary care and those short-supply specialties that are most needed in inland southern California; and (5) continuing UCR's commitment to the recruitment, retention, and advancement of talented students, faculty, and staff from historically excluded

~~(3) Ongoing operating support for faculty, staff, and other annual operating expenses for the School of Medicine at the University of California, Riverside.~~

~~(c)~~

SEC. 2. The School of Medicine at the University of California, Riverside, ~~shall~~ *is requested to* develop a program, consistent with its mission, in conjunction with the health facilities of its medical residency programs, to identify eligible medical residents and to assist those medical residents to apply for physician retention programs, including, but not limited to, the Steven M. Thompson ~~Physician Corps Loan Repayment~~ *Medical School Scholarship* Program, established pursuant to Article 6 (commencing with Section 128560) of Chapter 5 of Part 3 of Division 107 of the Health and Safety Code.

~~(d) On or before April 1 of each year, the University of California shall provide progress reports to the relevant policy and fiscal committees of the Legislature pertaining to funding, recruitment, hiring, and outcomes for the School of Medicine at the University of California, Riverside. Specifically, the report shall include, but not be limited to, information consistent with the published mission and vision for the School of Medicine at the University of California, Riverside, in all of the following areas:~~

~~(1) The number of students who have applied, been admitted, or been enrolled, broken out by race, ethnicity, and gender.~~

~~(2) The number of full-time faculty, part-time faculty, and administration, broken out by race, ethnicity, and gender.~~

~~(3) Funding and progress of ongoing medical education pipeline programs, including the UCR/UCLA Thomas Haider Program in Biomedical Sciences.~~

~~(4) Operating and capital budgets, including detail by funding source, and an explanation of how such funding affects base funding for other university purposes. The operating budget shall include a breakdown of research activities, instruction costs, administration, and executive management.~~

~~(5) Efforts to meet the health care delivery needs of California and the Inland Empire region of the state, including, but not limited to, the percentage of clinical placements, graduate medical education slots, and medical school graduates in primary care specialties who are providing service within California's medically underserved areas and populations.~~

AB 154

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 154
Author: Atkins
Bill Date: June 24, 2013, Amended
Subject: Abortion
Sponsor: ACCESS Women's Health Justice
American Civil Liberties Union of California
Black Women for Wellness California
Latinas for Reproductive Justice
NARAL Pro-Choice California
Planned Parenthood Affiliates of California
Position: Neutral

STATUS OF BILL:

This bill is in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

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

This bill was recently amended to require NPs and CNMs to adhere to standardized procedures and for PAs to comply with protocols that include specific information in order to perform an abortion by aspiration techniques. The amendments specify that it is unprofessional conduct for NPs, CNMs or PAs to perform an aspiration abortion without prior completion of training and validation of clinical competency.

ANALYSIS:

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

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

communication /interpersonal skills, professionalism, practice-based learning, and clinical knowledge.

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

This bill now would require NPs and CNMs to adhere to standardized procedures and for PAs to comply with protocols that include the following information, in order to perform an abortion by aspiration techniques:

- The extent of supervision by a physician and surgeon with relevant training and expertise.
- Procedures for transferring patients to the care of the physician and surgeon or hospital.
- Procedures for obtaining assistance and consultation from a physician and surgeon.
- Procedures for providing emergency care until physician assistance and consultation are available.
- The method of periodic review of the provisions of standardized procedures and protocols.

This bill now specifically states that it is unprofessional conduct for NPs, CNMs or PAs to perform an aspiration abortion without prior completion of training and validation of clinical competency.

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

Patient sample selection, enrollment and consent:

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

Abortion-related complications summary:

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

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

FISCAL: None

SUPPORT: ACCESS Women's Health Justice (sponsor); American Civil Liberties Union of California (Sponsor); Black Women for Wellness California (sponsor); Latinas for Reproductive Justice (sponsor); NARAL Pro-Choice California (sponsor); and Planned Parenthood Affiliates of California (sponsor); ACT for Women and Girls; American Association of University Women; American College of Nurse-Midwives; American Nurses Association; Bay Area Communities for Health Education; Business and Professional Women of Nevada County; California Association for Nurse Practitioners; California Church IMPACT; California Family Health Council; California Medical Association; California Nurse-Midwives Association; California Women's Law Center; Cardea Institute; Center on Reproductive Rights and Justice at UC Berkeley School of Law; Choice USA; Forward Together; Fresno Barrios Unidos; Khmer Girls in Action; Law Students for Reproductive Justice; League of Women Voters of California; National Asian Pacific American Women's Forum; National Center for Lesbian Rights; National Council of Jewish Women – California; National Health Law Program; National Latina Institute for Reproductive Health; National Network of Abortion Funds; Nevada County Citizens for Choice; Nursing Students for Choice – UCSF; Physicians for Reproductive Health; Planned Parenthood Mar Monte; Planned Parenthood of Orange and San Bernardino Counties; Planned Parenthood Pasadena & San Gabriel Valley; Planned Parenthood of Santa Barbara, Ventura, and San Luis Obispo Counties; Planned Parenthood of the Pacific Southwest; Reproductive Justice Coalition of Los Angeles; Six Rivers Planned Parenthood; Students for Reproductive Justice at Stanford University; Women's Community Clinic; Women's Health Specialists of California; and several individuals

OPPOSITION: California Catholic Conference; Coalition for Women and Children; Concerned Women for America; California Right to Life Committee; Capitol Resource Family Impact; Greg Watkins, City Councilman, City of Shasta Lake; John Paul the Great Catholic University Students for Life; Pro-Life Mission: International; San Jose State Students for Life; Traditional Values Coalition; University of Southern California Students for Life and several individuals

AMENDED IN SENATE JUNE 24, 2013

AMENDED IN ASSEMBLY APRIL 30, 2013

AMENDED IN ASSEMBLY MARCH 19, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 154

Introduced by Assembly Member Atkins
(Principal coauthor: Senator Jackson)
(Coauthors: Assembly Members Mitchell and Skinner)

January 22, 2013

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

LEGISLATIVE COUNSEL'S DIGEST

AB 154, as amended, Atkins. Abortion.

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

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

1 SECTION 1. Section 2253 of the Business and Professions
2 Code is amended to read:
3 2253. (a) Failure to comply with the Reproductive Privacy
4 Act (Article 2.5 (commencing with Section 123460) of Chapter 2
5 of Part 2 of Division 106 of the Health and Safety Code) constitutes
6 unprofessional conduct.
7 (b) (1) Except as provided in paragraph (2), a person is subject
8 to Section 2052 if he or she performs an abortion, and at the time
9 of so doing, does not have a valid, unrevoked, and unsuspended
10 license to practice as a physician and surgeon.
11 (2) A person shall not be subject to Section 2052 if he or she
12 performs an abortion by medication or aspiration techniques in
13 the first trimester of pregnancy, and at the time of so doing, has a
14 valid, unrevoked, and unsuspended license or certificate obtained
15 in accordance with the Nursing Practice Act (Chapter 6
16 (commencing with Section 2700)) or the Physician Assistant
17 Practice Act (Chapter 7.7 (commencing with Section 3500)), that
18 authorizes him or her to perform the functions necessary for an
19 abortion by medication or aspiration techniques.
20 (c) In order to perform an abortion by aspiration techniques
21 pursuant to paragraph (2) of subdivision (b), a person shall comply
22 with Section 2725.4 or 3502.4.
23 SEC. 2. Section 2725.4 is added to the Business and Professions
24 Code, to read:
25 2725.4. ~~(a)~~ *Notwithstanding any other provision of this*
26 *chapter, the following shall apply:*
27 *(a)* In order to perform an abortion by aspiration techniques
28 pursuant to Section 2253, a person with a license or certificate to
29 practice as a nurse practitioner or a certified nurse-midwife shall
30 complete training recognized by the Board of Registered Nursing.
31 Beginning January 1, 2014, and until January 1, 2016, the
32 competency-based training protocols established by Health
33 Workforce Pilot Project (HWPP) No. 171 through the Office of
34 Statewide Health Planning and Development shall be used.
35 (b) In order to perform an abortion by aspiration techniques
36 pursuant to Section 2253, a person with a license or certificate to
37 practice as a nurse practitioner or a certified nurse-midwife shall

comply with protocols developed in compliance with Section 3502 that specify:

(1) The extent of supervision by a physician and surgeon with relevant training and expertise.

(2) Procedures for transferring patients to the care of the physician and surgeon or a hospital.

(3) Procedures for obtaining assistance and consultation from a physician and surgeon.

(4) Procedures for providing emergency care until physician assistance and consultation ~~is~~ *are* available.

(5) The method of periodic review of the provisions of the protocols.

(c) The training protocols established by HWPP No. 171 shall be deemed to meet the standards of the board. A physician assistant who has completed training and achieved clinical competency through HWPP No. 171 shall be authorized to perform abortions by aspiration techniques pursuant to Section 2253, in adherence to protocols described in subdivision (b).

(d) It is unprofessional conduct for any physician assistant to perform an abortion by aspiration techniques pursuant to Section 2253 without prior completion of training and validation of clinical competency.

SEC. 4. Section 123468 of the Health and Safety Code is amended to read:

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

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

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

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

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

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or

AB 496

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 496
Author: Gordon
Bill Date: June 25, 2013, Amended
Subject: Medicine: Sexual Orientation, Gender Identity, and Gender Expression
Sponsor: Equality California
Position: Support

STATUS OF BILL:

This bill is in Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

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

This bill was amended to require local medical societies to develop and distribute a survey for language minority patients and LGBTI patients to measure the degree of satisfaction with physicians who have taken the educational classes on cultural and linguistic competency provided pursuant to this bill. This bill would require local medical societies to develop an evaluation survey for physicians to assess the quality of education or training programs on cultural and linguistic competency. This bill would require the survey information to be shared with the Board's Cultural and Linguistic Competency (CLC) Workgroup.

ANALYSIS:

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

This bill would specify that the duties of the Task Force would be the same as before: to develop recommendations for a continuing education program that includes language proficiency standards of foreign language to meet linguistic competence; to identify key cultural elements necessary to meet cultural competency by physicians, dentists, and their offices; and to assess the need for voluntary certification standards and examinations for cultural competency. This bill would require the Task Force to hold hearings and convene meetings to obtain input from persons belonging to language and ethnic minority groups, and this bill would add LGBT groups, to determine their needs and preferences for having culturally competent medical providers. This bill would require the hearings to be held in communities that have large populations of language and ethnic minority groups and LGBTI groups. This bill would require the Task Force to report its findings to the Legislature and appropriate licensing boards by January 1, 2016. This bill would require the Board and the Dental Board to pay the administrative costs of implementing the Task Force, the hearings, and the report.

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

This bill was amended to require local medical societies to develop and distribute a survey for language minority patients and LGBTI patients to measure the degree of satisfaction with physicians who have taken the educational classes on cultural and linguistic competency provided pursuant to this bill. This bill would require local medical societies to develop an evaluation survey for physicians to assess the quality of education or training programs on cultural and linguistic competency. This bill would require the survey information to be shared with the Board's Cultural and Linguistic Competency (CLC) Workgroup.

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

According to the author's office, LGBTI patients have reported a reluctance to reveal their sexual orientation or gender identity to their providers, despite the importance of such information for their health care. The author believes that cultural competency plays a crucial role in understanding, diagnosing, and delivering appropriate care to LGBTI patients. The ability of physicians to effectively communicate with, and to create a welcoming and safe environment for their LGBTI patients, has an impact on LGBTI 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, LGBTI 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 LGBTI issues for the Task Force to hold hearings on and include in its report to the Legislature. Since this bill does not expand the working group convened by the Board, the Board would only need to include agenda items at future meetings that address understanding and applying the roles that sexual orientation, gender identity, and gender expression play in diagnosis, treatment and clinical care and developing behaviors that increase a patient's satisfaction with, and trust in, his or her physicians and health care institutions. The Board's Executive Director would be required to participate in the reauthorized Task Force and the Board would be partially responsible for the costs associated with the Task Force, hearings, and the report to the Legislature.

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

SUPPORT: Equality California (sponsor); AIDS Legal Referral Panel; Asian & Pacific Islander Wellness Center; Asian Americans for Civil Rights and Equality; Asian Law Caucus; Asian Pacific Islander Equality – Northern Chapter; Betty T. Yee, Member, First District, State Board of Equalization; California Academy of Family Physicians; California Communities United Institute; California Mental Health Directors Association; California Pan Ethnic Health Network; California Primary Care Association; City of West Hollywood; Gay & Lesbian Medical Association; Gay Asian Pacific Alliance; L.A. Gay & Lesbian Center; Lyon-Martin Health Services; Medical Board of California; Mental Health American of Northern California; National Association of Social Workers – California Chapter; National Center for Lesbian Rights; Our Family Coalition; Planned Parenthood Affiliates of California; San Francisco Eligible Metropolitan Area HIV Health Services Planning Council; The Black AIDS Institute; The Gay & Lesbian Community Services Center of Orange County; The Greenlining Institute; The National Asian Pacific American Women's Forum; The Trevor Project; and 67 individuals

OPPOSITION: California Right to Life Committee, Inc.

AMENDED IN SENATE JUNE 25, 2013

AMENDED IN ASSEMBLY APRIL 10, 2013

AMENDED IN ASSEMBLY APRIL 2, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 496

Introduced by Assembly Member Gordon
(Coauthors: Assembly Members Ammiano and Atkins)
(Coauthors: Senators Lara and Leno)

February 20, 2013

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

LEGISLATIVE COUNSEL'S DIGEST

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

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

Existing law requires local medical societies to develop and distribute a survey for language minority patients to measure the degree of satisfaction with physicians who have taken the educational classes on cultural and linguistic competency described above.

This bill would also require local medical societies to develop and distribute a similar survey to lesbian, gay, bisexual, transgender, and intersex patients.

Existing law also defines "cultural and linguistic competency" for the purposes of those provisions as meaning cultural and linguistic abilities that can be incorporated into therapeutic and medical evaluation and treatment, including understanding and applying the roles that culture, ethnicity, and race play in diagnosis, treatment, and clinical care, and awareness of how the attitudes, values, and beliefs of health care providers and patients influence and impact professional and patient relations.

This bill would ~~also~~ redefine the term "cultural and linguistic competency" ~~as~~ *to also include* understanding and applying the roles that ~~culture, ethnicity, race,~~ sexual orientation, gender identity, and gender expression play in diagnosis, treatment, and clinical care, and ~~awareness of how the attitudes, values, and beliefs of health care providers, patients, and society influence and impact professional and patient relations~~ *developing behaviors that increase a patient's satisfaction with, and trust in, his or her physicians and health care institutions*. The bill would also make related technical, nonsubstantive changes.

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

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

1 SECTION 1. Section 852 of the Business and Professions Code
2 is amended to read:
3 852. (a) The Task Force on Culturally and Linguistically
4 Competent Physicians and Dentists is hereby created and shall
5 consist of the following members:
6 (1) The Deputy Director of the Office of Health Equity, or his
7 or her designee, and the Director of Consumer Affairs, or his or
8 her designee, who shall serve as cochairs of the task force.
9 (2) The Executive Director of the Medical Board of California,
10 or his or her designee.

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

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

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

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

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

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

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

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

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

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

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

~~programs on cultural and linguistic competency. This information shall be shared with the workgroup established by the Medical Board of California.~~

(j) (1) Local medical societies shall develop and distribute a survey for both of the following groups of individuals to measure the degree of satisfaction with physicians who have taken the educational classes on cultural and linguistic competency provided pursuant to this section:

(A) Language minority patients.

(B) Lesbian, gay, bisexual, transgender, and intersex patients.

(2) Local medical societies shall also develop an evaluation survey for physicians to assess the quality of education or training programs on cultural and linguistic competency provided pursuant to this section.

(3) The information provided by these surveys shall be shared with the workgroup established by the Medical Board of California pursuant to subdivision (h).

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

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

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

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

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

(d) Developing behaviors that increase a patient's satisfaction with, and trust in, his or her physicians and health care institutions.

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AB 512

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

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

STATUS OF BILL:

This bill is in the Assembly and is ready to be sent to enrollment.

DESCRIPTION OF CURRENT LEGISLATION:

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

ANALYSIS

AB 2699 (Bass, Chapter 270, Statutes of 2010) allows health care practitioners, including physicians, who are not licensed to practice in California, but that hold a valid license or certificate in good standing in another state, to volunteer to provide health care services at sponsored free health care events, under specified circumstances. The bill required that all appropriate boards under the Department of Consumer Affairs (DCA) promulgate regulations before the bill could be implemented. The Medical Board was the first board under DCA to develop regulations, which became effective on August 20, 2012. Physicians licensed in other states are required to submit a request for authorization to practice without a California license at a sponsored free health care event to the Board and must also submit fingerprints before they can participate. The authorization period may not be for more than 10 days.

Existing law would sunset the ability for out-of-state health care practitioners to participate in sponsored free health care events in 2014. Although the Medical Board has promulgated regulations, many boards under DCA have not. The author and sponsor would like to extend the sunset date in existing law to allow health care practitioners to participate in sponsored free health care events and give the program more time to demonstrate its success. According to Los Angeles County, an extension of the sunset date in existing law will allow California to continue to provide access to needed health care and dental services to uninsured and underinsured consumers in this state.

Although the Board has only issued one physician permit under the program that was created by AB 2699, the Board has already done the work to promulgate regulations; as such, it seems reasonable to extend the sunset date to allow more individuals to provide 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; the Board has taken a support position on this bill.

FISCAL: None

SUPPORT: Los Angeles County Board of Supervisors (Sponsor)
Association of Healthcare Districts
California Board of Behavioral Sciences (if amended)
California State Board of Pharmacy
Medical Board of California

OPPOSITION: California Nurses Association
American Nurses Association of California

ASSEMBLY BILL No. 512

Introduced by Assembly Member Rendon

February 20, 2013

An act to amend Section 901 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 512, as introduced, Rendon. Healing arts: licensure exemption.

Existing law provides for the licensure and regulation of various healing arts practitioners by boards within the Department of Consumer Affairs. Existing law provides an exemption from these requirements for a health care practitioner licensed in another state who offers or provides health care for which he or she is licensed during a state of emergency, as defined, and upon request of the Director of the Emergency Medical Services Authority, as specified.

Existing law provides, until January 1, 2014, an exemption from the licensure and regulation requirements for a health care practitioner, as defined, licensed or certified in good standing in another state or states, who offers or provides health care services for which he or she is licensed or certified through a sponsored event, as defined, (1) to uninsured or underinsured persons, (2) on a short-term voluntary basis, (3) in association with a sponsoring entity that registers with the applicable healing arts board, as defined, and provides specified information to the county health department of the county in which the health care services will be provided, and (4) without charge to the recipient or a 3rd party on behalf of the recipient, as specified. Existing law also requires an exempt health care practitioner to obtain prior authorization to provide these services from the applicable licensing

(A) Obtains authorization from the board to participate in the sponsored event after submitting to the board a copy of his or her valid license or certificate from each state in which he or she holds licensure or certification and a photographic identification issued by one of the states in which he or she holds licensure or certification. The board shall notify the sponsoring entity, within 20 calendar days of receiving a request for authorization, whether that request is approved or denied, provided that, if the board receives a request for authorization less than 20 days prior to the date of the sponsored event, the board shall make reasonable efforts to notify the sponsoring entity whether that request is approved or denied prior to the date of that sponsored event.

(B) Satisfies the following requirements:

(i) The health care practitioner has not committed any act or been convicted of a crime constituting grounds for denial of licensure or registration under Section 480 and is in good standing in each state in which he or she holds licensure or certification.

(ii) The health care practitioner has the appropriate education and experience to participate in a sponsored event, as determined by the board.

(iii) The health care practitioner shall agree to comply with all applicable practice requirements set forth in this division and the regulations adopted pursuant to this division.

(C) Submits to the board, on a form prescribed by the board, a request for authorization to practice without a license, and pays a fee, in an amount determined by the board by regulation, which shall be available, upon appropriation, to cover the cost of developing the authorization process and processing the request.

(2) The services are provided under all of the following circumstances:

(A) To uninsured or underinsured persons.

(B) On a short-term voluntary basis, not to exceed a 10-calendar-day period per sponsored event.

(C) In association with a sponsoring entity that complies with subdivision (d).

(D) Without charge to the recipient or to a third party on behalf of the recipient.

(c) The board may deny a health care practitioner authorization to practice without a license if the health care practitioner fails to

his or her license or certificate is not suspended or revoked pursuant to disciplinary proceedings in any jurisdiction. The sponsoring entity shall maintain these records for a period of at least five years following the provision of health care services under this section and shall, upon request, furnish those records to the board or any county health department.

(h) A contract of liability insurance issued, amended, or renewed in this state on or after January 1, 2011, shall not exclude coverage of a health care practitioner or a sponsoring entity that provides, or arranges for the provision of, health care services under this section, provided that the practitioner or entity complies with this section.

(i) Subdivision (b) shall not be construed to authorize a health care practitioner to render care outside the scope of practice authorized by his or her license or certificate or this division.

(j) (1) The board may terminate authorization for a health care practitioner to provide health care services pursuant to this section for failure to comply with this section, any applicable practice requirement set forth in this division, any regulations adopted pursuant to this division, or for any act that would be grounds for discipline if done by a licensee of that board.

(2) The board shall provide both the sponsoring entity and the health care practitioner with a written notice of termination including the basis for that termination. The health care practitioner may, within 30 days after the date of the receipt of notice of termination, file a written appeal to the board. The appeal shall include any documentation the health care practitioner wishes to present to the board.

(3) A health care practitioner whose authorization to provide health care services pursuant to this section has been terminated shall not provide health care services pursuant to this section unless and until a subsequent request for authorization has been approved by the board. A health care practitioner who provides health care services in violation of this paragraph shall be deemed to be practicing health care in violation of the applicable provisions of this division, and be subject to any applicable administrative, civil, or criminal fines, penalties, and other sanctions provided in this division.

(k) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall

ABC 123

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 565
Author: Salas
Bill Date: July 2, 2013, Amended
Subject: California Physician Corps Program
Sponsor: California Medical Association
Position: Support

STATUS OF BILL:

This bill is currently in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would tighten the guidelines for selection of applicants to the Steven M. Thompson Physician Corps Loan Repayment Program (STLRP) and would expand the definition of practice settings for this program.

This bill was recently amended to amend the definition of "practice setting" and to make technical, clarifying amendments related to the STLRP guidelines being developed by the Office of Statewide Health Planning and Development (OSHPD).

ANALYSIS:

The STLRP was created in 2002 via legislation which was co-sponsored by the Medical Board of California (Board). The STLRP encourages recently licensed physicians to practice in underserved locations in California by authorizing a plan for repayment of their student loans (up to $105,000) in exchange for a minimum three years of service. In 2006, the administration of STLRP was transitioned from the Board to the Health Professions Education Foundation (HPEF). Since 1990, HPEF has administered statewide scholarship and loan repayment programs for a wide range of health professions' students and recent graduates, these programs are funded through grants and contributions from public and private agencies, hospitals, health plans, foundations, and corporations, as well as through a surcharge on the renewal fees of various health professionals, including a $25 fee paid by physicians and surgeons.

AB 565 would amend the STLRP guidelines to require applicants to have three years of experience providing health care services to medically underserved populations 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 the patients are from a medically underserved population.

For purposes of the STLRP, this bill would also add to the definition of a "practice setting" a private practice that provides primary care located in a medically underserved area and has a minimum of 30 percent uninsured, Medi-Cal, or other publicly funded program that serves patients who earn less than 250 percent of the federal poverty level.

Recent amendments delete the above addition and instead add to the definition of a "practice setting" a physician owned and operated medical practice setting that provides primary care located in a medically underserved area and has a minimum of 30 percent of its patients who are uninsured, Medi-Cal beneficiaries, or beneficiaries of another publicly funded program that serves patients who earn less than 250 percent of the 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, which will further the Board's mission of promoting access to care; the Board has taken a support position on this bill. The recent amendments do not impact the Board's Support position or the reasons for taking that position.

FISCAL: None

SUPPORT: California Medical Association (Sponsor); American Academy of Pediatrics, California; American College of Emergency Physicians, California Chapter; Association of California Healthcare Districts; Board of Trustees of the Delano Joint Union High School District; California Academy of Physician Assistants; California Optometric Association; City of Hanford; Community Action Partnership of Kern; Community Clinic Association of Los Angeles County; Kern Medical Center; Medical Board of California; Osteopathic Physicians and Surgeons of California; Rural County Representatives of California; and Semitropic Elementary School District

OPPOSITION: None on file

AMENDED IN SENATE JULY 2, 2013

AMENDED IN ASSEMBLY APRIL 23, 2013

AMENDED IN ASSEMBLY APRIL 10, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 565

Introduced by Assembly Member Salas
(Coauthors: Assembly Members Chesbro, Logue, and Pan)
(Coauthor: Senator Anderson)

February 20, 2013

An act to amend Sections 128552 and 128553 of the Health and Safety Code, relating to physicians and surgeons.

LEGISLATIVE COUNSEL'S DIGEST

AB 565, as amended, Salas. California Physician Corps Program.

Existing law establishes the Steven M. Thompson Physician Corps Loan Repayment Program in the California Physician Corps Program within the Health Professions Education Foundation, which provides financial incentives, as specified, to a physician and surgeon for practicing in a medically underserved community. Existing law authorizes the Office of Statewide Health Planning and Development to adopt guidelines by regulation and requires the foundation to use guidelines for selection and placement of program applicants. These guidelines provide priority consideration to applicants who meet specified criteria, including that the applicant has 3 years of experience working in medically underserved areas or with medically underserved populations. The guidelines also must seek to place the most qualified applicants in the areas with the greatest need.

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

1 SECTION 1. Section 128552 of the Health and Safety Code
2 is amended to read:
3 128552. For purposes of this article, the following definitions
4 shall apply:
5 (a) "Account" means the Medically Underserved Account for
6 Physicians established within the Health Professions Education
7 Fund pursuant to this article.
8 (b) "Foundation" means the Health Professions Education
9 Foundation.
10 (c) "Fund" means the Health Professions Education Fund.
11 (d) "Medi-Cal threshold languages" means primary languages
12 spoken by limited-English-proficient (LEP) population groups
13 meeting a numeric threshold of 3,000, eligible LEP Medi-Cal
14 beneficiaries residing in a county, 1,000 Medi-Cal eligible LEP
15 beneficiaries residing in a single ZIP Code, or 1,500 LEP Medi-Cal
16 beneficiaries residing in two contiguous ZIP Codes.
17 (e) "Medically underserved area" means an area defined as a
18 health professional shortage area in Part 5 of Subchapter A of
19 Chapter 1 of Title 42 of the Code of Federal Regulations or an
20 area of the state where unmet priority needs for physicians exist
21 as determined by the California Healthcare Workforce Policy
22 Commission pursuant to Section 128225.
23 (f) "Medically underserved population" means the Medi-Cal
24 program, Healthy Families Program, and uninsured populations.
25 (g) "Office" means the Office of Statewide Health Planning and
26 Development (OSHPD).
27 (h) "Physician Volunteer Program" means the Physician
28 Volunteer Registry Program established by the Medical Board of
29 California.
30 (i) "Practice ~~setting"~~ *setting," for the purposes of this article*
31 *only,* means either of the following:
32 (1) A community clinic as defined in subdivision (a) of Section
33 1204 and subdivision (c) of Section 1206, a clinic owned or
34 operated by a public hospital and health system, *or* a clinic owned
35 and operated by a hospital that maintains the primary contract with
36 a county government to fulfill the county's role pursuant to Section
37 17000 of the Welfare and Institutions Code, which is located in a
38 medically underserved area and at least 50 percent of whose

patients from medically underserved populations and who meet one or more of the following criteria:

(A) Speak a Medi-Cal threshold language.

(B) Come from an economically disadvantaged background.

(C) Have received significant training in cultural and linguistically appropriate service delivery.

(D) Have three years of experience providing health care services to medically underserved populations or in a medically underserved area, as defined in subdivision (e) of Section 128552.

(E) Have recently obtained a license to practice medicine.

(2) Include a process for determining the needs for physician services identified by the practice setting and for ensuring that the practice setting meets the definition specified in subdivision (h) of Section 128552.

(3) Give preference to applicants who have completed a three-year residency in a primary specialty.

(4) Give preference to applicants who agree to practice in a medically underserved area, as defined in subdivision (e) of Section 128552, and who agree to serve a medically underserved population.

(5) Give priority consideration to applicants from rural communities who agree to practice in a physician owned and operated medical practice setting as defined in paragraph (2) of subdivision (i) of Section 128552.

(6) Include a factor ensuring geographic distribution of placements.

(7) Provide priority consideration to applicants who agree to practice in a geriatric care setting and are trained in geriatrics, and who can meet the cultural and linguistic needs and demands of a diverse population of older Californians. On and after January 1, 2009, up to 15 percent of the funds collected pursuant to Section 2436.5 of the Business and Professions Code shall be dedicated to loan assistance for physicians and surgeons who agree to practice in geriatric care settings or settings that primarily serve adults over the age of 65 years or adults with disabilities.

(d) (1) The foundation may appoint a selection committee that provides policy direction and guidance over the program and that complies with the requirements of subdivision (*l*) of Section 128552.

AB 635

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 635
Author: Ammiano
Bill Date: June 24, 2013, Amended
Subject: Drug Overdose Treatment: Liability
Sponsor: Harm Reduction Coalition
California Society of Addiction Medicine
Position: Support

STATUS OF BILL:

This bill is on the Senate Third Reading File.

DESCRIPTION OF CURRENT LEGISLATION:

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

The recent amendment adds that a person not otherwise licensed to administer an opioid antagonist, but trained as required by this bill, who acts with reasonable care in administering an opioid antagonist in good faith and not for compensation, shall not be subject to professional review, be liable in a civil action, or be subject to criminal prosecution for the administration.

BACKGROUND (taken from the fact sheet)

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

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

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

ANALYSIS

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

This bill would require a person who is prescribed an opioid antagonist or possesses it pursuant to a standing order to receive training provided by an opioid overdose prevention and treatment training program. An opioid overdose prevention and treatment training program is defined in the bill as a program operated by a local health jurisdiction or that is registered by a local health jurisdiction to train individuals to prevent, recognize, and respond to an opiate overdose, and that provides, at a minimum, training in the following: the causes of an opiate overdose; mouth to mouth resuscitation; how to contact appropriate emergency medical services; and how to administer an opioid antagonist.

Language in existing law for the pilot project only provides civil and criminal liability, it does not exclude health care providers from "professional review". According to the author's office, the intent of the professional review language is to make it clear that the action of prescribing an opioid antagonist by standing order cannot be grounds for disciplinary action. Many states that have similar law include this type of language. Kentucky's statute says that a practitioner operating under the law shall not "be subject to disciplinary or other adverse action

under any professional licensing statute". Illinois statute contains the same language, while Washington's statute says that actions under the law "shall not constitute unprofessional conduct". Massachusetts law declares that a naloxone script "shall be regarded as being issued for a legitimate medical purpose in the usual course of professional practice".

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

This bill will help to further the Board's mission of consumer protection, and the Board has taken a support position on this bill.

FISCAL: None

SUPPORT: Harm Reduction Coalition (sponsor); California Society of Addiction Medicine (sponsor); Berkeley Needle Exchange Emergency Distribution; California Association of Alcohol & Drug Program Executives, Inc.; California Attorneys for Criminal Justice; California Opioid Maintenance Providers; California Public Defenders Association; City and County of San Francisco; Civil Justice Association of California; Common Ground, the Westside HIV Community Center; County Alcohol & Drug Program Administrators Association of California; Drug Policy Alliance; Harm Reduction Therapy Center; Homeless Health Care Los Angeles; Medical Board of California; National Coalition Against Prescription Drug Abuse; San Francisco Drug Users Union; and Shasta Community Health Center

OPPOSITION: None on file

AMENDED IN SENATE JUNE 24, 2013

AMENDED IN ASSEMBLY APRIL 11, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 635

Introduced by Assembly Member Ammiano

February 20, 2013

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

LEGISLATIVE COUNSEL'S DIGEST

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

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

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

1714.22. (a) For purposes of this section, the following definitions shall apply:

(1) "Opioid antagonist" means naloxone hydrochloride that is approved by the federal Food and Drug Administration for the treatment of an opioid overdose.

(2) "Opioid overdose prevention and treatment training program" means any program operated by a local health jurisdiction or that is registered by a local health jurisdiction to train individuals to prevent, recognize, and respond to an opiate overdose, and that provides, at a minimum, training in all of the following:

(A) The causes of an opiate overdose.

(B) Mouth to mouth resuscitation.

(C) How to contact appropriate emergency medical services.

(D) How to administer an opioid antagonist.

(b) A licensed health care provider who is authorized by law to prescribe an opioid antagonist may, if acting with reasonable care, prescribe and subsequently dispense or distribute an opioid antagonist to a person at risk of an opioid-related overdose or to a family member, friend, or other person in a position to assist a person at risk of an opioid-related overdose.

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

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

(d) A person who is prescribed an opioid antagonist or possesses it pursuant to a standing order shall receive the training provided by an opioid overdose prevention and treatment training program.

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

AJB 809

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 809
Author: Logue
Bill Date: June 25, 2013, Amended
Subject: Healing Arts: Telehealth
Sponsor: Author
Position: Support

STATUS OF BILL:

This bill is currently in the Senate Health Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill, as originally introduced, 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.

This bill was recently amended to instead require health care providers to obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health during a specified course of health care and treatment. This consent must be documented in the patient's medical record and the documentation must be transmitted with initiation of any telehealth for the specified course of health care and treatment to any distant-site health care provider from whom telehealth is obtained.

ANALYSIS:

The Telehealth Advancement Act of 2011 was signed into law as a result of AB 415 (Logue, Chapter 547). This bill would delete the requirement included in that Act that is now in existing law that requires physicians, prior to the delivery of health care via telehealth, to verbally inform the patient at the originating site that telehealth may be used and obtain verbal consent from the patient for this use.

This bill was recently amended to instead require health care providers to obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health during a specified course of health care and treatment. This consent must be documented in the patient's medical record and the documentation must be transmitted with initiation of any telehealth for the specified course of health care and treatment to any distant-site health care provider from whom telehealth is obtained. This bill would require the distant-site health care provider to obtain confirmation of the patient's consent from the originating site provider or to separately obtain consent from the patient about the use of telehealth as an acceptable

mode of delivering health care services and public health during a specified course of health care and treatment.

According to the author, under existing law, in order to ensure that both physicians and patients understand that telehealth may be used to treat the patient, a physician is required to obtain verbal consent for each and every visit with the patient. Physicians have reported that this constant requirement is burdensome on their ability to treat patients effectively. This was a requirement added to statute from AB 415 (Logue, Chapter 547, Statutes of 2011). The author of this bill, who also authored AB 415, believes that the requirement included in his bill in 2011 eliminates efficiencies achieved in rendering telehealth services and was an unintended consequence that is inconsistent with the intent and principles of his bill.

The California Association of Physician Groups supports this bill because telehealth is a critical component of expanding access to care and this bill is an important clean up provision.

This bill would allow the Telemedicine Advancement Act of 2011 to be implemented as intended, which will help to improve access to care via telehealth, as such, the Board has taken a support position on this bill.

FISCAL: None

SUPPORT: Association of California Healthcare Districts
California Association of Physician Assistants
California Association of Physician Groups
Medical Board of California

OPPOSITION: American Federation of State, County, and Municipal Employees

AMENDED IN SENATE JUNE 25, 2013

AMENDED IN ASSEMBLY APRIL 29, 2013

AMENDED IN ASSEMBLY APRIL 3, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 809

Introduced by Assembly Member Logue
(Coauthor: Senator Galgiani)

February 21, 2013

An act to amend Section 2290.5 of the Business and Professions Code, relating to telehealth, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 809, as amended, Logue. Healing arts: telehealth.

Existing law requires a health care provider, as defined, prior to the delivery of health care services via telehealth, as defined, to verbally inform the patient that telehealth may be used and obtain verbal consent from the patient for this use. Existing law also provides that failure to comply with this requirement constitutes unprofessional conduct.

This bill would ~~allow the verbal consent for the use of telehealth to apply in the present instance and for any subsequent use of telehealth.~~ *require the health care provider initiating the use of telehealth at the originating site to obtain verbal or written consent from the patient for the use of telehealth, as specified. The bill would require that health care provider to document the consent in the patient's medical record and to transmit that documentation with the initiation of any telehealth to any distant-site health care provider from whom telehealth is requested or obtained. The bill would require a distant-site health care*

(b) Prior to the delivery of health care via telehealth, the health care provider initiating the use of telehealth at the originating site shall ~~verbally~~ inform the patient about the use of telehealth and ~~request the patient's~~ *obtain* verbal *or written* consent~~, which may apply in the present instance and for any subsequent use of telehealth.~~ *from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health during a specified course of health care and treatment.* The ~~verbal~~ consent shall be documented in the patient's medical ~~record.~~ *record, and the documentation shall be transmitted with the initiation of any telehealth for that specified course of health care and treatment to any distant-site health care provider from whom telehealth is requested or obtained. A distant-site health care provider shall either obtain confirmation of the patient's consent from the originating site provider or separately obtain and document consent from the patient about the use of telehealth as an acceptable mode of delivering health care services and public health during a specified course of health care and treatment.*

(c) Nothing in this section shall preclude a patient from receiving in-person health care delivery services during a *specified* course of *health care and* treatment after agreeing to receive services via telehealth.

(d) The failure of a health care provider to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.

(e) This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

(f) All laws regarding the confidentiality of health care information and a patient's rights to his or her medical information shall apply to telehealth interactions.

(g) This section shall not apply to a patient under the jurisdiction of the Department of Corrections and Rehabilitation or any other correctional facility.

(h) (1) Notwithstanding any other provision of law and for purposes of this section, the governing body of the hospital whose patients are receiving the telehealth services may grant privileges to, and verify and approve credentials for, providers of telehealth services based on its medical staff recommendations that rely on

ABC 1000

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 1000
Author:	Wieckowski and Maienschein
Bill Date:	June 24, 2013, Amended
Subject:	Physical Therapists: Direct Access to Services: Professional Corporations
Sponsor:	California Physical Therapy Association

STATUS OF BILL:

This bill is in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

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

This bill was significantly amended to address concerns raised by the opposition. This bill no longer contains the provision that would have allowed a PT to make a physical therapy diagnosis. This bill was also amended to only allow a PT to see a patient for a specified period of time and would require the PT to provide specified notice to the patient regarding the direct PT services.

This bill now also incorporates the language from AB 1003 (Maienschein) which the Board had taken a position of support. The language from AB 1003 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 by professional corporations to the licensed professionals listed in that section and would specify that any person duly licensed under the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act, may be employed to render professional services by a professional corporation listed in existing law. This bill would also add physical therapists, and other licensed professionals, to the listing in the Corporations Code.

ANALYSIS:

This bill no longer allows a PT to make a "physical therapy diagnosis". This bill would allow a patient to directly access PT services, without being referred by a physician, provided that the treatment is within the scope of a PT and the following conditions are met:

- If the PT has reason to believe the patient has signs or symptoms of a condition

that requires treatment beyond the scope of practice of a PT or the patient is not progressing toward documented treatment goals as demonstrated by the objective, measurable, or functional improvement, 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, and, if working in a professional corporation, shall comply with existing law related to advertising.
- The PT shall notify the patient's physician, with the patient's written authorization, that the PT is treating the patient.

This bill was amended to only allow a PT to treat a patient for 45 calendar days or 12 visits, whichever occurs first. Once this limit has been reached, the PT's plan of care must be signed, dated, and approved by a physician, osteopathic physician, or podiatrist, acting within his or her scope of practice. Approval of the PT's plan of care must include an in-person patient examination and evaluation of the patient' condition, and if indicated, testing by the physician, osteopathic physician, or podiatrist.

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 services rendered to a patient who directly accessed the services of a PT.

This bill was amended to require a PT to provide notice to a patient before initiating PT treatment services. The notice must be provided orally and in writing to the patient in at least 14-point type and signed by the patient. The notice states that the patient is receiving direct PT treatment services by a PT licensed by the Physical Therapy Board of California. The notice further states the limits for PT care being provided (45 calendar days or 12 visits, whichever occurs first) and the requirement for approval and sign off by a physician, osteopathic physician or podiatrist, of the PT's plan of care and the requirements for an in-person patient examination and evaluation.

Lastly, this bill adds the language from AB 1003 (Maienschein), which the Board had taken a position of support. The language that was added 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 by 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, occupational therapists, and other licensed professionals, to the listing in the Corporations Code.

SB 543 (Steinberg, Chapter 448, Statutes of 2011) was signed into law and was effective from January 1, 2012 to January 1, 2013. This bill specified that no physical therapist shall be subject to discipline by the Physical Therapy Board for providing physical therapy services as a professional employee of a professional medical corporation; this provision was sunset on January 1, 2013. The language in SB 543 was added because the Physical Therapy Board was attempting to take action against physical therapists employed by a medical corporation. SB 543 put this issue in a holding pattern, until January 1, 2013; however, this issue was not addressed in legislation last year, so it still remains an issue that must be addressed. This bill will now codify the practice that has been allowed for over 20 years and will allow physicians in medical corporations to employ physical therapists. The Board is supportive of these provisions.

This bill no longer allows a PT to make a "physical therapy diagnosis". Although it would still allow patients to directly access PT services, it would now put limits on how long a patient can see a PT before the PT's plan of care is required to be reviewed by a physician, osteopathic physician, or podiatrist and would require the patient to get an in-patient examination and evaluation before the plan of care can be approved and signed off. This bill would also require the patient to be provided information on the requirements in this bill regarding time limits for receiving direct PT services and would require the patient to sign the notice before the PT can provide services. This bill includes language that has been negotiated by interested parties. Board staff believes that this bill includes adequate safeguards to ensure consumer protection. As such, Board staff is suggesting that the Board no longer oppose this bill and instead take a neutral position.

FISCAL: None

SUPPORT:
California Physical Therapy Association (Sponsor)
California Medical Association
California Orthopaedic Association
Mount St. Mary's College Doctor of Physical Therapy Program
Over 80 Individuals

OPPOSITION:
American College of Physicians
California Board of Chiropractic Examiners
California Chiropractic Association (unless amended)
Independent Physical Therapists of California
Physical Therapy Business Alliance
1061 Individuals

POSITION: Recommendation: Neutral

AMENDED IN SENATE JUNE 24, 2013

AMENDED IN ASSEMBLY MAY 8, 2013

AMENDED IN ASSEMBLY MAY 7, 2013

AMENDED IN ASSEMBLY APRIL 25, 2013

AMENDED IN ASSEMBLY MARCH 21, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1000

Introduced by Assembly Members Wieckowski and Maienschein

February 22, 2013

An act to amend Sections 2406 and 2660 of, and to add Sections 2406.5 and 2620.1 to, the Business and Professions Code, and to amend Section 13401.5 of the Corporations Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 1000, as amended, Wieckowski. Physical therapists: direct access to services: professional corporations.

Existing law, the Physical Therapy Practice Act, creates the Physical Therapy Board of California and makes it responsible for the licensure and regulation of physical therapists. The act makes it a crime to violate any of its provisions. The act authorizes the board to suspend, revoke, or impose probationary conditions on a license, certificate, or approval issued under the act for unprofessional conduct, as specified.

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

medical corporation. The bill would also provide that specified healing arts licensees may be shareholders, officers, directors, or professional employees of a physical therapy corporation. The bill would also require a practitioner, *except as specified,* who refers a patient to a physical therapist who is employed by a professional corporation to make a specified disclosure to the patient.

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

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

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

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

1 SECTION 1. The Legislature finds and declares that an
2 individual's access to early intervention to physical therapy
3 treatment may decrease the duration of a disability, reduce pain,
4 and lead to a quicker recovery.
5 SEC. 2. Section 2406 of the Business and Professions Code is
6 amended to read:
7 2406. A medical corporation or podiatry corporation is a
8 corporation that is authorized to render professional services, as
9 defined in Section 13401 of the Corporations Code, so long as that
10 corporation and its shareholders, officers, directors, and employees
11 rendering professional services who are physicians and surgeons,
12 psychologists, registered nurses, optometrists, podiatrists,
13 chiropractors, acupuncturists, naturopathic doctors, physical
14 therapists, occupational therapists, or, in the case of a medical
15 corporation only, physician assistants, marriage and family
16 therapists, clinical counselors, or clinical social workers, are in
17 compliance with the Moscone-Knox Professional Corporation Act,
18 the provisions of this article, and all other statutes and regulations
19 now or hereafter enacted or adopted pertaining to the corporation
20 and the conduct of its affairs.
21 With respect to a medical corporation or podiatry corporation,
22 the governmental agency referred to in the Moscone-Knox
23 Professional Corporation Act is the board.

person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California or to a person licensed to practice dentistry, podiatric medicine, or chiropractic.

(2) The physical therapist shall comply with Section 2633, and shall disclose to the patient any financial interest he or she has in treating the patient and, if working in a physical therapy corporation, shall comply with Article 6 (commencing with Section 650) of Chapter 1.

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

(4) The physical therapist shall not continue treating the patient beyond 45 calendar days or 12 visits, whichever occurs first, without receiving, from a person holding a physician and surgeon's certificate from the Medical Board of California or the Osteopathic Medical Board of California or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice, a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care. Approval of the physical therapist's plan of care shall include an in-person patient examination and evaluation of the patient's condition and, if indicated, testing by the physician and surgeon or podiatrist.

(b) The conditions in paragraph (4) of subdivision (a) do not apply to a physical therapist when he or she is only providing wellness physical therapy services to a patient as described in subdivision (a) of Section 2620.

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

(d) This section does not require a health care service plan or insurer to provide coverage for services rendered to a patient who directly accessed the services of a physical therapist.

(e) When a person initiates physical therapy treatment services directly, pursuant to this section, the physical therapist shall not perform physical therapy treatment services without first providing the following notice to the patient, orally and in writing, in at least 14-point type and signed by the patient:

(f) Addiction to the excessive use of any habit-forming drug.

(g) Gross negligence in his or her practice as a physical therapist or physical therapist assistant.

(h) Conviction of a violation of any of the provisions of this chapter or of the Medical Practice Act, or violating, or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter or of the Medical Practice Act.

(i) The aiding or abetting of any person to violate this chapter or any regulations duly adopted under this chapter.

(j) The aiding or abetting of any person to engage in the unlawful practice of physical therapy.

(k) The commission of any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, or duties of a physical therapist or physical therapist assistant.

(*l*) Except for good cause, the knowing failure to protect patients by failing to follow infection control guidelines of the board, thereby risking transmission of bloodborne infectious diseases from licensee to patient, from patient to patient, and from patient to licensee. In administering this subdivision, the board shall consider referencing the standards, regulations, and guidelines of the State Department of Public Health developed pursuant to Section 1250.11 of the Health and Safety Code and the standards, regulations, and guidelines pursuant to the California Occupational Safety and Health Act of 1973 (Part 1 (commencing with Section 6300) of Division 5 of the Labor Code) for preventing the transmission of HIV, hepatitis B, and other bloodborne pathogens in health care settings. As necessary, the board shall consult with the Medical Board of California, the California Board of Podiatric Medicine, the Dental Board of California, the Board of Registered Nursing, and the Board of Vocational Nursing and Psychiatric Technicians of the State of California, to encourage appropriate consistency in the implementation of this subdivision.

The board shall seek to ensure that licensees are informed of the responsibility of licensees and others to follow infection control guidelines, and of the most recent scientifically recognized safeguards for minimizing the risk of transmission of bloodborne infectious diseases.

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

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

(8) Licensed physical therapists.
(c) Psychological corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Registered nurses.
(4) Licensed optometrists.
(5) Licensed marriage and family therapists.
(6) Licensed clinical social workers.
(7) Licensed chiropractors.
(8) Licensed acupuncturists.
(9) Naturopathic doctors.
(10) Licensed professional clinical counselors.
(d) Speech-language pathology corporation.
(1) Licensed audiologists.
(e) Audiology corporation.
(1) Licensed speech-language pathologists.
(f) Nursing corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Licensed psychologists.
(4) Licensed optometrists.
(5) Licensed marriage and family therapists.
(6) Licensed clinical social workers.
(7) Licensed physician assistants.
(8) Licensed chiropractors.
(9) Licensed acupuncturists.
(10) Naturopathic doctors.
(11) Licensed professional clinical counselors.
(g) Marriage and family therapist corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.
(3) Licensed clinical social workers.
(4) Registered nurses.
(5) Licensed chiropractors.
(6) Licensed acupuncturists.
(7) Naturopathic doctors.
(8) Licensed professional clinical counselors.
(h) Licensed clinical social worker corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.

1 (10) Naturopathic doctors.
2 (11) Licensed professional clinical counselors.
3 (m) Naturopathic doctor corporation.
4 (1) Licensed physicians and surgeons.
5 (2) Licensed psychologists.
6 (3) Registered nurses.
7 (4) Licensed physician assistants.
8 (5) Licensed chiropractors.
9 (6) Licensed acupuncturists.
10 (7) Licensed physical therapists.
11 (8) Licensed doctors of podiatric medicine.
12 (9) Licensed marriage and family therapists.
13 (10) Licensed clinical social workers.
14 (11) Licensed optometrists.
15 (12) Licensed professional clinical counselors.
16 (n) Dental corporation.
17 (1) Licensed physicians and surgeons.
18 (2) Dental assistants.
19 (3) Registered dental assistants.
20 (4) Registered dental assistants in extended functions.
21 (5) Registered dental hygienists.
22 (6) Registered dental hygienists in extended functions.
23 (7) Registered dental hygienists in alternative practice.
24 (o) Professional clinical counselor corporation.
25 (1) Licensed physicians and surgeons.
26 (2) Licensed psychologists.
27 (3) Licensed clinical social workers.
28 (4) Licensed marriage and family therapists.
29 (5) Registered nurses.
30 (6) Licensed chiropractors.
31 (7) Licensed acupuncturists.
32 (8) Naturopathic doctors.
33 (p) Physical therapy corporation.
34 (1) Licensed physicians and surgeons.
35 (2) Licensed doctors of podiatric medicine.
36 (3) Licensed acupuncturists.
37 (4) Naturopathic doctors.
38 (5) Licensed occupational therapists.
39 (6) Licensed speech-language therapists.
40 (7) Licensed audiologists.

AB 1288

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1288
Author: Perez, V.
Bill Date: June 6, 2013, Amended
Subject: Medical Board & Osteopathic Medical Board: Licensing: Application Processing
Sponsor: California Medical Association
Position: Neutral

STATUS OF BILL:

This bill is currently on the Senate Third Reading File.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require the Medical Board of California (Board) to develop a process to give priority review status to the application of an applicant who can demonstrate that he or she intends to practice in a medically underserved area or population. This bill would allow an applicant to demonstrate his or her intent to practice in a medically underserved area by providing proper documentation, including a letter from the employer.

Recent amendments put the same requirements for a priority application review process on the Osteopathic Medical Board of California.

ANALYSIS:

Currently, the Board is completing an initial review of applications within 45 calendar days, well under the statutorily mandated 60 business days. However, many times the application does not have all the required information and primary source documentation at the time of initial review; only about 10% of applications are complete at initial review. The Board does not currently request any information on the application regarding where the applicant is planning on working once licensed.

This bill would require the Board to develop a process to give priority review status to an applicant who can demonstrate that he or she intends to practice in a medically underserved area or serve a medically underserved population as defined in existing law. This bill would allow an applicant to demonstrate his or her intent to practice in a medically underserved area or serve a medically underserved population by providing proper documentation, including but not limited to, a letter from the employer indicating that the applicant has accepted employment and identifying a start date.

The Board does not currently have a process for priority review of applications and the application does not currently request information on where an applicant plans on practicing. However, the Board would be able to review these applications on a priority basis, but would need to revise the application to ask applicants to provide this additional information. The priority review process could be established, but it still would require the applicant to provide all the original source documentation, and this seems to be the 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. The Board currently does not have any backlog in processing applications, and many times the initial review of the application is done before all the primary source documents are received. The Board has taken a neutral position on this bill and recent amendments do not impact the Board's position or the reason for taking that position.

FISCAL: Minimal and absorbable costs to develop a process for priority review status and to revise the licensing application.

SUPPORT: California Medical Association (sponsor)
Association of California Healthcare Districts
California Optometric Association

OPPOSITION: None on file

AMENDED IN SENATE JUNE 6, 2013

AMENDED IN ASSEMBLY APRIL 11, 2013

AMENDED IN ASSEMBLY MARCH 21, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1288

Introduced by Assembly Member V. Manuel Pérez

February 22, 2013

An act to add ~~Section~~ *Sections* 2092 *and 2099.6* to the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 1288, as amended, V. Manuel Pérez. Medical Board of *California and Osteopathic Medical Board of* California: licensing: application processing.

Existing law, the Medical Practice Act, provides for licensure and regulation of physicians and surgeons by the Medical Board of California. *Existing law establishes the Osteopathic Medical Board of California and authorizes the board to issue an originating or reciprocal osteopathic physician and surgeon's certificate to an applicant who satisfies specified criteria.* Existing law establishes the California Healthcare Workforce Policy Commission and requires the commission to, among other things, identify specific areas of the state where unmet priority needs for primary care exist.

This bill would require the Medical Board of California *and the Osteopathic Medical Board of California* to develop a process to give priority review status to the application of an applicant who can demonstrate, as specified, that he or she intends to practice in a medically underserved area or serve a medical underserved population.

AB 1308

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1308
Author: Bonilla
Bill Date: July 9, 2013, Amended
Subject: Midwifery
Sponsor: American Congress of Obstetricians and Gynecologists, District IX
Position: Support if Amended

STATUS OF BILL:

This bill is in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

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

Recent amendments would also allow a LM to obtain devices and obtain and administer drugs and diagnostic tests. Amendments would specify that a LM is not required to identify a specific physician in the arrangement for the referral of complications to a physician and surgeon for consultation. The amendments would also allow a LM to be an attendant in an alternative birth center (ABC) and change the standards of certification that must be met by an ABC to those established by the American Association of Birth Centers. Lastly, the author took amendments in Senate Business, Professions, and Economic Development Committee (recommended by the Committee) that delete the requirement in this bill and existing law for the Board to develop regulations defining the appropriate standard of care and level of physician supervision required for the practice of midwifery.

ANALYSIS

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

divergent opinions of interested parties and their inability to reach consensus.

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

Recent amendments allow a LM to also obtain devices and administer drugs and diagnostic tests that are consistent with the LM scope of practice and are necessary to his or her practice of midwifery. Amendments would specify that a LM is not required to identify a specific physician in the arrangement for the referral of complications to a physician and surgeon for consultation. Amendments were also taken that delete the requirement in this bill and existing law for the Board to develop regulations defining the appropriate standard of care and level of physician supervision required for the practice of midwifery.

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

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

The Board, through the Midwifery Advisory Council (MAC) has held many meetings regarding physician supervision of LMs and has attempted to create regulations to address this issue. The concepts of collaboration, such as required consultation, referral, transfer of care, and physician liability have been discussed among the interested parties with little success. There is disagreement over the appropriate level of physician supervision, with LMs expressing concern with any limits being placed on their ability to practice independently. The

physician and liability insurance communities have concerns over the safety of midwife-assisted homebirths, specifically delays and/or the perceived reluctance of LMs to refer patients when the situation warrants referral or transfer of care.

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

This bill would address one of the barriers of care by allowing a LM to directly obtain supplies and devices, obtain and administer drugs and diagnostic tests, and to order testing and receive reports necessary to the LM's practice of midwifery and within the scope of practice.

The amendments would also allow a LM to be an attendant in an ABC and change the standards of certification that must be met by an ABC to those established by the American Association of Birth Centers.

This bill no longer requires the Board to adopt regulations to address physician supervision and to identify complications necessitating referral to a physician. However, Board staff still believes that it is essential that this bill address the issue of physician supervision. Board staff will continue to work with the author's office and sponsors on language that will help to solve the issue of physician supervision and remove barriers to care, while at the same time ensuring that consumers are protected. Board staff is suggesting that the Board continue to support this bill, but work with the sponsors, author's office, and interested parties on language that will address the physician supervision issue.

FISCAL: None

SUPPORT: ACOG (sponsor)
California Association of Midwives (if amended)
Medical Board of California (if amended)
Numerous Individuals (if amended)

OPPOSITION: California Families for Access to Midwives

AMENDED IN SENATE JULY 9, 2013

AMENDED IN SENATE JUNE 13, 2013

AMENDED IN ASSEMBLY MARCH 21, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1308

Introduced by Assembly Member Bonilla

February 22, 2013

An act to amend Sections 2507 and 2508 of the Business and Professions Code, and to amend Section 1204.3 of the Health and Safety Code, relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

AB 1308, as amended, Bonilla. Midwifery.

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

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

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

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

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

(b) As used in this article, the practice of midwifery constitutes the furthering or undertaking by any licensed midwife, under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics, to assist a woman in childbirth so long as progress meets criteria accepted as normal. All complications shall be referred to a physician and surgeon immediately. The practice of midwifery does not include the assisting of childbirth by any artificial, forcible, or mechanical means, nor the performance of any version.

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

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

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

(f) A midwife is authorized to directly obtain supplies and devices, obtain and administer drugs and diagnostic tests, order testing, and receive reports that are necessary to his or her practice of midwifery and consistent with his or her scope of practice.

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

(A) Be located in proximity, in time and distance, to a facility with the capacity for management of obstetrical and neonatal emergencies, including the ability to provide cesarean section delivery, within 30 minutes from time of diagnosis of the emergency.

(B) Require the presence of at least two attendants at all times during birth, one of whom shall be a physician and surgeon, a licensed midwife, or a certified nurse-midwife.

(5) Have a written policy relating to the dissemination of the following information to patients:

(A) A summary of current state laws requiring child passenger restraint systems to be used when transporting children in motor vehicles.

(B) A listing of child passenger restraint system programs located within the county, as required by Section 27362 of the Vehicle Code.

(C) Information describing the risks of death or serious injury associated with the failure to utilize a child passenger restraint system.

(b) The state department shall issue a permit to a primary care clinic licensed pursuant to subdivision (a) of Section 1204 certifying that the primary care clinic has met the requirements of this section and may provide services as an alternative birth center. Nothing in this section shall be construed to require that a licensed primary care clinic obtain an additional license in order to provide services as an alternative birth center.

(c) (1) Notwithstanding subdivision (a) of Section 1206, no place or establishment owned or leased and operated as a clinic or office by one or more licensed health care practitioners and used as an office for the practice of their profession, within the scope of their license, shall be represented or otherwise held out to be an alternative birth center licensed by the state unless it meets the requirements of this section.

(2) Nothing in this subdivision shall be construed to prohibit licensed health care practitioners from providing birth related services, within the scope of their license, in a place or establishment described in paragraph (1).

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school

SB 20

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 20
Author: Hernandez
Bill Date: February 14, 2013, Amended
Subject: Health Care: Workforce Training
Sponsor: Author
Position: Support

STATUS OF BILL:

This bill is currently in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require that when the California Major Risk Medical Insurance Program (MRMIP) becomes inoperative, all the funds in the Managed Care Administrative Fines and Penalties Fund (Managed Care Fund) must be transferred each year to the Medically Underserved Account in the Health Professions Education Foundation (HPEF) Fund for use by the Steven M. Thompson Loan Repayment Program (STLRP).

ANALYSIS:

The STLRP was created in 2002 via legislation which was co-sponsored by the Medical Board of California (Board). The STLRP encourages recently licensed physicians to practice in underserved locations in California by authorizing a plan for repayment of their student loans (up to $105,000) in exchange for a minimum three years of service. In 2006, the administration of STLRP was transitioned from the Board to HPEF. Since 1990, HPEF has administered statewide scholarship and loan repayment programs for a wide range of health professions' students and recent graduates. These programs are funded through grants and contributions from public and private agencies, hospitals, health plans, foundations, and corporations, as well as through a surcharge on the renewal fees of various health professionals, including a $25 fee paid by physicians and surgeons.

Under existing law, revenue from fines and penalties levied on health plans is deposited in the Managed Care Fund. The first $1 million is used for the STLRP, and fines and penalties above $1 million are used to augment funding for MRMIP, which provides subsidized health insurance for individuals unable to obtain coverage due to a pre-existing condition. In 2014, MRMIP will no longer be necessary due to the reforms enacted under the Affordable Care Act (ACA).

This bill would require all funds from the Managed Care Fund to go to HPEF once MRMIP is inoperative, for purposes of funding STLRP. This will provide the STLRP a more robust funding source by shifting monies no longer needed for MRMIP. According to the author's office, implementation of the ACA will result in a further strain on the demand for primary care physicians. This bill will help to ensure that more physicians have incentive to practice in underserved areas of California. As such, this bill promotes the Board's mission of access to care and the Board has taken a support position on this bill.

FISCAL: None

SUPPORT: Association of California Healthcare Districts; California Association of Clinical Nurse Specialists; California Association of Physician Groups; California Communities United Institute; California Hospital Association; California Medical Association; California Optometric Association; California Primary Care Association; Hospital Corporation of America; Los Angeles County Board of Supervisors; Medical Board of California; National Association of Pediatric Nurse Practitioners; and Osteopathic Physicians and Surgeons of California

OPPOSITION: None on file

AMENDED IN SENATE FEBRUARY 14, 2013

SENATE BILL **No. 20**

Introduced by Senator Hernandez

December 3, 2012

An act ~~relating to health care coverage.~~ *to amend Section 1341.45 of the Health and Safety Code, relating to health.*

LEGISLATIVE COUNSEL'S DIGEST

SB 20, as amended, Hernandez. ~~Health care coverage: basic health program.~~ *Health care: workforce training.*

Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and imposes certain requirements on health care service plans. Existing law imposes, for certain violations of these provisions, various fines and administrative penalties, which are deposited in the Managed Care Administrative Fines and Penalties Fund. Existing law requires the first $1,000,000 in the fund to be transferred each year to the Medically Underserved Account for Physicians in the Health Professions Education Fund for purposes of the Steven M. Thompson Physician Corps Loan Repayment Program. Existing law requires all remaining funds to be transferred each year to the Major Risk Medical Insurance Fund for purposes of the Major Risk Medical Insurance Program.

This bill, beginning on the date that the Major Risk Medical Insurance Program becomes inoperative, would instead require all the funds in the Managed Care Administrative Fines and Penalties Fund to be transferred each year to the Medically Underserved Account for Physicians in the Health Professions Education Fund for purposes of the Steven M. Thompson Physician Corps Loan Repayment Program.

shall not be used to provide funding for the Physician Volunteer Program.

~~(2)~~

(B) Any amount over the first one million dollars ($1,000,000), including accrued interest, in the fund shall be transferred to the Major Risk Medical Insurance Fund created pursuant to Section 12739 of the Insurance Code and shall, upon appropriation by the Legislature, be used for the Major Risk Medical Insurance Program for the purposes specified in Section 12739.1 of the Insurance Code.

(C) Transfers under this paragraph shall cease on the date the Managed Risk Medical Insurance Program becomes inoperative. The Director of Finance shall notify the Joint Legislative Budget Committee at the time the program becomes inoperative.

(2) Commencing on the date transfers under paragraph (1) cease, and annually thereafter, the fines and administrative penalties deposited into the Managed Care Administrative Fines and Penalties Fund shall be transferred by the department to the Medically Underserved Account for Physicians within the Health Professions Education Fund and shall, upon appropriation by the Legislature, be used for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program, as specified in Article 5 (commencing with Section 128550) of Chapter 5 of Part 3 of Division 107 and, notwithstanding Section 128555, shall not be used to provide funding for the Physician Volunteer Program.

(d) Notwithstanding subdivision (b) of Section 1356 and Section 1356.1, the fines and administrative penalties authorized pursuant to this chapter shall not be used to reduce the assessments imposed on health care service plans pursuant to Section 1356.

~~SECTION 1. It is the intent of the Legislature to enact legislation that would establish the basic health program described in Section 1331 of the federal Patient Protection and Affordable Care Act (42 U.S.C. Sec. 18051).~~

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SB 21

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 27 and SB 21
Author: Medina and Roth
Bill Date: July 3 and June 26, 2013, Amended
Subject: UC Riverside Medical School: Funding
Sponsor: Author and the California Medical Association
Position: Support

STATUS OF BILL:

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

DESCRIPTION OF CURRENT LEGISLATION:

These bills contain 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 (UC), Riverside. Both bills contain urgency clauses, which mean that the bills would take effect immediately once signed into law. SB 21 would 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 AB 27 and SB 21 were amended to add findings and declarations and to require the moneys appropriated to only be used for funding the UC Riverside School of Medicine, not for other purposes or to supplant other funding. The amendments would require the UC Riverside School of Medicine to develop a program to identify eligible medical residents and to assist those residents to apply for physician retention programs, including the Steven M. Thompson Medical School Scholarship Program (STMSSP).

AB 27 and SB 21 were amended to remove the appropriation language as the Higher Education Trailer Bill, AB 94, was amended to include a $15,000,000 appropriation allocated to UC Riverside School of Medicine. Both bills reference AB 94 and the appropriation.

ANALYSIS:

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

In July 2008, the UC Board of Regents officially approved the proposed establishment of an independent four-year School of Medicine at UC Riverside, intended to serve the medically underserved

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

The purpose of these bills is to provide funding from the General Fund in order to establish a more viable funding source for the UC Riverside School of Medicine. AB 27 and SB 21 no longer include an appropriation, but refer to AB 94, which includes the appropriation for UC Riverside School of Medicine. Both bills specify that funds provided shall be available for planning and startup costs associated with academic programs to be offered at the UC Riverside School of Medicine, including: Academic planning activities, support of academic program offerings, and faculty recruitment; the acquisition of instructional materials and equipment; and ongoing operating support for faculty, staff, and other annual operating expenses for the UC Riverside School of Medicine. Both bills were also amended to add findings and declarations and to require the moneys appropriated to only be used for funding the UC Riverside School of Medicine, not for other purposes or to supplant other funding. The amendments would also require the UC Riverside School of Medicine to develop a program to identify eligible medical residents and to assist those residents to apply for physician retention programs, including the STMSSP.

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

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

These bills will help to increase access to care and help the Inland Empire area of California to prepare and be ready for implementation of the Affordable Care Act; the Board has taken a support position on these bills.

FISCAL: None to the Board

SUPPORT: SB 21 - California Medical Association (Sponsor); American College of Emergency Physicians; Bourns, Gordon Bourns, CEO; California Association of Physician Groups; California Podiatric Medical Association; California Primary Care Association; City of Murieta; Enterprise Media and the Press-Enterprise; Inland Empire Economic Partnership; Insurance Commissioner Dave Jones; Kaiser Permanente; Mayor Rusty Bailey, City of Riverside; Medical Board of California; Riverside County Superintendent of Schools; Southwest California Legislative Council; Southwest Riverside County Association of Realtors; University of California; University of California Riverside Alumni Association; and Western Riverside Council of Governments

AB 27 – California Primary Care Association; California Podiatric Medical Association; Medical Board of California; and Riverside County Superintendent of Schools

OPPOSITION: None on file

AMENDED IN ASSEMBLY JUNE 26, 2013

AMENDED IN SENATE MAY 24, 2013

AMENDED IN SENATE APRIL 23, 2013

AMENDED IN SENATE MARCH 18, 2013

SENATE BILL No. 21

Introduced by Senator Roth
(Principal coauthor: Assembly Member Medina)
(Coauthors: Senators Correa and Hueso)

December 3, 2012

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

LEGISLATIVE COUNSEL'S DIGEST

SB 21, as amended, Roth. University of California: UC Riverside Medical ~~School: funding.~~ *School.*

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

~~This bill would annually appropriate $15,000,000 from the General Fund to the Regents of the University of California for allocation to the School of Medicine at the University of California, Riverside. The bill would require the Regents of the University of California to use these moneys for the sole purpose of funding the School of Medicine at the University of California, Riverside, and would prohibit the regents from~~

independent four-year school of medicine has received preliminary accreditation from the Liaison Committee on Medical Education, the nationally recognized accrediting body for medical education programs leading to M.D. degrees in the United States and Canada. When this new four-year medical school opens in August 2013, it will become the first new public medical school in California in more than 40 years.

(e) This community-based medical school with a public mission to expand and diversify the region's physician workforce and to improve the health of people living in inland southern California has made a commitment to underserved patient populations.

(f) There are two principal determinants of where a physician practices: (1) where he or she grew up, and (2) where he or she completes residency training following medical school graduation.

(g) The UCR medical school has strategies to capitalize on both of these factors. Among these strategies are all of the following: (1) developing student pipeline programs that inspire more young people in the region to pursue careers in medicine and other allied health professions and to recruit them to the UCR medical school; (2) utilizing a holistic review of medical school applicants that takes into account diverse life experiences in addition to academic performance; (3) teaching a curriculum that emphasizes key competencies for primary care medicine, including wellness and prevention, evidence-based medicine, and chronic disease management; (4) creating new residency training programs in primary care and those short-supply specialties that are most needed in inland southern California; and (5) continuing UCR's commitment to the recruitment, retention, and advancement of talented students, faculty, and staff from historically excluded populations who are currently underrepresented in medical education and the practice of medicine.

(h) As a further incentive for medical students to choose primary care specialties, the UCR medical school has developed an innovative "loan-to-scholarship" program, is actively raising nonstate funds to expand that program, and is educating students and graduates about existing public and private physician recruitment and retention programs, including, but not limited to, the Steven M. Thompson ~~Physician Corps Loan Repayment~~ *Medical School Scholarship* Program established pursuant to

with Section 128560) of Chapter 5 of Part 3 of Division 107 of the Health and Safety Code.

~~SEC. 3. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:~~

~~In order to provide crucial funding to launch the vital health care mission of the School of Medicine at the University of California, Riverside, it is necessary that this act take effect immediately.~~

CORRECTIONS:

Text—Page 4.

O

SB 62

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 62
Author: Price
Bill Date: June 27, 2013, Amended
Subject: Coroners: Reporting Requirements: Prescription Drug Use
Sponsor: Author
Position: Support

STATUS OF BILL:

This bill is in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill was previously amended to 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. 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 allow the follow-up coroner's report and autopsy protocol to be filed with the Board within 90 days or as soon as possible once the coroner's final report of investigation is complete.

This bill was amended to specify that deaths are only required to be reported to the Board when the cause of death (instead of a contributing factor in the cause of death) is due to a Schedule II, III, or IV drug. Technical amendments were made to clarify that the pathologist does not have to be board certified, to reflect current practice and clarify language in this bill and in existing law.

ANALYSIS:

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

The Board has reason to believe that numerous death have occurred in California that are related to prescription drug overdoses. However, complaints regarding drug-related offenses are often hard for the Board to obtain. In most instances, patients who are receiving prescription drugs in a manner that is not within the standard of practice, are unlikely to make a complaint to the Board. Some complaints regarding overprescribing come from anonymous tips, which usually do not have enough information to allow forwarding to the Board's district office for investigation, as there is no patient to obtain records for or not enough information to open an investigation. Family members of patients may make a complaint to the Board; however, the Board must have a patient release in order to obtain medical records or seek a subpoena. Sometimes it is difficult to obtain evidence to warrant a subpoena, or the family is not responsive.

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

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

The 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 was 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 review process.

Recent amendments narrow the bill to only require reporting of deaths to the Board when the cause of death (instead of a contributing factor in the cause of death) is due to a Schedule II, III, or IV drug. Although this amendment may narrow the number of reports received, this amendment was taken at the request of the coroners to help

ensure that they can implement and meet the mandates of the bill, as all coroners do not list contributing factors in their reports. This bill will still help to ensure that the Board is notified of deaths that are a result of a drug overdose. The Board will handle coroner reports received as it would handle any other complaint and will triage and order medical records, as appropriate. Physicians will be notified when a patient's medical record is being requested by the Board and physicians will still be entitled to a summary of their central file under Business and Professions Code Section 800(c). Board staff believes that this bill will still help to ensure consumer protection and ensure that the Board is aware of these drug overdose deaths, which will allow the Board to review the information and investigate as appropriate. Board staff is suggesting that the Board continue to support this bill.

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 ASSEMBLY JUNE 27, 2013

AMENDED IN ASSEMBLY JUNE 14, 2013

AMENDED IN SENATE APRIL 22, 2013

AMENDED IN SENATE APRIL 9, 2013

SENATE BILL No. 62

Introduced by ~~Senator~~ *Senators* Price *and Lieu*

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 require the coroner's report and other information to follow the report within 90 days or as soon as possible once the coroner's final report of investigation is complete. The bill would additionally require a coroner to file a report with the Medical Board of California when he or she receives information that indicates that the cause of death is due to a Schedule II, III, or IV drug. By increasing the duties of county officers, this bill would create a state-mandated local program.

1 the cause of death is due to a Schedule II, III, or IV drug, a report
2 shall be filed with the Medical Board of California. The initial
3 report shall include, when known, the name of the decedent, date
4 and place of death, attending physicians, podiatrists, or physician
5 assistants, and all other relevant information, including, but not
6 limited to, any information available to identify the prescription
7 drugs, prescribing physicians, and dispensing pharmacy. The initial
8 report shall be followed, within 90 days or as soon as possible
9 once the coroner's final report of investigation is complete, by
10 copies of the coroner's report, autopsy protocol, and all other
11 relevant information.
12 SEC. 2. If the Commission on State Mandates determines that
13 this act contains costs mandated by the state, reimbursement to
14 local agencies and school districts for those costs shall be made
15 pursuant to Part 7 (commencing with Section 17500) of Division
16 4 of Title 2 of the Government Code.

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SB304

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 304
Author: Price
Bill Date: April 24, 2013, Amended
Subject: Healing Arts: Boards
Sponsor: Author
Position: Support if Amended

STATUS OF BILL:

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

DESCRIPTION OF CURRENT LEGISLATION:

This bill is the bill that includes language on a portion of the new issues from the Board's 2012 Sunset Review Report, and eventually will extend the Board's sunset date. This bill would also remove the sunset date from the provisions in existing law related to vertical enforcement.

This bill was amended and effective January 1, 2014, would transfer all investigators employed by the Medical Board of California (Board) and their staff to the Department of Justice (DOJ).

ANALYSIS:

The Board included new issues in its 2012 Sunset Review Report to the Legislature and in its 2013 Supplemental Report. This report was submitted to the Legislature and the Legislature prepared a background paper that raised 39 issues, some of them related to the new issues included in the Board's Sunset Review Report. Here are the new issues that were included in the Board's Sunset Review Report that would require legislation:

- Revise existing law, Business and Professions (B&P) Code Section 2177, in order to accommodate the upcoming two parts of the United States Medical Licensing Examination (USMLE) Step 3 examination, and any new evolving examination requirement - **This bill includes language to accommodate two parts of the USMLE Step 3 examination**
- Require all licensees who have an email address to provide the Board with an email address, and specify that the email address shall be confidential - **This bill includes language that would require licensees who have an email address to provide the Board with an email address by July 1, 2014 and would specify that the email address is confidential and not subject to public disclosure.**

- The Board recommended that the requirement in existing law for the Board to post a physician's approved postgraduate training be eliminated - The Committee directed the Board to further discuss this proposal with stakeholders, including those stakeholders representing consumer interests and advise the Committee of the results of those discussions, and submit language if appropriate.
- The Board recommended that it be clarified in statute that residents in California accredited resident/fellowship programs are exempt from corporate practice laws related to how they are paid – **This bill includes language that clarifies that the corporate practice laws do not apply to physicians enrolled in an approved residency postgraduate training program or fellowship program.**
- The Board recommended that a section be added to existing law to require coroners to report all deaths related to prescription drug overdoses to the Board – this language is contained in SB 62 (Price), which the Board currently has a position of support.
- The Board recommended that legislation be introduced to provide an adequate funding source for CURES, so it can be funded and upgraded (e.g. funded by all individuals who prescribe or dispense medications, pharmaceutical companies, and the public). The prescribers/dispensers would include physicians, dentists, pharmacists, veterinarians, nurse practitioners, physician assistants, osteopathic physicians, optometrists, and podiatrists. This funding source would support the necessary enhancements to the computer system and provide for adequate staffing to run the system – The CURES funding and upgrading language is included in SB 809 (DeSaulnier and Steinberg).
- The Board recommended that medical malpractice reports received pursuant to Section 801.01 be excluded from the requirements in existing law that require an upfront review by a medical expert with the expertise necessary to evaluate the specific standard of care issue raised in the complaint – **This bill includes language to exclude 801.01 reports from upfront review.**
- The Board recommended that, in the interest of consumer protection, legislation be written to require that regulations be adopted for physician availability in all clinical settings and for the Board to establish by regulation the knowledge, training, and ability a physician must possess in order to supervise other health care providers – This issue was not addressed in the Committee's background paper and language is not included in this bill.
- The Board recommended that the law be amended to allow a facility only 15 days to provide medical records, upon request, if the facility has electronic health records (EHRs) – **This bill includes language to require health care facilities that have EHRs to provide the authorizing patient's certified medical records to the Board within 15 days of receiving the request and would subject the health care facility to penalties if the facility does not adhere to the timeline.**
- The Board recommended an amendment to existing law to require the California Department of Public Health (CDPH) and hospital accrediting agencies to send reportable peer review incidents found during an inspection of the facility to the Board and to require these entities to notify the Board if a hospital is not performing peer review - The Board was directed to further discuss this proposal with the Committee,

and consideration should be given to the Board entering into an arrangement or a MOU with CDPH and hospital accrediting agencies to send reportable peer review incidents found during an inspection of the facility to the Board; and to further require that these entities notify the Board if a hospital is not performing peer review. This bill does not include language to address this issue.

- The Board recommended elimination of the ten year posting requirement in existing law in order to ensure transparency to the public – In the Committee's background paper, it was recommended that in the interest of transparency and disclosure of information to the public, existing law should be amended to remove the 10 year limit on how long information should be posted on the Board's Internet Web site; however, this bill does not include language that would remove the 10 year limit on posting information.
- The Board recommended amending existing law to require a respondent to provide the full expert reviewer report and to clarify the timeframes in existing law for providing the reports, such as 90 days from the filing of an accusation – **This bill includes language that would require the complete expert reviewer report to be provided and that would require the expert testimony information to be provided within 90 days from the filing of a notice of defense. The Board is working with Committee staff and the California Medical Association (CMA) on amendments to address CMA's concerns.**
- The Board recommended that the provision in existing law that requires the Board to approve non-ABMS specialty boards be deleted. The Board suggested that the law should continue to require physicians to advertise as board certified only if they have been certified by ABMS boards and the four additional boards currently approved by the Board – **This bill deletes provisions in existing law that require the Board to approve non-ABMS specialty boards and only allows physicians to advertise that they have been certified by a non-ABMS board approved by the Board if it was approved prior to January 1, 2014. This language will be removed from the bill due to heavy opposition and concerns raised; the Board can bring this back in another bill next legislative session if it wishes to do so.**
- The Board suggested the transfer of the registered dispensing optician (RDO) Program to the Optometry Board or DCA should be examined – The Committee suggested that the Board initiate discussions with all stakeholders and report back to the Committees with findings by July 1, 2014. This bill does not include language to address this issue.
- The Board made suggestions related to the Licensed Midwifery Program, including that the issue of physician supervision and obtaining lab accounts and medical supplies should be addressed through legislation – The Committee agreed and AB 1308, which is sponsored by the American Congress of Obstetricians and Gynecologists, contains these changes. The Board has a support if amended position on this bill.
- The Board recommended that the issue of midwife students/apprenticeships needs to be clarified in legislation, due to confusion in the midwifery community – **This bill includes language that would define a "bona fide student" as an individual who is enrolled and participating in a midwifery education program or who is enrolled in a program of supervised clinical training as part of the instruction of a three year**

postsecondary midwifery education program approved by the Board.

- The Board recommended that the issue of midwife assistants needs to be addressed in legislation, and what duties the assistant may legally perform, as it has been brought to the attention of the Board that licensed midwives use midwife assistants. Currently, there is no definition for a midwife assistant or the specific training requirements or the duties that a midwife assistant may perform – The Committee directed the Board to provide more information regarding the proposal to address the issue of midwife assistants in legislation. This bill does not include language to address this issue.
- The Board suggested that existing law be amended to include certified nurse midwives (CNM) as being able to supervise midwifery students – **This bill includes language that would allow a CNM to supervise a midwifery student.**
- The Board recommended that language be added to existing law to allow the Board the authority to issue a cease practice order in cases where a licensee fails to comply with an order to compel a physical or mental examination - **This bill includes language that would allow the Board to issue a cease practice order when a licensee fails to comply with an order issued under Section 820, which compels a physical or mental examination. The Board is working with Committee staff and CMA on amendments to address CMA's concerns.**
- The Board recommended that existing law be amended to include American Osteopathic Association-Healthcare Facilities Accreditation Program as an approved accreditation agency for hospitals offering accredited postgraduate training programs – **This item, suggested in the Supplemental Report, was not addressed by the background paper as it was included after the paper was drafted and language was not included in this bill.**
- The Board recommended that the Vertical Enforcement Program be continued and stated that the Board and the Health Quality Enforcement Section (HQES) will continue to work together to establish best practices and identify areas where improvements can be made – **This bill deletes the sunset date in the vertical enforcement statutes, making vertical enforcement permanent. This bill would also require the Board, in consultation with DOJ and the Department of Consumer Affairs (DCA) to report and make recommendations to the Governor and the Legislature on the Vertical Enforcement Program by March 1, 2015. This bill was amended, and effective January 1, 2014, would transfer all investigators employed by the Board and their staff to DOJ.**

Transfer of Investigators to DOJ:

Moving the investigators over to DOJ could streamline the enforcement process by placing investigations and prosecutions under the jurisdiction of one agency. Allowing investigations and Deputy Attorneys General to be more easily co-located will also help to enhance communication.

Tenure/Retention Information

Regarding information on retention, this data was broken down into three time periods that equal the last 10 years. In the last 5 years, 53 investigators and supervising investigators left the Board; 29 retired, 21 transferred to another department or agency, and 3 were rejected on probation. In the last 5 to 7.5 years, 25 investigators and supervising investigators left the Board; 15 retired and 20 transferred to another department or agency. In the last 7.5 to 10 years, 22 investigators and supervising investigators left the Board; 20 retired and 2 transferred to another department or agency.

Regarding information on Board tenure, the data reflects a snapshot in time, and the same date was used (June 30) for each year data was collected. In 2013, investigators were employed for an average of 6 years; in 2008, investigators were employed for an average number of 9 years; and in 2003, investigators were employed for an average number of 7 years. In 2013, supervising investigators were employed for an average number of 8 years; in 2008, supervising investigators were employed for an average number of 10 years; and in 2003, supervising investigators were employed for an average number of 6 years.

Transferring investigators to DOJ would allow the investigators to receive a higher salary, which may reduce the number of investigators who retire or transfer from the Board and may increase the length of time investigators remain at the Board.

Issues/Concerns

If the investigators are transferred to DOJ, they will become employees of DOJ, meaning that the Board will no longer have control or authority over investigations and associated timelines, once cases are sent to DOJ for investigation. If investigations are handled by DOJ, the Board will have no input on the decisions made regarding the outcome of a case: whether it is referred for discipline, whether it is closed, whether a public reprimand is offered, etc. In addition, the Board will still be held accountable for its cases and timelines, even though it will have no oversight or control over the investigations and outcomes.

Fiscal Impact

If the investigators are transferred to DOJ, it will result in an increase of $1.294 million per year (for salaries only), due to the fact that the investigators at DOJ are classified as Special Agents and have a higher salary. 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 the billing methodology and bill the Board an hourly rate for the investigative services – currently the Board charges/is reimbursed

$149/hour for investigative services for physician and surgeon cases. The Board recently voted to approve pay differentials for investigators, which would have a total annual fiscal impact of $110,943 (chart attached), in comparison to the $1.294 million that this proposal would cost the Board.

Implementation

As far as implementation is concerned, investigative staff in the Board's Operation Safe Medicine Unit (OSM) would not be transferred to DOJ, as they do criminal investigations. All other staff in the Enforcement Program (besides staff performing investigations and their staff) would remain at the Board (Central Complain Unit, Discipline Coordination Unit, Probation Unit, Non-Sworn Special Investigative Unit, and the Central File Unit). The Board would need to have an individual assigned to review investigation reports to ensure appropriate action was taken.

Implementation Issues/Concerns

There are some implementation issues and concerns that Board staff has with this proposal. The Office of Standards and Training staff would be needed at both DOJ and at the Board. It is uncertain whether boards who currently utilize the Board's investigators would continue to use the transferred investigators or if they would use the DCA's Division of Investigation (DOI). If the Board hits the financial threshold for the hours that could be paid to DOJ from the line item, the Board would have to HALT investigations until July 1 of the next fiscal year; this is a serious consumer protection issue. Lastly, the implementation date of this bill, January 1, 2014, is not reasonable, as it is only three months after the bill is signed.

Due to discussion that ensued at the last meeting by the Board Members when this proposal was discussed, and the concerns that were raised by the Members, Board staff is suggesting that the Board request amendments to delete this proposal from the bill.

This bill would also extend the timeframe in which an accusation must be filed once an interim suspension order (ISO) is issued. Currently, in order for the Board to stop a physician from practicing while the physician is under investigation, the Board must request an Interim Suspension Order (ISO), which must be granted by an Administrative Law Judge (ALJ). In existing law there is a 15-day time restraint in law to file an accusation after being granted an ISO, and a 30-day time restraint between the accusation being filed and a hearing being set, which means an investigation must be nearly complete in order to petition for an ISO. This bill would extend the timeframe to file an accusation from 15 days to 30 days, which would help to further the Board's mission of consumer protection.

This bill would address many of the new issues raised in the Board's 2012 Sunset Review Report and the 2013 Supplemental Report and includes language to make the legislative changes suggested by the Board to accommodate the continuing evolution of medical training and testing, to improve the efficiencies of the Board's Licensing and

Enforcement Programs, and most importantly, to enhance consumer protection. There are some issues that the Committee background paper did not address or that recommended the Board's changes be made, but that the changes are not included in this bill, i.e., removing the 10-year posting requirement in existing law. More importantly, this bill no longer extends the Board's sunset date, which must be extended in order for the Board to continue. Board staff is suggesting that the Board continue to take a support if amended position on this bill and request amendments to extend the sunset date and delete the proposal to transfer Board investigators to DOJ.

FISCAL: If the investigators are transferred to DOJ, it will result in an increase of $1.294 million per year (for salaries only), due to the fact that the investigators at DOJ are classified as Special Agents and have a higher salary.

SUPPORT: Center for Public Interest Law
Medical Board of California (if amended)

OPPOSITION: American Board of Cosmetic Surgery
California Academy of Cosmetic Surgery
California Medical Association (unless amended)
Department of Finance

POSITION: Recommendation: Support if Amended – include sunset extension language and delete language that would require Board investigators to be transferred to DOJ.

MBC Tenure and Retention Data

	Average Months Employed with MBC	Average Years Employed with MBC
MBC Investigators as of 6/30/2003	90	7
MBC Investigators as of 6/30/2008	106	9
MBC Investigators as of 6/30/2013	71	6

	Average Months Employed with MBC	Average Years Employed with MBC
MBC Supervisor I as of 6/30/2003	78	6
MBC Supervisor I as of 6/30/2008	125	10
MBC Supervisor I as of 6/30/2013	101	8

MBC Investigator Retention Data 07/01/03 through 06/30/13

	Separated	Retired/ Resigned	Agency Transfer	Rejected
Last 5 years	53	29	21	3
Last 5 - 7.5 years	25	15	20	0
Last 7.5 - 10 years	22	20	2	0

Fiscal Impact of Pay Differentials for MBC Investigators On an Annual Basis

1. Geographic Pay Differential

$200/month for investigators in LA, Alameda, Orange, San Francisco, and Santa Clara Counties

$200 x 39 Investigators x 12 months = $93,600.00/year

2. Range Master Pay Differential

$309.70 (5% of max base pay of $6,194)

$309.70 x 12 Investigators x 1 month = $3,716.40

3. Field Training Officer Pay Differential

$309.70 (5% of max base pay of $6,194)

$309.70 x 11 Investigators x 4 months = $13,626.80

TOTAL ANNUAL FISCAL IMPACT = $110,943.20

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

Chief/Deputy Chief - $30,000

TOTAL ANNUAL FISCAL IMPACT = $1,294,344

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 proposal does not include the Operation Safe Medicine Unit and its staff (4 Investigators and 1 Supervising Investigator I)

AMENDED IN SENATE APRIL 24, 2013

AMENDED IN SENATE APRIL 16, 2013

SENATE BILL No. 304

Introduced by Senator Price
(Principal coauthor: Assembly Member Gordon)

February 15, 2013

An act to amend Sections 651, 2021, 2177, 2220.08, 2225.5, 2334, 2514, and 2569 of, and to add Sections 2291.5 and 2403 to, the Business and Professions Code, and to amend Sections ~~11529, 12529.6,~~ *11529* and 12529.7 of, and to amend and repeal Sections 12529 and 12529.5 of, the Government Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 304, as amended, Price. Healing arts: boards.

Existing law makes it unlawful for a healing arts practitioner to disseminate, or cause to be disseminated, any form of public communication containing a false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of, or likely to induce, the rendering of professional services or furnishing of products in connection with the professional practice or business for which he or she is licensed. Existing law provides for the licensure of physicians and surgeons by the Medical Board of California. Existing law prohibits a physician and surgeon's advertisements from including a statement that he or she is certified or eligible for certification by a private or public board or parent association, including a multidisciplinary board or association, as defined, unless that board or association meets at least one of several standards, including being a board or association with equivalent requirements approved by that physician and surgeon's licensing board. A violation of these requirements is a crime.

result in the issuance of notification from the board to cease the practice of medicine immediately until the ordered examinations have been completed and would provide that continued failure to comply would be grounds for suspension or revocation of his or her certificate.

Existing law prohibits a party from bringing expert testimony in a matter brought by the board unless certain information is exchanged in written form with counsel for the other party, as specified, within 30 calendar days prior to the commencement of the hearing. Existing law provides that the information exchanged include a brief narrative statement of the testimony the expert is expected to bring.

This bill would instead require that information to be exchanged within 90 days from the filing of a notice of defense and would instead require the information to include a complete expert witness report.

Existing law establishes that corporations and other artificial legal entities have no professional rights, privileges, or powers.

This bill would provide that those provisions do not apply to physicians and surgeons enrolled in approved residency postgraduate training programs or fellowship programs.

Existing law, the Licensed Midwifery Practice Act of 1993, licenses and regulates licensed midwives by the Medical Board of California. Existing law specifies that a midwife student meeting certain conditions is not precluded from engaging in the practice of midwifery as part of his or her course of study, if certain conditions are met, including, that the student is under the supervision of a licensed midwife.

This bill would require that to engage in those practices, the student is to be enrolled and participating in a midwifery education program or enrolled in a program of supervised clinical training, as provided. The bill would add that the student is permitted to engage in those practices if he or she is under the supervision of a licensed nurse-midwife.

Existing law provides for the regulation of registered dispensing opticians by the Medical Board of California and requires that the powers and duties of the board in that regard be subject to review by the Joint Sunset Review Committee as if those provisions were scheduled to be repealed on January 1, 2014.

This bill would instead make the powers and duties of the board subject to review by the appropriate policy committees of the Legislature as if those provisions were scheduled to be repealed on January 1, 2018.

Existing law authorizes the administrative law judge of the Medical Quality Hearing Panel to issue an interim order related to licenses, as provided. Existing law requires that in all of those cases in which an

that individuals performing investigations would retain their status as peace officers.

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

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

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

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

1 SECTION 1. Section 651 of the Business and Professions Code
2 is amended to read:
3 651. (a) It is unlawful for any person licensed under this
4 division or under any initiative act referred to in this division to
5 disseminate or cause to be disseminated any form of public
6 communication containing a false, fraudulent, misleading, or
7 deceptive statement, claim, or image for the purpose of or likely
8 to induce, directly or indirectly, the rendering of professional
9 services or furnishing of products in connection with the
10 professional practice or business for which he or she is licensed.
11 A "public communication" as used in this section includes, but is
12 not limited to, communication by means of mail, television, radio,
13 motion picture, newspaper, book, list or directory of healing arts
14 practitioners, Internet, or other electronic communication.
15 (b) A false, fraudulent, misleading, or deceptive statement,
16 claim, or image includes a statement or claim that does any of the
17 following:
18 (1) Contains a misrepresentation of fact.
19 (2) Is likely to mislead or deceive because of a failure to disclose
20 material facts.
21 (3) (A) Is intended or is likely to create false or unjustified
22 expectations of favorable results, including the use of any
23 photograph or other image that does not accurately depict the
24 results of the procedure being advertised or that has been altered
25 in any manner from the image of the actual subject depicted in the
26 photograph or image.
27 (B) Use of any photograph or other image of a model without
28 clearly stating in a prominent location in easily readable type the

nature. In connection with price advertising, the price for each product or service shall be clearly identifiable. The price advertised for products shall include charges for any related professional services, including dispensing and fitting services, unless the advertisement specifically and clearly indicates otherwise.

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

(e) Any person so licensed may not use any professional card, professional announcement card, office sign, letterhead, telephone directory listing, medical list, medical directory listing, or a similar professional notice or device if it includes a statement or claim that is false, fraudulent, misleading, or deceptive within the meaning of subdivision (b).

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

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

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

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

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

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

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

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

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

(D) A doctor of podiatric medicine licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California may include a statement that he or she is certified or eligible or qualified for certification by a private or public board or parent association, including, but not limited to, a multidisciplinary board or association, if that board or association meets one of the following requirements: (i) is approved by the Council on Podiatric Medical Education, (ii) is a board or association with equivalent requirements approved by the California Board of Podiatric Medicine, or (iii) is a board or association with the Council on Podiatric Medical Education approved postgraduate training programs that provide training in podiatric medicine and podiatric surgery. A doctor of podiatric medicine licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" unless the full name of the certifying board is also used and given comparable prominence with the term "board certified" in the statement. A doctor of podiatric medicine licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by an organization other than a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" in reference to that certification.

For purposes of this subparagraph, a "multidisciplinary board or association" means an educational certifying body that has a psychometrically valid testing process, as determined by the California Board of Podiatric Medicine, for certifying doctors of podiatric medicine that is based on the applicant's education, training, and experience. For purposes of the term "board certified," as used in this subparagraph, the terms "board" and "association" mean an organization that is a Council on Podiatric Medical Education approved board, an organization with equivalent requirements approved by the California Board of Podiatric Medicine, or an organization with a Council on Podiatric Medical Education approved postgraduate training program that provides training in podiatric medicine and podiatric surgery.

The California Board of Podiatric Medicine shall adopt regulations to establish and collect a reasonable fee from each board or association applying for recognition pursuant to this

service has been issued, no advertisement for that service shall be disseminated. However, if a definition of a service has not been issued by a board or committee within 120 days of receipt of a request from a licensee, all those holding the license may advertise the service. Those boards and committees shall adopt or modify regulations defining what services may be advertised, the manner in which defined services may be advertised, and restricting advertising that would promote the inappropriate or excessive use of health services or commodities. A board or committee shall not, by regulation, unreasonably prevent truthful, nondeceptive price or otherwise lawful forms of advertising of services or commodities, by either outright prohibition or imposition of onerous disclosure requirements. However, any member of a board or committee acting in good faith in the adoption or enforcement of any regulation shall be deemed to be acting as an agent of the state.

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

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

SEC. 2. Section 2021 of the Business and Professions Code is amended to read:

2021. (a) If the board publishes a directory pursuant to Section 112, it may require persons licensed pursuant to this chapter to

is the subject of a pending accusation or investigation or who is on probation, any complaint determined to involve quality of care, before referral to a field office for further investigation, shall meet the following criteria:

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

(2) It shall include the review of the following, which shall be requested by the board:

(A) Relevant patient records.

(B) The statement or explanation of the care and treatment provided by the physician and surgeon.

(C) Any additional expert testimony or literature provided by the physician and surgeon.

(D) Any additional facts or information requested by the medical expert reviewers that may assist them in determining whether the care rendered constitutes a departure from the standard of care.

(b) If the board does not receive the information requested pursuant to paragraph (2) of subdivision (a) within 10 working days of requesting that information, the complaint may be reviewed by the medical experts and referred to a field office for investigation without the information.

(c) Nothing in this section shall impede the board's ability to seek and obtain an interim suspension order or other emergency relief.

SEC. 5. Section 2225.5 of the Business and Professions Code is amended to read:

2225.5. (a) (1) A licensee who fails or refuses to comply with a request for the certified medical records of a patient, that is accompanied by that patient's written authorization for release of records to the board, within 15 days of receiving the request and authorization, shall pay to the board a civil penalty of one thousand dollars ($1,000) per day for each day that the documents have not been produced after the 15th day, up to ten thousand dollars ($10,000), unless the licensee is unable to provide the documents within this time period for good cause.

(2) A health care facility shall comply with a request for the certified medical records of a patient that is accompanied by that patient's written authorization for release of records to the board

by the board shall be tolled during the period the licensee is out of compliance with the court order and during any related appeals.

(3) A health care facility that fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of patient records to the board, that is accompanied by a notice citing this section and describing the penalties for failure to comply with this section, shall pay to the board a civil penalty of up to one thousand dollars ($1,000) per day for each day that the documents have not been produced, up to ten thousand dollars ($10,000), after the date by which the court order requires the documents to be produced, unless it is determined that the order is unlawful or invalid. Any statute of limitations applicable to the filing of an accusation by the board against a licensee shall be tolled during the period the health care facility is out of compliance with the court order and during any related appeals.

(4) Any health care facility that fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the board is guilty of a misdemeanor punishable by a fine payable to the board not to exceed five thousand dollars ($5,000). Any statute of limitations applicable to the filing of an accusation by the board against a licensee shall be tolled during the period the health care facility is out of compliance with the court order and during any related appeals.

(c) Multiple acts by a licensee in violation of subdivision (b) shall be punishable by a fine not to exceed five thousand dollars ($5,000) or by imprisonment in a county jail not exceeding six months, or by both that fine and imprisonment. Multiple acts by a health care facility in violation of subdivision (b) shall be punishable by a fine not to exceed five thousand dollars ($5,000) and shall be reported to the State Department of Public Health and shall be considered as grounds for disciplinary action with respect to licensure, including suspension or revocation of the license or certificate.

(d) A failure or refusal of a licensee to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the board constitutes unprofessional conduct and is grounds for suspension or revocation of his or her license.

(e) Imposition of the civil penalties authorized by this section shall be in accordance with the Administrative Procedure Act

SEC. 8. Section 2403 is added to the Business and Professions Code, to read:

2403. The provisions of Section 2400 do not apply to physicians and surgeons enrolled in approved residency postgraduate training programs or fellowship programs.

SEC. 9. Section 2514 of the Business and Professions Code is amended to read:

2514. (a) Nothing in this chapter shall be construed to prevent a bona fide student from engaging in the practice of midwifery in this state, as part of his or her course of study, if both of the following conditions are met:

(1) The student is under the supervision of a licensed midwife or certified nurse-midwife, who holds a clear and unrestricted license in this state, who is present on the premises at all times client services are provided, and who is practicing pursuant to Section 2507 or 2746.5, or a physician and surgeon.

(2) The client is informed of the student's status.

(b) For the purposes of this section, a "bona fide student" means an individual who is enrolled and participating in a midwifery education program or who is enrolled in a program of supervised clinical training as part of the instruction of a three year postsecondary midwifery education program approved by the board.

SEC. 10. Section 2569 of the Business and Professions Code is amended to read:

2569. Notwithstanding any other law, the powers and duties of the board, as set forth in this chapter, shall be subject to review by the appropriate policy committees of the Legislature. The review shall be performed as if this chapter were scheduled to be repealed as of January 1, 2018.

SEC. 11. Section 11529 of the Government Code is amended to read:

11529. (a) The administrative law judge of the Medical Quality Hearing Panel established pursuant to Section 11371 may issue an interim order suspending a license, or imposing drug testing, continuing education, supervision of procedures, or other license restrictions. Interim orders may be issued only if the affidavits in support of the petition show that the licensee has engaged in, or is about to engage in, acts or omissions constituting a violation of the Medical Practice Act or the appropriate practice act governing

(1) There is a reasonable probability that the petitioner will prevail in the underlying action.

(2) The likelihood of injury to the public in not issuing the order outweighs the likelihood of injury to the licensee in issuing the order.

(f) In all cases where an interim order is issued, and an accusation is not filed and served pursuant to Sections 11503 and 11505 within 30 days of the date in which the parties to the hearing on the interim order have submitted the matter, the order shall be dissolved.

Upon service of the accusation the licensee shall have, in addition to the rights granted by this section, all of the rights and privileges available as specified in this chapter. If the licensee requests a hearing on the accusation, the board shall provide the licensee with a hearing within 30 days of the request, unless the licensee stipulates to a later hearing, and a decision within 15 days of the date the decision is received from the administrative law judge, or the board shall nullify the interim order previously issued, unless good cause can be shown by the Division of Medical Quality for a delay.

(g) Where an interim order is issued, a written decision shall be prepared within 15 days of the hearing, by the administrative law judge, including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached.

(h) Notwithstanding the fact that interim orders issued pursuant to this section are not issued after a hearing as otherwise required by this chapter, interim orders so issued shall be subject to judicial review pursuant to Section 1094.5 of the Code of Civil Procedure. The relief which may be ordered shall be limited to a stay of the interim order. Interim orders issued pursuant to this section are final interim orders and, if not dissolved pursuant to subdivision (c) or (f), may only be challenged administratively at the hearing on the accusation.

(i) The interim order provided for by this section shall be:

(1) In addition to, and not a limitation on, the authority to seek injunctive relief provided for in the Business and Professions Code.

(2) A limitation on the emergency decision procedure provided in Article 13 (commencing with Section 11460.10) of Chapter 4.5.

~~(d)~~

(e) Funding for the Health Quality Enforcement Section shall be budgeted in consultation with the Attorney General from the special funds financing the operations of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Psychology, and the committees under the jurisdiction of the Medical Board of California, with the intent that the expenses be proportionally shared as to services rendered.

SEC. 13. Section 12529 of the Government Code, as amended by Section 113 of Chapter 332 of the Statutes of 2012, is repealed.

SEC. 14. Section 12529.5 of the Government Code, as amended by Section 114 of Chapter 332 of the Statutes of 2012, is amended to read:

12529.5. (a) All complaints or relevant information concerning licensees that are within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, or the Board of Psychology shall be made available to the Health Quality Enforcement Section.

(b) The Senior Assistant Attorney General of the Health Quality Enforcement Section shall assign attorneys to work on location at the intake unit of the boards described in subdivision (d) of Section 12529 to assist in evaluating and screening complaints and to assist in developing uniform standards and procedures for processing complaints.

(c) The Senior Assistant Attorney General or his or her deputy attorneys general shall assist the boards or committees in designing and providing initial and in-service training programs for staff of the boards or committees, including, but not limited to, information collection and investigation.

(d) The determination to bring a disciplinary proceeding against a licensee of the boards shall be made by the executive officer of the boards or committees as appropriate in consultation with the senior assistant.

SEC. 15. Section 12529.5 of the Government Code, as amended by Section 115 of Chapter 332 of the Statutes of 2012, is repealed.

~~SEC. 16. Section 12529.6 of the Government Code is amended to read:~~

~~12529.6. (a) The Legislature finds and declares that the Medical Board of California, by ensuring the quality and safety of medical care, performs one of the most critical functions of state~~

~~(3) Establish and implement a plan to assist in team building between its enforcement staff and the staff of the Health Quality Enforcement Section in order to ensure a common and consistent knowledge base.~~

~~SEC. 17.~~

SEC. 16. Section 12529.7 of the Government Code is amended to read:

12529.7. By March 1, 2015, the Medical Board of California, in consultation with the Department of Justice and the Department of Consumer Affairs, shall report and make recommendations to the Governor and the Legislature on the vertical enforcement and prosecution model created under Section 12529.6.

~~SEC. 18.~~

SEC. 17. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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SBIS

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 305
Author: Price
Bill Date: June 19, 2013, Amended
Subject: Healing Arts: Boards
Sponsor: Author
Position: Support provisions related to records of arrests and convictions for applicants and licensees

STATUS OF BILL:

This bill is in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

Among other provisions, this bill would allow all boards under the Department of Consumer Affairs (DCA) that require licensees to submit fingerprints, including the Medical Board of California (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.

ANALYSIS:

Currently, the Board does receive records of arrests and convictions. However, records regarding probation and records from other state and local agencies would be beneficial for the Board to receive and use in applicant and licensee investigations. This bill would clarify that a local or state agency may provide the records and that a board may receive the records.

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; the Board has taken a support position on this particular provision in the bill. Recent amendments do not impact the Board's support position or the reasons for taking that position.

FISCAL: None

SUPPORT: California Naturopathic Doctors Association; California Optometric Association; California State Board of Optometry; Medical Board of California; National Board of Examiners in Optometry; Naturopathic Medicine Committee; Osteopathic Physicians and Surgeons of California; Physical Therapy Board of California; and SEIU California

OPPOSITION: None on file

AMENDED IN ASSEMBLY JUNE 19, 2013

AMENDED IN ASSEMBLY JUNE 14, 2013

AMENDED IN SENATE APRIL 25, 2013

AMENDED IN SENATE APRIL 15, 2013

SENATE BILL No. 305

Introduced by Senator Price
(Principal coauthor: Assembly Member Gordon)

February 15, 2013

An act to amend Sections 1000, 2450, 2450.3, 2530.2, 2531, 2531.75, 2533, 2570.19, 2602, 2607.5, 3010.5, 3014.6, 3685, 3686, 3710, 3716, ~~3765, 4938, and 4939~~ *and 3765* of, and to add Section 144.5 to, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 305, as amended, Price. Healing arts: boards.

~~Existing~~

(1) Existing law requires specified regulatory boards within the Department of Consumer Affairs to require an applicant for licensure to furnish to the board a full set of fingerprints in order to conduct a criminal history record check.

This bill would additionally authorize those boards to request and receive from a local or state agency certified records of all arrests and convictions, certified records regarding probation, and any and all other related documentation needed to complete an applicant or licensee investigation and would authorize a local or state agency to provide those records to the board upon request.

~~The~~

by the California Board of Occupational Therapy. Existing law repeals those provisions on January 1, 2014, and subjects the board to review by the Joint Committee on Boards, Commissions, and Consumer Protection.

This bill would extend the operation of these provisions until January 1, 2018, and provide that the repeal of these provisions subjects the board to review by the appropriate policy committees of the Legislature.

~~Existing~~

(6) Existing law, the Physical Therapy Practice Act, provides for the licensure and regulation of physical therapists by the Physical Therapy Board of California. The act authorizes the board to appoint an executive officer. Existing law repeals these provisions on January 1, 2014.

This bill would extend the operation of these provisions until January 1, 2018.

~~Existing~~

(7) Existing law, the Naturopathic Doctors Act, until January 1, 2014, provides for the licensure and regulation of naturopathic doctors by the Naturopathic Medicine Committee within the Osteopathic Medical Board of California. Existing law also specifies that the repeal of the committee subjects it to review by the appropriate policy committees of the Legislature.

This bill would extend the operation of these provisions until January 1, 2018, and make conforming changes.

~~Existing~~

(8) Existing law, the Optometry Practice Act, provides for the licensure and regulation of optometrists by the State Board of Optometry. The Respiratory Care Act provides for the licensure and regulation of respiratory care practitioners by the Respiratory Care Board of California. Each of those acts authorizes the board to employ an executive officer. Existing law repeals these provisions on January 1, 2014, and subjects the boards to review by the Joint Committee on Boards, Commissions, and Consumer Protection.

This bill would extend the operation of these provisions until January 1, 2018, and provide that the repeal of these provisions subjects the boards to review by the appropriate policy committees of the Legislature.

~~The~~

(9) The Respiratory Care Act also prohibits a person from engaging in the practice of respiratory care unless he or she is a licensed respiratory care practitioner. However, the act does not prohibit specified

1000. (a) The law governing practitioners of chiropractic is found in an initiative act entitled "An act prescribing the terms upon which licenses may be issued to practitioners of chiropractic, creating the State Board of Chiropractic Examiners and declaring its powers and duties, prescribing penalties for violation hereof, and repealing all acts and parts of acts inconsistent herewith," adopted by the electors November 7, 1922.

(b) The State Board of Chiropractic Examiners is within the Department of Consumer Affairs.

(c) Notwithstanding any other law, the powers and duties of the State Board of Chiropractic Examiners, as set forth in this article and under the act creating the board, shall be subject to review by the appropriate policy committees of the Legislature. The review shall be performed as if this chapter were scheduled to be repealed as of January 1, 2018.

SEC. 3. Section 2450 of the Business and Professions Code is amended to read:

2450. There is a Board of Osteopathic Examiners of the State of California, established by the Osteopathic Act, which shall be known as the Osteopathic Medical Board of California which enforces this chapter relating to persons holding or applying for physician's and surgeon's certificates issued by the Osteopathic Medical Board of California under the Osteopathic Act.

Persons who elect to practice using the term of suffix "M.D.," as provided in Section 2275, shall not be subject to this article, and the Medical Board of California shall enforce the provisions of this chapter relating to persons who made the election.

Notwithstanding any other law, the powers and duties of the Osteopathic Medical Board of California, as set forth in this article and under the Osteopathic Act, shall be subject to review by the appropriate policy committees of the Legislature. The review shall be performed as if this chapter were scheduled to be repealed as of January 1, 2018.

SEC. 4. Section 2450.3 of the Business and Professions Code is amended to read:

2450.3. There is within the jurisdiction of the Osteopathic Medical Board of California a Naturopathic Medicine Committee authorized under the Naturopathic Doctors Act (Chapter 8.2 (commencing with Section 3610)). This section shall become inoperative on January 1, 2018, and, as of that date is repealed,

(2) Nothing in this subdivision shall be construed as a diagnosis. Any observation of an abnormality shall be referred to a physician and surgeon.

(f) A licensed speech-language pathologist shall not perform a flexible fiberoptic nasendoscopic procedure unless he or she has received written verification from an otolaryngologist certified by the American Board of Otolaryngology that the speech-language pathologist has performed a minimum of 25 flexible fiberoptic nasendoscopic procedures and is competent to perform these procedures. The speech-language pathologist shall have this written verification on file and readily available for inspection upon request by the board. A speech-language pathologist shall pass a flexible fiberoptic nasendoscopic instrument only under the direct authorization of an otolaryngologist certified by the American Board of Otolaryngology and the supervision of a physician and surgeon.

(g) A licensed speech-language pathologist shall only perform flexible endoscopic procedures described in subdivision (e) in a setting that requires the facility to have protocols for emergency medical backup procedures, including a physician and surgeon or other appropriate medical professionals being readily available.

(h) "Speech-language pathology aide" means any person meeting the minimum requirements established by the board, who works directly under the supervision of a speech-language pathologist.

(i) (1) "Speech-language pathology assistant" means a person who meets the academic and supervised training requirements set forth by the board and who is approved by the board to assist in the provision of speech-language pathology under the direction and supervision of a speech-language pathologist who shall be responsible for the extent, kind, and quality of the services provided by the speech-language pathology assistant.

(2) The supervising speech-language pathologist employed or contracted for by a public school may hold a valid and current license issued by the board, a valid, current, and professional clear clinical or rehabilitative services credential in language, speech, and hearing issued by the Commission on Teacher Credentialing, or other credential authorizing service in language, speech, and hearing issued by the Commission on Teacher Credentialing that is not issued on the basis of an emergency permit or waiver of

by this section, shall only be performed by a licensed audiologist. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but shall include all of the following:

(1) Collaboration on the development of written standardized protocols. The protocols shall include a requirement that the supervised audiologist immediately refer to an appropriate physician any trauma, including skin tears, bleeding, or other pathology of the ear discovered in the process of cerumen removal as defined in this subdivision.

(2) Approval by the supervising physician of the written standardized protocol.

(3) The supervising physician shall be within the general vicinity, as provided by the physician-audiologist protocol, of the supervised audiologist and available by telephone contact at the time of cerumen removal.

(4) A licensed physician and surgeon may not simultaneously supervise more than two audiologists for purposes of cerumen removal.

SEC. 6. Section 2531 of the Business and Professions Code is amended to read:

2531. (a) There is in the Department of Consumer Affairs the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board in which the enforcement and administration of this chapter are vested. The Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board shall consist of nine members, three of whom shall be public members.

(b) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date. Notwithstanding any other law, the repeal of this section renders the board subject to review by the appropriate policy committees of the Legislature.

SEC. 7. Section 2531.75 of the Business and Professions Code is amended to read:

2531.75. (a) The board may appoint a person exempt from civil service who shall be designated as an executive officer and who shall exercise the powers and perform the duties delegated by the board and vested in him or her by this chapter.

(i) The use, or causing the use, of any advertising or promotional literature in a manner that has the capacity or tendency to mislead or deceive purchasers or prospective purchasers.

(j) Any cause that would be grounds for denial of an application for a license.

(k) Violation of Section 1689.6 or 1793.02 of the Civil Code.

(*l*) Violation of a term or condition of a probationary order of a license issued by the board pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 9. Section 2570.19 of the Business and Professions Code is amended to read:

2570.19. (a) There is hereby created a California Board of Occupational Therapy, hereafter referred to as the board. The board shall enforce and administer this chapter.

(b) The members of the board shall consist of the following:

(1) Three occupational therapists who shall have practiced occupational therapy for five years.

(2) One occupational therapy assistant who shall have assisted in the practice of occupational therapy for five years.

(3) Three public members who shall not be licentiates of the board, of any other board under this division, or of any board referred to in Section 1000 or 3600.

(c) The Governor shall appoint the three occupational therapists and one occupational therapy assistant to be members of the board. The Governor, the Senate Committee on Rules, and the Speaker of the Assembly shall each appoint a public member. Not more than one member of the board shall be appointed from the full-time faculty of any university, college, or other educational institution.

(d) All members shall be residents of California at the time of their appointment. The occupational therapist and occupational therapy assistant members shall have been engaged in rendering occupational therapy services to the public, teaching, or research in occupational therapy for at least five years preceding their appointments.

(e) The public members may not be or have ever been occupational therapists or occupational therapy assistants or in training to become occupational therapists or occupational therapy assistants. The public members may not be related to, or have a household member who is, an occupational therapist or an

2602. The Physical Therapy Board of California, hereafter referred to as the board, shall enforce and administer this chapter.

This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.

Notwithstanding any other provision of law, the repeal of this section renders the board subject to review by the appropriate policy committees of the Legislature.

SEC. 11. Section 2607.5 of the Business and Professions Code is amended to read:

2607.5. (a) The board may appoint a person exempt from civil service who shall be designated as an executive officer and who shall exercise the powers and perform the duties delegated by the board and vested in him or her by this chapter.

(b) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.

SEC. 12. Section 3010.5 of the Business and Professions Code is amended to read:

3010.5. (a) There is in the Department of Consumer Affairs a State Board of Optometry in which the enforcement of this chapter is vested. The board consists of 11 members, five of whom shall be public members.

Six members of the board shall constitute a quorum.

(b) The board shall, with respect to conducting investigations, inquiries, and disciplinary actions and proceedings, have the authority previously vested in the board as created pursuant to Section 3010. The board may enforce any disciplinary actions undertaken by that board.

(c) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date. Notwithstanding any other law, the repeal of this section renders the board subject to review by the appropriate policy committees of the Legislature.

SEC. 13. Section 3014.6 of the Business and Professions Code is amended to read:

3014.6. (a) The board may appoint a person exempt from civil service who shall be designated as an executive officer and who

(a) The performance of respiratory care that is an integral part of the program of study by students enrolled in approved respiratory therapy training programs.

(b) Self-care by the patient or the gratuitous care by a friend or member of the family who does not represent or hold himself or herself out to be a respiratory care practitioner licensed under the provisions of this chapter.

(c) The respiratory care practitioner from performing advances in the art and techniques of respiratory care learned through formal or specialized training.

(d) The performance of respiratory care in an emergency situation by paramedical personnel who have been formally trained in these modalities and are duly licensed under the provisions of an act pertaining to their speciality.

(e) Respiratory care services in case of an emergency. "Emergency," as used in this subdivision, includes an epidemic or public disaster.

(f) Persons from engaging in cardiopulmonary research.

(g) Formally trained licensees and staff of child day care facilities from administering to a child inhaled medication as defined in Section 1596.798 of the Health and Safety Code.

(h) The performance by a person employed by a home medical device retail facility or by a home health agency licensed by the State Department of Public Health of specific, limited, and basic respiratory care or respiratory care related services that have been authorized by the board.

(i) The performance of pulmonary function testing by persons who are currently employed by Los Angeles County hospitals and have performed pulmonary function testing for at least 15 years.

~~SEC. 19. Section 4938 of the Business and Professions Code is amended to read:~~

~~4938. The board shall issue a license to practice acupuncture to any person who makes an application and meets the following requirements:~~

~~(a) Is at least 18 years of age.~~

~~(b) Furnishes satisfactory evidence of completion of one of the following:~~

~~(1) An educational and training program approved by the board pursuant to Section 4939.~~

~~those schools and colleges and tutorial programs, completion of which will satisfy the requirements of Section 4938.~~

~~(b) Standards for the approval of training programs shall include a minimum of 3,000 hours of study in curriculum pertaining to the practice of an acupuncturist. This subdivision shall apply to all students entering programs on or after January 1, 2005.~~

~~(c) Beginning January 1, 2017, all training programs approved by the board shall be accredited by the Accrediting Commission for Acupuncture and Oriental Medicine.~~

~~(d) Within three years of initial approval by the board, each program so approved by the board shall receive full institutional approval under Article 6 (commencing with Section 94885) of Chapter 8 of Part 59 of Division 10 of Title 3 of the Education Code in the field of traditional Asian medicine, or in the case of institutions located outside of this state, approval by the appropriate governmental educational authority using standards equivalent to those of Article 6 (commencing with Section 94885) of Chapter 8 of Part 59 of Division 10 of Title 3 of the Education Code, or the board's approval of the program shall automatically lapse.~~

~~SEC. 21.~~

SEC. 19. The Legislature finds and declares that a special law, as set forth in Section 18 of this act, is necessary and that a general law cannot be made applicable within the meaning of Section 16 of Article IV of the California Constitution because of the unique circumstances relating to persons who are currently employed by Los Angeles County hospitals and have performed pulmonary function testing for at least 15 years.

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SB 352

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 352
Author: Pavley
Bill Date: June 19, 2013, Amended
Subject: Medical Assistants: Supervision
Sponsor: California Academy of Physician Assistants (CAPA)
Position: Support

STATUS OF BILL:

This bill is on the Assembly Third Reading File.

DESCRIPTION OF CURRENT LEGISLATION:

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

This bill was amended to specify that if a PA, NP, or CNM authorizes a MA to perform any clinical laboratory test or examination that the MA is not authorized to perform, it would constitute unprofessional conduct.

ANALYSIS:

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

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

According to the sponsors, physicians have been delegating the task of supervising MAs when the physician is not in the office for over a decade in community clinics and the Physician Assistant Board and the Department of Consumer Affairs have not reported any patient safety issues or disciplinary action related to PA supervision of MAs. The sponsors

believe that this bill will eliminate legal restrictions and barriers to efficient coordinated care. The sponsors believe this change is necessary if California hopes to accommodate the dramatic increase in patients expected to result from health care reform.

With the health care reform being implemented in 2014, this bill may help to accommodate the expected increase in patients, as well as help to ensure that MAs are being supervised while a physician is not physically present in the office. Given that PAs, NPs, and NMs are currently allowed to supervise MAs in some settings now, and that this authority would have to be delegated by the physician, it makes sense for this to be allowed in all settings.

The Board had a support if amended position on this bill and requested amendments to specify that if a PA, NP, or NM were to allow the MA to perform tasks that are not in the approved scope of responsibility, that the PA, NP, or NM would be held responsible and subject to discipline by their licensing board. This bill was amended to specify that if a PA, NP, or CNM authorizes a MA to perform any clinical laboratory test or examination that the MA is not authorized to perform, it would constitute unprofessional conduct. This amendment addresses the Board's concern, as such, the Board now has a support position on this bill.

FISCAL: None

SUPPORT: CAPA (sponsor); Bay Area Council; California Academy of Family Physicians; California Association for Nurse Practitioners; California Optometric Association; Kaiser Permanente; Medical Board of California; U.S. HealthWorks Medical Group; United Nurses Associations of California/Union of Health Care Professionals; and 1 individual

OPPOSITION: California Nurses Association

AMENDED IN ASSEMBLY JUNE 19, 2013

AMENDED IN SENATE APRIL 10, 2013

SENATE BILL No. 352

Introduced by Senator Pavley
(Principal coauthor: Senator Hernandez)

February 20, 2013

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

LEGISLATIVE COUNSEL'S DIGEST

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

Existing law authorizes a medical assistant to perform specified services relating to the administration of medication and performance of skin tests and simple routine medical tasks and procedures upon specific authorization from and under the supervision of a licensed physician and surgeon or podiatrist, or in a specified clinic upon specific authorization of a physician assistant, nurse practitioner, or nurse-midwife. Existing law requires the Board of Registered Nursing to issue a certificate to practice nurse-midwifery to a qualifying applicant who is licensed pursuant to the Nursing Practice Act.

This bill would delete the requirement that the services performed by the medical assistant be in a specified clinic when under the specific authorization of a physician assistant, nurse practitioner, or certified nurse-midwife. *The bill would prohibit a nurse practitioner, certified nurse-midwife, or physician assistant from authorizing a medical assistant to perform any clinical laboratory test or examination for which the medical assistant is not authorized, as specified, a violation of which would constitute unprofessional conduct.* The bill would also

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

(1) "Medical assistant" means a person who may be unlicensed, who performs basic administrative, clerical, and technical supportive services in compliance with this section and Section 2070 for a licensed physician and surgeon or a licensed podiatrist, or group thereof, for a medical or podiatry corporation, for a physician assistant, a nurse practitioner, or a certified nurse-midwife as provided in subdivision (a), or for a health care service plan, who is at least 18 years of age, and who has had at least the minimum amount of hours of appropriate training pursuant to standards established by the board. The medical assistant shall be issued a certificate by the training institution or instructor indicating satisfactory completion of the required training. A copy of the certificate shall be retained as a record by each employer of the medical assistant.

(2) "Specific authorization" means a specific written order prepared by the supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the certified nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed on a patient, which shall be placed in the patient's medical record, or a standing order prepared by the supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the certified nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed, the duration of which shall be consistent with accepted medical practice. A notation of the standing order shall be placed on the patient's medical record.

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

(A) A licensed physician and surgeon.

(B) A licensed podiatrist.

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

(4) "Technical supportive services" means simple routine medical tasks and procedures that may be safely performed by a

SB 491

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 491
Author: Hernandez
Bill Date: May 21, 2013, Amended
Subject: Nurse Practitioners
Sponsor: Author
Position: Oppose

STATUS OF BILL:

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

DESCRIPTION OF CURRENT LEGISLATION:

This bill would make findings and declarations related to the role and importance of nurse practitioners (NPs). This bill would establish independent practice for NPs by removing provisions in existing law that require physician supervision through standardized procedures, collaboration or consultation with a physician. This bill would also expand the scope of practice for a NP and would allow a NP to order, furnish or prescribe drugs.

As amended, this bill would require a NP to only delegate tasks to a medical assistant (MA) pursuant to standardized procedures and protocols that are within the MAs scope of practice. The amendments also make other technical and clarifying changes.

ANALYSIS:

This bill is part of a package of bills intended to expand the scope of NPs, pharmacists, and optometrists. Currently, NPs operate under standardized procedures, that are overseen by a supervising physician. NPs are advanced practice registered nurses (RNs) who have pursued higher education and certification as a NP. There are approximately 17,000 NPs licensed by the Board of Registered Nursing (BRN) 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.

- Establish a physical diagnosis by client history, physical examination, and other criteria, consistent with this bill.
- Order, furnish, or prescribe drugs or devices, as specified.
- Refer patients to other health care providers, as specified.
- Delegate tasks to a MA pursuant to standardized procedures and protocols developed by the NP and MA, that are within the MAs scope of practice.
- 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 scope of practice.

As stated in the bullets above, this bill will allow NPs to refer a patient to a physician or other licensed health care provider if the referral will protect the health and welfare of the patient, and must consult with a physician or other licensed health care provider if a situation or condition of a patient is beyond the NPs education, training, or certification. This bill would allow a NP to furnish order or prescribe drugs or devices if they are consistent with the practitioners' education preparation or for which clinical competency has been established and maintained and the BRN has certified that the NP has satisfactorily completed a course in pharmacology covering the drugs or devices. A NP would not be allowed to furnish, order or prescribe a dangerous drug without an appropriate prior examination and a medical indication, unless one of the following applies:

- The NP was a designated practitioner serving in the absence of the patient's physician, podiatrist, or NP and the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but no longer than 72 hours.
- The NP transmitted the order for drugs to a RN or licensed vocational nurse (LVN) in an inpatient facility and the NP consulted with the RN or LVN who reviewed the patients records and the NP was designated as the practitioner to serve in the absence of the patient's physician, podiatrist or NP.
- The NP was a designated practitioner serving in the absence of the patient's physician, podiatrist, or NP and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount for more than one renewal.

Beginning on and after July 1, 2016, this bill would require an applicant for initial qualification or certification as a NP to hold a national certification as a NP from a national certifying body recognized by the BRN. This bill would also require a NP to maintain professional liability insurance that is appropriate for his or her practice setting.

According to the author, this bill will establish independent practice for NPs and enable them to perform all tasks and functions consistent with their education and training and would allow NPs to choose to see Medi-Cal patients. According to the author, the Institutes of Medicine and the National Council of State Boards of Nursing have recommended full practice

for NPs. The author believes 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; as such, the Board is opposed to this bill. The recent amendments do not impact the Board's oppose position, or the reasons for taking that position.

FISCAL: None

SUPPORT: AARP; Association of California Healthcare Districts; Blue Shield of California; C.W. Brower, Inc. (Modesto); California Association for Nurse Practitioners; California Association of Nurse Anesthetists; California Association of Physician Groups; California Hospital Association; California Nurse-Midwives Association; California Optometric Association; California Pharmacists Association/California Society of Health-System Pharmacists; Californians for Patient Care; Ceres Department of Public Safety; Indiana State University College of Nursing, Health and Human Services; Latino Community Roundtable; NAACP; National Asian American Coalition; National Association of Pediatric Nurse Practitioners; United Nurses Associations of California/Union of Health Care Professionals; University of California; and Western University of Health Sciences

OPPOSITION: American Academy of Pediatrics, California; American College of Emergency Physicians - California Chapter; California Academy of Eye Physicians & Surgeons; California Academy of Family Physicians; California Medical Association; California Psychiatric Association; California Right to Life Committee, Inc.; California Society of Anesthesiologists; Canvasback Missions Inc.; Lighthouse for Christ Mission Eye Center; Medical Board of California; Osteopathic Physicians & Surgeons of California; and Union of American Physicians and Dentists

AMENDED IN SENATE MAY 21, 2013

AMENDED IN SENATE MAY 1, 2013

AMENDED IN SENATE APRIL 16, 2013

AMENDED IN SENATE APRIL 1, 2013

SENATE BILL No. 491

Introduced by Senator Hernandez

February 21, 2013

An act to amend Sections 2835.5, 2835.7, 2836.1, 2836.2, and 2836.3 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 491, as amended, Hernandez. Nurse practitioners.

Existing law, the Nursing Practice Act, provides for the licensure and regulation of nurse practitioners by the Board of Registered Nursing. Existing law requires an applicant for initial qualification or certification as a nurse practitioner who has never been qualified or certified as a nurse practitioner in California or in any other state to meet specified requirements, including possessing a master's degree in nursing, a master's degree in a clinical field related to nursing, or a graduate degree in nursing, and to have satisfactorily completed a nurse practitioner program approved by the board. Existing law authorizes the implementation of standardized procedures that authorize a nurse practitioner to perform certain acts, including, among others, ordering durable medical equipment, and, in consultation with a physician and surgeon, approving, signing, modifying, or adding to a plan of treatment or plan for an individual receiving home health services or personal care services.

1 treatment or obtain diagnostic tests that are ordered by a nurse
2 practitioner.
3 SEC. 2. Section 2835.5 of the Business and Professions Code
4 is amended to read:
5 2835.5. (a) A registered nurse who is holding himself or herself
6 out as a nurse practitioner or who desires to hold himself or herself
7 out as a nurse practitioner shall, within the time prescribed by the
8 board and prior to his or her next license renewal or the issuance
9 of an initial license, submit educational, experience, and other
10 credentials and information as the board may require for it to
11 determine that the person qualifies to use the title "nurse
12 practitioner," pursuant to the standards and qualifications
13 established by the board.
14 (b) Upon finding that a person is qualified to hold himself or
15 herself out as a nurse practitioner, the board shall appropriately
16 indicate on the license issued or renewed, that the person is
17 qualified to use the title "nurse practitioner." The board shall also
18 issue to each qualified person a certificate evidencing that the
19 person is qualified to use the title "nurse practitioner."
20 (c) A person who has been found to be qualified by the board
21 to use the title "nurse practitioner" prior to January 1, 2005, shall
22 not be required to submit any further qualifications or information
23 to the board and shall be deemed to have met the requirements of
24 this section.
25 (d) On and after January 1, 2008, an applicant for initial
26 qualification or certification as a nurse practitioner under this article
27 who has not been qualified or certified as a nurse practitioner in
28 California or any other state shall meet the following requirements:
29 (1) Hold a valid and active registered nursing license issued
30 under this chapter.
31 (2) Possess a master's degree in nursing, a master's degree in
32 a clinical field related to nursing, or a graduate degree in nursing.
33 (3) Satisfactorily complete a nurse practitioner program
34 approved by the board.
35 (e) On and after July 1, 2016, an applicant for initial
36 qualification or certification as a nurse practitioner shall, in
37 addition, hold a national certification as a nurse practitioner from
38 a national certifying body recognized by the board.
39 SEC. 3. Section 2835.7 of the Business and Professions Code
40 is amended to read:

~~occurs in a patient that~~ *of a patient* is beyond the nurse practitioner's ~~knowledge and experience~~ *education, training, or certification.*

(c) A nurse practitioner shall maintain ~~medical malpractice~~ *professional liability* insurance *that is appropriate for his or her practice setting.*

SEC. 4. Section 2836.1 of the Business and Professions Code is amended to read:

2836.1. (a) Neither this chapter nor any other provision of law shall be construed to prohibit a nurse practitioner from furnishing, ordering, or prescribing drugs or devices when both of the following apply:

(1) The drugs or devices that are furnished, ordered, or prescribed are consistent with the practitioner's educational preparation or for which clinical competency has been established and maintained.

(2) (A) The board has certified in accordance with Section 2836.3 that the nurse practitioner has satisfactorily completed a course in pharmacology covering the drugs or devices to be furnished, ordered, or prescribed under this section.

(B) Nurse practitioners who are certified by the board and hold an active furnishing number and who are registered with the United States Drug Enforcement Administration, shall complete, as part of their continuing education requirements, a course including Schedule II controlled substances based on the standards developed by the board. The board shall establish the requirements for satisfactory completion of this subdivision.

(b) A nurse practitioner shall not furnish, order, or prescribe a dangerous drug, as defined in Section 4022, without an appropriate prior examination and a medical indication, unless one of the following applies:

(1) The nurse practitioner was a designated practitioner serving in the absence of the patient's physician and surgeon, podiatrist, or nurse practitioner, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

(2) The nurse practitioner transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

1 requirements of paragraph (2) of subdivision ~~(b)~~ *(a)* of Section
2 2836.1. The number shall be included on all transmittals of orders
3 for drugs or devices by the nurse practitioner. The board shall
4 make the list of numbers issued available to the *California State*
5 Board of Pharmacy. The board may charge the applicant a fee to
6 cover all necessary costs to implement this section.
7 (b) The number shall be renewable at the time of the applicant's
8 registered nurse license renewal.
9 (c) The board may revoke, suspend, or deny issuance of the
10 numbers for incompetence or gross negligence in the performance
11 of functions specified in Sections 2836.1 and 2836.2.

O

SB 492

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 492
Author: Hernandez
Bill Date: May 8, 2013, Amended
Subject: Optometrist Practice: Licensure
Sponsor: Author

STATUS OF BILL:

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

DESCRIPTION OF CURRENT LEGISLATION:

This bill originally would have deleted the definition of the practice of optometry in existing law and would have expand the scope of an optometrist by allowing an optometrist: to examine, prevent, diagnose, and treat any disease, condition, or disorder of the visual system, the human eye, and adjacent and related structures; to perform surgical and nonsurgical primary care procedures; and to prescribe drugs, including narcotics, among other allowances.

This bill was amended to repeal the language in the April 16 version of the bill and instead revised the current definition of the practice of optometry to allow optometrists to diagnose, treat and manage specific eye disorders and other common diseases such as diabetes, hypertension, and hypercholesterolemia. In addition, this bill would expand the drugs optometrists can prescribe and permits optometrists to perform surgical and non-surgical procedures.

ANALYSIS:

This bill is part of a package of bills intended to expand the scope of NPs, pharmacists, and optometrists. Currently, optometrists measure and correct vision, prescribe and fit lenses, as well as provide some basic primary care services.

This bill would revise the definition of the practice of optometry in existing law and would expand the scope of an optometrist. The bill would do the following:

- Allow an optometrist to provide habilitative optometric services.
- Allow an optometrist who is certified to use therapeutic pharmaceutical agents (TPA) to treat the lacrimal gland, lacrimal drainage system, and the sclera in patients under 12 years of age.
- Allow an optometrist to treat ocular inflammation and pain non-surgically, except when co-managed with the patient's treating physician.

- Allow an optometrist to treat eyelid disorders, including hypotrichosis and blepharitis.
- Remove the requirement in existing law for optometrists to only utilize specific TPAs and would allow optometrists to use all TPAs approved by the Food and Drug Administration (FDA) for use in treating eye conditions, including codeine with compounds and hydrocodone with compounds as listed in the California Uniform Controlled Substances Act and the U.S. Controlled Substances Act. Use of these agents would be limited to three days.
- Allow TPA certified optometrists to remove sutures, upon notification of the treating physician.
- Remove the restriction that optometrists can only administer oral fluorescein to patients suspected as having diabetic retinopathy.
- Delete the list of specific tests optometrists are allowed to order and allow optometrists to order any laboratory and diagnostic imaging tests for conditions authorized to be treated, pursuant to this bill.
- Allow an optometrist to perform a clinical laboratory test or exam classified as waived under CLIA, necessary for the diagnosis of conditions and diseases of the eye or adnexa.
- Allow an optometrist to administer immunizations for influenza, Herpes Zoster Virus, and additional immunizations that may be necessary to protect public health during a declared disaster or public health emergency.
- Allow an optometrist to test for and diagnose diabetes mellitus, hypertension, and hypercholesterolemia.
- Require, in any case that an optometrist consults with a physician, for the physician and optometrist to both maintain a written record in the patient's file of the information provided to the physician, the physician's response, and any other relevant information.
- Specify that an optometrist treating eye disease or diagnosing another disease shall be held to the same standard of care as physicians or osteopathic physicians.
- Require an optometrist, if a situation or condition occurs that is beyond the optometrists scope of practice, to consult with and refer the patient to a physician or other appropriate health care provider.

Although this bill was significantly amended, it still expands the scope of practice of an optometrist by allowing optometrists to diagnose diabetes mellitus, hypertension, and hypercholesterolemia, treat ocular inflammation and pain non-surgically and surgically, treat all eyelid disorders, treat the lacrimal gland, lacrimal drainage system, and the sclera in patients under 12 years of age, and use all TPAs approved by the FDA for use in treating eye conditions, including codeine with compounds and hydrocodone with compounds. This is a significant expansion of the scope of practice of an optometrist. Although some provisions in this bill are reasonable, this bill would allow optometrists to diagnose, treat, and manage ocular conditions and common diseases, perform surgical procedures, and be granted full drug prescribing authority, including controlled substances, which is a significant scope expansion. Optometrists do not have the appropriate education to prepare them for this significant scope expansion; as such, this could put patients at serious risk of harm and significantly impact consumer protection. The Board's primary mission is consumer protection and by significantly

expanding the scope of practice for an optometrist, patient care and consumer protection could be compromised. Board staff suggests that the Board oppose this bill unless it is amended to remove the provisions that allow an optometrist to diagnose and treat common diseases, perform surgical procedures, and be granted full drug prescribing authority, including authority to prescribe controlled substances.

FISCAL: None

SUPPORT: Bay Area Council; Blue Shield of California; California Hospital Association; California Optometric Association; California Pharmacists Association/California Society of Health-System Pharmacists; Californians for Patient Care; United Nurses Associations of California/Union of Health Care Professionals; Vision Service Plan; and Western University of Health Sciences

OPPOSITION: American College of Emergency Physicians- California Chapter; Blind Children's Center; California Academy of Eye Physicians & Surgeons; California Academy of Family Physicians; California Association for Medical Laboratory Technology; California Medical Association; California Society of Anesthesiologists; California Society of Plastic Surgeons; Canvasback Missions Inc.; Here4Them; Lighthouse for Christ Mission Eye Center; Osteopathic Physicians & Surgeons of California; and Union of American Physicians and Dentists

POSITION: Oppose Unless Amended

AMENDED IN SENATE MAY 8, 2013

AMENDED IN SENATE APRIL 24, 2013

AMENDED IN SENATE APRIL 16, 2013

AMENDED IN SENATE APRIL 1, 2013

SENATE BILL No. 492

Introduced by Senator Hernandez

February 21, 2013

An act to amend Sections 3041 and 3041.1 of the Business and Professions Code, relating to optometry.

LEGISLATIVE COUNSEL'S DIGEST

SB 492, as amended, Hernandez. Optometrist: practice: licensure.

The Optometry Practice Act creates the State Board of Optometry, which licenses optometrists and regulates their practice. Existing law defines the practice of optometry to include, among other things, the prevention and diagnosis of disorders and dysfunctions of the visual system, and the treatment and management of certain disorders and dysfunctions of the visual system, as well as the provision of rehabilitative optometric services, and doing certain things, including, but not limited to, the examination of the human eyes, the determination of the powers or range of human vision, and the prescribing of contact and spectacle lenses. Existing law authorizes an optometrist certified to use therapeutic pharmaceutical agents to diagnose and treat specified conditions, use specified pharmaceutical agents, and order specified diagnostic tests. Any violation of the act is a crime.

This bill would add the provision of habilitative optometric services to the definition of the practice of optometry. The bill would expand the practice parameters of optometrists who are certified to use

(1) The examination of the human eye or eyes, or its or their appendages, and the analysis of the human vision system, either subjectively or objectively.

(2) The determination of the powers or range of human vision and the accommodative and refractive states of the human eye or eyes, including the scope of its or their functions and general condition.

(3) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, vision training, or orthoptics.

(4) The prescribing of contact and spectacle lenses for, or the fitting or adaptation of contact and spectacle lenses to, the human eye, including lenses that may be classified as drugs or devices by any law of the United States or of this state.

(5) The use of topical pharmaceutical agents for the purpose of the examination of the human eye or eyes for any disease or pathological condition.

(b) (1) An optometrist who is certified to use therapeutic pharmaceutical agents, pursuant to Section 3041.3, may also diagnose and treat the human eye or eyes, or any of its or their appendages, for all of the following conditions:

(A) Through medical treatment, infections of the anterior segment and adnexa.

(B) Ocular allergies of the anterior segment and adnexa.

(C) Ocular inflammation, *nonsurgical in cause except when comanaged with the treating physician and surgeon.*

(D) Traumatic or recurrent conjunctival or corneal abrasions and erosions.

(E) Corneal surface disease and dry eyes.

(F) Ocular pain, *nonsurgical in cause except when comanaged with the treating physician and surgeon.*

(G) Pursuant to subdivision ~~(e)~~ *(f)*, glaucoma in patients over 18 years of age, as described in subdivision ~~(i)~~ *(j)*.

(H) Eyelid disorders, *including hypotrichosis and blepharitis.*

(2) For purposes of this section, "treat" means the use of therapeutic pharmaceutical agents, as described in subdivision (c), and the procedures described in subdivision ~~(d)~~ *(e)*.

(c) In diagnosing and treating the conditions listed in subdivision (b), an optometrist certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 may use all therapeutic

(11) Punctal occlusion by plugs, excluding laser, diathermy, cryotherapy, or other means constituting surgery as defined in this chapter.

~~(11)~~

(12) The prescription of therapeutic contact lenses, including lenses or devices that incorporate a medication or therapy the optometrist is certified to prescribe or provide.

~~(12)~~

(13) Removal of foreign bodies from the cornea, eyelid, and conjunctiva with any appropriate instrument other than a scalpel . Corneal foreign bodies shall be nonperforating, be no deeper than the midstroma, and require no surgical repair upon removal.

~~(13)~~

(14) For patients over 12 years of age, lacrimal irrigation and dilation, excluding probing of the nasal lacrimal tract. The board shall certify any optometrist who graduated from an accredited school of optometry before May 1, 2000, to perform this procedure after submitting proof of satisfactory completion of 10 procedures under the supervision of an ophthalmologist as confirmed by the ophthalmologist. Any optometrist who graduated from an accredited school of optometry on or after May 1, 2000, shall be exempt from the certification requirement contained in this paragraph.

~~(14)~~

(15) ~~Immunizations~~ *Administration of immunizations* for influenza~~ and shingles~~*, Herpes Zoster Virus,* and additional immunizations that may be necessary to protect public health during a declared disaster or public health emergency.

~~(15)~~

(16) In addition to diagnosing and treating conditions of the visual system pursuant to~~ subdivision (a)~~ *this section, testing for and,* diagnoses of diabetes mellitus, hypertension, and ~~hyperlipidemia~~ *hypercholesterolemia.*

~~(c)~~

(f) The board shall grant a certificate to an optometrist certified pursuant to Section 3041.3 for the treatment of glaucoma, as described in subdivision~~ (i)~~ *(j)*, in patients over 18 years of age after the optometrist meets the following applicable requirements:

(i) An optometrist licensed under this chapter is subject to the provisions of Section 2290.5 for purposes of practicing telehealth.

~~(i)~~

(j) For purposes of this chapter, "glaucoma" means either of the following:

(1) All primary open-angle glaucoma.

(2) Exfoliation and pigmentary glaucoma.

~~(j)~~

(k) For purposes of this chapter, "adnexa" means ocular adnexa.

~~(k)~~

(l) In an emergency, an optometrist shall stabilize, if possible, and immediately refer any patient who has an acute attack of angle closure to an ophthalmologist.

SEC. 2. Section 3041.1 of the Business and Professions Code is amended to read:

3041.1. With respect to the practices set forth in Section 3041, optometrists diagnosing or treating eye *disease* or *diagnosing* other diseases shall be held to the same standard of care to which physicians and surgeons and osteopathic physicians and surgeons are held. An optometrist shall consult with and, if necessary, refer to a physician and surgeon or other appropriate health care provider if a situation or condition occurs that is beyond the optometrist's ~~education and training~~ *scope of practice*.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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SB 463

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 493
Author: Hernandez
Bill Date: May 28, 2013 Amended
Subject: Pharmacy Practice
Sponsor: Author
Position: Support

STATUS OF BILL:

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

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow pharmacists to furnish medication, order and interpret tests, and furnish self-administered hormonal contraceptives, initiate and administer vaccines, and furnish prescription smoking cessation drugs and devices. This bill would establish an Advanced Practice Pharmacist (APP) recognition. In addition, this bill, as originally introduced, would allow an APP to perform patient assessments and if operating under a protocol, it would allow an APP to initiate, adjust, or discontinue drug therapy and participate in the evaluation and management of disease and health conditions.

This bill was amended to delete the provisions that would have allowed an APP to independently initiate, adjust or discontinue drug therapy and instead would only allow an APP to initiate, adjust or discontinue drug therapy pursuant to a specific written order or authorization made by the individual patient's treating prescriber, pursuant to existing law. This bill was amended to require the pharmacist to consult with the patient's primary care provider before furnishing a smoking cessation drug to the patient that may produce serious neuropsychiatric events, which addresses the concern raised by the Board.

ANALYSIS:

This bill is part of a package of bills intended to expand the scope of NPs, pharmacists, and optometrists. Currently, pharmacists provide patient care that optimized medication therapy.

This bill expands the scope of a pharmacist by allowing a pharmacist to do the following:

- Provide training and education to patients about drug therapy, disease management, and disease prevention.

- Participate in multidisciplinary review of patient progress, including access to medical records.
- Furnish emergency contraception drug therapy and self-administered hormonal contraceptives in accordance with standardized procedures or protocols developed and approved by the Board of Pharmacy (BOP) and the Medical Board of California (Board).
- Furnish prescription smoking cessation drugs and devices - The pharmacist must maintain records of drugs and devices furnished for three years, notify the patient's primary care provider, be certified in smoking cessation therapy, and complete one hour of continuing education focused on smoking cessation therapy biennially. **This bill was amended to require the pharmacist to consult with the patient's primary care provider before furnishing a smoking cessation drug to the patient that may produce serious neuropsychiatric events.**
- Furnish Prescription medications not requiring a diagnosis that are recommended by the federal Centers for Disease Control and Prevention for individuals traveling outside of the United States.
- Independently initiate and administer vaccines listed on the routine immunization schedules recommended by the federal Advisory Committee on Immunization Practices - A pharmacist must complete an immunization training program, be certified in basic life support, and comply with all state and federal recordkeeping reporting requirements, in order to initiate and administer an immunization.

This bill would require the BOP and the Board to develop standardized procedures or protocols for emergency contraception drug therapy and self-administered hormonal contraceptives. This bill would authorize both the BOP and the Board to ensure compliance with procedures or protocols, with respect to the appropriate licensees.

This bill would establish an APP, which means a pharmacist who has been recognized as an APP by BOP. An APP may perform patient assessments; order and interpret drug therapy-related tests; and refer patients to other health care providers. This bill would have allowed an APP to initiate, adjust, or discontinue drug therapy. **This provision is no longer included in the bill.** This bill would also allow an APP to participate in the evaluation and management of diseases and health conditions in collaboration with other health care providers.

This bill would require a pharmacist who seeks recognition as an APP to meet the following requirements:

- Hold an active license to practice pharmacy that is in good standing.
- Either earn certification in a relevant area of practice specified in the bill from an organization recognized by the Accreditation Council for Pharmacy education or another entity recognized by the 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 pharmacist's clinical practice.

This bill would expand the scope of a pharmacist and create a new APP recognition category. Currently, pharmacists do provide education to patients regarding drug therapy, and allowing this to be expanded would help in the implementation of the Affordable Care Act. Allowing pharmacists to furnish self-administered hormonal contraceptives in accordance with standardized procedures developed by BOP, the Board, and stakeholders and allowing pharmacists to furnish some smoking cessation drugs and devices 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 seems appropriate.

This bill was amended and no longer allows APPs to initiate, adjust, or discontinue drug therapy, except as allowed under existing law. The Board voted to support this bill if it is amended to exempt smoking cessation drugs that are known to have a risk of neuropsychiatric events, like Chantix and Zyban. This bill was amended to require the pharmacist to consult with the patient's primary care provider before furnishing a smoking cessation drug to the patient that may produce serious neuropsychiatric events, which addresses the Board's concern. This bill will help to further the Board's mission of promoting access to care and the Board now has a support position on this bill.

FISCAL: Minimal and absorbable workload to help develop standardized procedures.

SUPPORT: American Society of Health-System Pharmacists; Bay Area Council; Blue Shield of California; California Association for Nurse Practitioners; California Chronic Care Coalition; California Hospital Association; California Korean American Pharmacists Association; California Northstate University, College of Pharmacy; California Optometric Association; California Pharmacists Association; California Retailers Association; California Society of Health-System Pharmacists; California State Board of Pharmacy; Californians for Patient Care; Cedars-Sinai Medical Center; Indian Pharmacists Association of California; Kaiser Permanente; Medical Board of California; National Asian American Coalition; Pharmacy Choice and Access Now; United Nurses Association of California/Union of Health Care Professionals; and Western University of Health Sciences

OPPOSITION: American College of Emergency Physicians, California Chapter; California Academy of Eye Physicians and Surgeons; California Academy of Family Physicians; California Medical Association; California Psychiatric Association; California Right to Life Committee, Inc.; California Society of Anesthesiologists; California Society of Plastic Surgeons; Canvasback Missions, Inc.; Lighthouse for Christ Mission and Eye Center; Osteopathic Physicians and Surgeons of California; Union of American Physicians and Dentists; and Various Individuals

AMENDED IN SENATE MAY 28, 2013

AMENDED IN SENATE APRIL 24, 2013

AMENDED IN SENATE APRIL 1, 2013

SENATE BILL No. 493

Introduced by Senator Hernandez

February 21, 2013

An act to amend Sections 733, 4050, 4051, 4052, 4052.3, and 4060 of, and to add Sections 4016.5, 4052.6, 4052.8, 4052.9, 4210, and 4233 to, the Business and Professions Code, relating to pharmacy.

LEGISLATIVE COUNSEL'S DIGEST

SB 493, as amended, Hernandez. Pharmacy practice.

The Pharmacy Law provides for the licensing and regulation of pharmacists by the California State Board of Pharmacy in the Department of Consumer Affairs. The law specifies the functions pharmacists are authorized to perform, including to administer, orally or topically, drugs and biologicals pursuant to a prescriber's order, and to administer immunizations pursuant to a protocol with a prescriber. Pharmacists may also furnish emergency contraception drug therapy pursuant to standardized procedures if they have completed a training program. A violation of the Pharmacy Law is a crime.

This bill, instead, would authorize a pharmacist to administer drugs and biological products that have been ordered by a prescriber. The bill would expand other functions pharmacists are authorized to perform, including, among other things, to furnish self-administered hormonal contraceptives, prescription smoking cessation drugs, and prescription medications not requiring a diagnosis that are recommended for international travelers, as specified. Additionally, the bill would

drug or device would cause a harmful drug interaction or would otherwise adversely affect the patient's medical condition.

(2) The prescription drug or device is not in stock. If an order, other than an order described in Section 4019, or prescription cannot be dispensed because the drug or device is not in stock, the licentiate shall take one of the following actions:

(A) Immediately notify the patient and arrange for the drug or device to be delivered to the site or directly to the patient in a timely manner.

(B) Promptly transfer the prescription to another pharmacy known to stock the prescription drug or device that is near enough to the site from which the prescription or order is transferred, to ensure the patient has timely access to the drug or device.

(C) Return the prescription to the patient and refer the patient. The licentiate shall make a reasonable effort to refer the patient to a pharmacy that stocks the prescription drug or device that is near enough to the referring site to ensure that the patient has timely access to the drug or device.

(3) The licentiate refuses on ethical, moral, or religious grounds to dispense a drug or device pursuant to an order or prescription. A licentiate may decline to dispense a prescription drug or device on this basis only if the licentiate has previously notified his or her employer, in writing, of the drug or class of drugs to which he or she objects, and the licentiate's employer can, without creating undue hardship, provide a reasonable accommodation of the licentiate's objection. The licentiate's employer shall establish protocols that ensure that the patient has timely access to the prescribed drug or device despite the licentiate's refusal to dispense the prescription or order. For purposes of this section, "reasonable accommodation" and "undue hardship" shall have the same meaning as applied to those terms pursuant to subdivision (*l*) of Section 12940 of the Government Code.

(c) For the purposes of this section, "prescription drug or device" has the same meaning as the definition in Section 4022.

(d) This section applies to emergency contraception drug therapy and self-administered hormonal contraceptives described in Section 4052.3.

(e) This section imposes no duty on a licentiate to dispense a drug or device pursuant to a prescription or order without payment for the drug or device, including payment directly by the patient

information, or patient consultation, as set forth in this chapter, if all of the following conditions are met:

(1) The clinical advice, services, information, or patient consultation is provided to a health care professional or to a patient.

(2) The pharmacist has access to prescription, patient profile, or other relevant medical information for purposes of patient and clinical consultation and advice.

(3) Access to the information described in paragraph (2) is secure from unauthorized access and use.

SEC. 5. Section 4052 of the Business and Professions Code is amended to read:

4052. (a) Notwithstanding any other law, a pharmacist may:

(1) Furnish a reasonable quantity of compounded drug product to a prescriber for office use by the prescriber.

(2) Transmit a valid prescription to another pharmacist.

(3) Administer drugs and biological products that have been ordered by a prescriber.

(4) Perform procedures or functions in a licensed health care facility as authorized by Section 4052.1.

(5) Perform procedures or functions as part of the care provided by a health care facility, a licensed home health agency, a licensed clinic in which there is a physician oversight, a provider who contracts with a licensed health care service plan with regard to the care or services provided to the enrollees of that health care service plan, or a physician, as authorized by Section 4052.2.

(6) Perform procedures or functions as authorized by Section 4052.6.

(7) Manufacture, measure, fit to the patient, or sell and repair dangerous devices, or furnish instructions to the patient or the patient's representative concerning the use of those devices.

(8) Provide consultation, training, and education to patients about drug therapy, disease management, and disease prevention.

(9) Provide professional information, including clinical or pharmacological information, advice, or consultation to other health care professionals, and participate in multidisciplinary review of patient progress, including appropriate access to medical records.

(10) Furnish the following medications:

(A) Emergency contraception drug therapy and self-administered hormonal contraceptives, as authorized by Section 4052.3.

(b) (1) Notwithstanding any other law, a pharmacist may furnish emergency contraception drug therapy in accordance with either of the following:

(A) Standardized procedures or protocols developed by the pharmacist and an authorized prescriber who is acting within his or her scope of practice.

(B) Standardized procedures or protocols developed and approved by both the board and the Medical Board of California in consultation with the American Congress of Obstetricians and Gynecologists, the California Pharmacists Association, and other appropriate entities. The board and the Medical Board of California are both authorized to ensure compliance with this clause, and each board is specifically charged with the enforcement of this provision with respect to its respective licensees. This subdivision does not expand the authority of a pharmacist to prescribe any prescription medication.

(2) Prior to performing a procedure authorized under this subdivision, a pharmacist shall complete a training program on emergency contraception that consists of at least one hour of approved continuing education on emergency contraception drug therapy.

(3) A pharmacist, pharmacist's employer, or pharmacist's agent shall not directly charge a patient a separate consultation fee for emergency contraception drug therapy services initiated pursuant to this subdivision, but may charge an administrative fee not to exceed ten dollars ($10) above the retail cost of the drug. Upon an oral, telephonic, electronic, or written request from a patient or customer, a pharmacist or pharmacist's employee shall disclose the total retail price that a consumer would pay for emergency contraception drug therapy. As used in this paragraph, total retail price includes providing the consumer with specific information regarding the price of the emergency contraception drugs and the price of the administrative fee charged. This limitation is not intended to interfere with other contractually agreed-upon terms between a pharmacist, a pharmacist's employer, or a pharmacist's agent, and a health care service plan or insurer. Patients who are insured or covered and receive a pharmacy benefit that covers the cost of emergency contraception shall not be required to pay an administrative fee. These patients shall be required to pay copayments pursuant to the terms and conditions of their coverage.

the patient's primary care provider or diagnosing provider, as appropriate.

(c) This section shall not interfere with a physician's order to dispense a prescription drug as written, or other order of similar meaning.

(d) Prior to initiating or adjusting a controlled substance therapy pursuant to this section, a pharmacist shall personally register with the federal Drug Enforcement Administration.

SEC. 8. Section 4052.8 is added to the Business and Professions Code, to read:

4052.8. (a) In addition to the authority provided in paragraph (9) of subdivision (a) of Section 4052, a pharmacist may independently initiate and administer vaccines listed on the routine immunization schedules recommended by the federal Advisory Committee on Immunization Practices (ACIP), in compliance with individual ACIP vaccine recommendations, and published by the federal Centers for Disease Control and Prevention (CDC) for persons three years of age and older.

(b) In order to initiate and administer an immunization described in subdivision (a), a pharmacist shall do all of the following:

(1) Complete an immunization training program endorsed by the CDC or the Accreditation Council for Pharmacy Education that, at a minimum, includes hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines, and shall maintain that training.

(2) Be certified in basic life support.

(3) Comply with all state and federal recordkeeping and reporting requirements, including providing documentation to the patient's primary care provider and entering information in the appropriate immunization registry designated by the immunization branch of the State Department of Public Health.

(c) A pharmacist administering immunizations pursuant to this section, or paragraph (9) of subdivision (a) of Section 4052, may also initiate and administer epinephrine or diphenhydramine by injection for the treatment of a severe allergic reaction.

SEC. 9. Section 4052.9 is added to the Business and Professions Code, to read:

SEC. 11. Section 4210 is added to the Business and Professions Code, to read:

4210. (a) A person who seeks recognition as an advanced practice pharmacist shall meet all of the following requirements:

(1) Hold an active license to practice pharmacy issued pursuant to this chapter that is in good standing.

(2) Satisfy any two of the following criteria:

(A) Earn certification in a relevant area of practice, including, but not limited to, ambulatory care, critical care, nuclear pharmacy, nutrition support pharmacy, oncology pharmacy, pediatric pharmacy, pharmacotherapy, or psychiatric pharmacy, from an organization recognized by the Accreditation Council for Pharmacy Education or another entity recognized by the board.

(B) Complete a one-year postgraduate residency through an accredited postgraduate institution where at least 50 percent of the experience includes the provision of direct patient care services with interdisciplinary teams.

(C) Have actively managed patients for at least one year under a collaborative practice agreement or protocol with a physician, advanced practice pharmacist, pharmacist practicing collaborative drug therapy management, or health system.

(3) File an application with the board for recognition as an advanced practice pharmacist.

(4) Pay the applicable fee to the board.

(b) An advanced practice pharmacist recognition issued pursuant to this section shall be valid for two years, coterminous with the certificate holder's license to practice pharmacy.

(c) The board shall adopt regulations establishing the means of documenting completion of the requirements in this section.

(d) The board shall, by regulation, set the fee for the issuance and renewal of advanced practice pharmacist recognition at the reasonable cost of regulating advanced practice pharmacists pursuant to this chapter. The fee shall not exceed three hundred dollars ($300).

SEC. 12. Section 4233 is added to the Business and Professions Code, to read:

4233. A pharmacist who is recognized as an advanced practice pharmacist shall complete 10 hours of continuing education each renewal cycle in addition to the requirements of Section 4231. The

SB 570

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 670
Author: Steinberg
Bill Date: May 24, 2013, Amended
Subject: Physicians: Drug Prescribing Privileges: Investigation
Sponsor: Author
Position: Support if Amended

STATUS OF BILL:

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

DESCRIPTION OF CURRENT LEGISLATION:

This bill would authorize the Medical Board of California (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.

This bill was amended to change the burden of proof for restricting a physician's prescribing privileges to "probable cause" that the physician prescribed, furnished, administered, or dispensed controlled substances in violation of the Medical Practice Act. The amendments would also allow the Board to inspect and copy the medical records of a deceased patient without the consent of the patient's next of kin in any case that involves the death of a patient. The amendments also specify that compliance with this section is consistent with the public interest and benefit activities of the federal Health Insurance Portability and Accountability Act (HIPAA)

ANALYSIS:

Currently, if the Board is investigating a physician whose patient has died, the Board must receive written authorization by the patient's next of kin in order to obtain the patient's medical records. The Board needs the medical records in order to determine if a physician is prescribing appropriately. If the Board cannot obtain written authorization to release the medical records, it has to go to court to get the records through a subpoena and it must be

proven that there is a compelling state need in order to obtain those records through a subpoena. In the past, prescription drug monitoring data (from CURES) has not been successful in compelling the state to release those records.

The Board has reason to believe that numerous deaths have occurred in California that are related to prescription drug overdoses. However, complaints regarding drug-related offenses are often hard for the Board to obtain. In most instances, patients who are receiving prescription drugs in a manner that is not within the standard of practice, are unlikely to make a complaint to the Board. Some complaints regarding overprescribing come from anonymous tips, which usually do not have enough information to allow forwarding to the Board's district office for investigation, as there is no patient to obtain records for or not enough information to open an investigation. Family members of patients may make a complaint to the Board; however, the Board must have a patient release in order to obtain medical records or seek a subpoena. Sometimes it is difficult to obtain evidence to warrant a subpoena, or the family is not responsive.

This bill would allow the Board to obtain medical records without a written release by the patient's next of kin or a court order in any case that involves the death of a patient in order to determine the extent to which the death was the result of the physician's conduct in violation of the Medical Practice Act. This bill would also specify that compliance with this section is consistent with the public interest and benefit activities of the federal HIPAA. These provisions will allow the Board to move forward with its investigation in a more expedient manner, and help to ensure consumer protection.

In the Board's 2012 Sunset Review Report, information was included related to existing law regarding unprofessional conduct and physician interviews. Existing law provides that it only constitutes unprofessional conduct if a physician repeatedly fails to appear at the interview that has been scheduled by "mutual agreement" of the physician and the Board. Although the existing statute was well intended, it has been ineffective in reducing the time it takes to complete an interview with a licensee and in fact may have resulted in physicians failing to agree to any interview with the Board. The report recommended that no more than thirty days should elapse between the time the interview is requested and completed.

This bill would require a physician to attend and participate in an interview within 30 days of notification from the Board.

Requiring the interview to be conducted within 30 days will significantly reduce the timeline for the physician interview and will force the physician to agree to an interview time.

Currently, in order for the Board to stop a physician from practicing while the physician is under investigation, the Board must request an Interim Suspension Order (ISO), which must be granted by an Administrative Law Judge (ALJ). An ISO is considered extraordinary relief and the Board must prove that a physician's continued practice presents an immediate danger

to public health, safety, or welfare. In addition, there is a 15-day time restraint in law to file an accusation after being granted an ISO, and a 30-day time restraint between the accusation being filed and a hearing being set, which means an investigation must be nearly complete in order to petition 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 probable cause to believe that the physician has prescribed, furnished, administered, or dispensed controlled substances in violation of the Medical Practice Act.

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. If the prescribing restriction were tied to the interim suspension order process, it would allow for due process.

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. The Board has a support if amended position on this bill and would like it amended to make it clear when and how the Board can impose limitations on a physician's prescribing privileges and the due process afforded to the physician.

FISCAL: Minimal and absorbable

SUPPORT: Center for Public Interest Law
Medical Board of California (if amended)

OPPOSITION: California Medical Association

AMENDED IN SENATE MAY 24, 2013

AMENDED IN SENATE APRIL 8, 2013

SENATE BILL **No. 670**

Introduced by Senator Steinberg

February 22, 2013

An act to amend Sections 2225 and 2234 of, and to add Section 2221.5 to, the Business and Professions Code, and to amend Section 11529 of the Government Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 670, as amended, Steinberg. Physicians and surgeons: drug prescribing privileges: investigation.

(1) Existing law authorizes investigators and representatives of the Medical Board of California, among others, to inquire into any alleged violation of the Medical Practice Act or any other federal or state law, regulation, or rule relevant to the practice of medicine or podiatric medicine, and to inspect documents relevant to those investigations, including the inspection and copying of any document relevant to an investigation where patient consent is given.

Existing law requires specified persons, including the administrator of a peer review body, to file a report with the board within 15 days after the effective date of any specified action taken against a licensee for a medical disciplinary cause or reason. Existing law also requires a coroner to make a report to the board, among other specified entities, when he or she receives information that indicates that a death may be the result of a physician and surgeon's, podiatrist's, or physician assistant's gross negligence or incompetence.

This bill would authorize the board, ~~if it receives a report pursuant to either of the provisions described above~~ *in any case* that involves the

2221.5. Notwithstanding Section 11529 of the Government Code, the board shall impose limitations on the authority of a physician and surgeon to prescribe, furnish, administer, or dispense controlled substances during a pending investigation if there is ~~a reasonable suspicion~~ *probable cause to believe* that the physician and surgeon has ~~engaged in either of the following:~~ *prescribed, furnished, administered, or dispensed controlled substances in violation of the Medical Practice Act.*

~~(a) Overprescribing drugs.~~

~~(b) Other behavior related to his or her drug prescribing privileges that has resulted in the death of a patient.~~

SEC. 2. Section 2225 of the Business and Professions Code is amended to read:

2225. (a) Notwithstanding Section 2263 and any other law making a communication between a physician and surgeon or a doctor of podiatric medicine and his or her patients a privileged communication, those provisions shall not apply to investigations or proceedings conducted under this chapter. Members of the board, the Senior Assistant Attorney General of the Health Quality Enforcement Section, members of the California Board of Podiatric Medicine, and deputies, employees, agents, and representatives of the board or the California Board of Podiatric Medicine and the Senior Assistant Attorney General of the Health Quality Enforcement Section shall keep in confidence during the course of investigations, the names of any patients whose records are reviewed and shall not disclose or reveal those names, except as is necessary during the course of an investigation, unless and until proceedings are instituted. The authority of the board or the California Board of Podiatric Medicine and the Health Quality Enforcement Section to examine records of patients in the office of a physician and surgeon or a doctor of podiatric medicine is limited to records of patients who have complained to the board or the California Board of Podiatric Medicine about that licensee.

(b) Notwithstanding any other law, the Attorney General and his or her investigative agents, and investigators and representatives of the board or the California Board of Podiatric Medicine, may inquire into any alleged violation of the Medical Practice Act or any other federal or state law, regulation, or rule relevant to the practice of medicine or podiatric medicine, whichever is applicable,

is in addition to any other authority of the board to sanction a licensee for a delay in producing requested records.

(f) Searches conducted of the office or medical facility of any licensee shall not interfere with the recordkeeping format or preservation needs of any licensee necessary for the lawful care of patients.

SEC. 3. Section 2234 of the Business and Professions Code is amended to read:

2234. The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon

(d) For the purposes of the hearing conducted pursuant to this section, the licentiate shall, at a minimum, have the following rights:

(1) To be represented by counsel.

(2) To have a record made of the proceedings, copies of which may be obtained by the licentiate upon payment of any reasonable charges associated with the record.

(3) To present written evidence in the form of relevant declarations, affidavits, and documents.

The discretion of the administrative law judge to permit testimony at the hearing conducted pursuant to this section shall be identical to the discretion of a superior court judge to permit testimony at a hearing conducted pursuant to Section 527 of the Code of Civil Procedure.

(4) To present oral argument.

(e) Consistent with the burden and standards of proof applicable to a preliminary injunction entered under Section 527 of the Code of Civil Procedure, the administrative law judge shall grant the interim order if, in the exercise of discretion, the administrative law judge concludes that:

(1) There is a reasonable probability that the petitioner will prevail in the underlying action.

(2) The likelihood of injury to the public in not issuing the order outweighs the likelihood of injury to the licensee in issuing the order.

(f) In all cases in which an interim order is issued, and an accusation is not filed and served pursuant to Sections 11503 and 11505 within 15 days of the date on which the parties to the hearing on the interim order have submitted the matter, the order shall be dissolved.

Upon service of the accusation the licensee shall have, in addition to the rights granted by this section, all of the rights and privileges available as specified in this chapter. If the licensee requests a hearing on the accusation, the board shall provide the licensee with a hearing within 30 days of the request, unless the licensee stipulates to a later hearing, and a decision within 15 days of the date the decision is received from the administrative law judge, or the board shall nullify the interim order previously issued, unless good cause can be shown by the Division of Medical Quality for a delay.

SBB 608

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 809
Author: DeSaulnier and Steinberg
Bill Date: June 26, 2013, Amended
Subject: Controlled Substances: Reporting
Sponsor: California Attorney General Kamala Harris

STATUS OF BILL:

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

DESCRIPTION OF CURRENT LEGISLATION:

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

This bill was amended and would no longer mandate that manufacturers and insurers contribute to funding for the CURES system or the DOJ enforcement program. This bill would allow DOJ to seek private funds from qualified manufacturers, insurers, and health care service plans for the purpose of supporting CURES.

The amendments would also allow DOJ to invite stakeholders to assist, advise and make recommendations on the establishment of rules and regulations necessary to ensure proper administration and enforcement of the CURES database. This bill would require DOJ to consult with prescribers, regulatory boards, and other stakeholders to identify desirable capabilities and upgrades to the CURES system. The amendments would also specify how the CURES data can be used.

This bill would require the Medical Board of California (Board) to periodically develop and disseminate information and educational materials related to assessing a patient's risk of abusing or diverting controlled substance and information on CURES to each licensed physician and general acute care hospital (GACH).

Lastly, this bill was amended to no longer require, but strongly encourage, all prescribers and dispensers to consult CURES before prescribing and dispensing Schedule II, III, or IV controlled substances.

ANALYSIS:

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

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

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

This bill would make findings and declarations related to the importance of CURES. This bill would establish the CURES Fund that would be funded by an annual 1.16% (as of July 1, 2013) licensing, certification and renewal fee increase for licensees of the following boards that are authorized to prescribe or dispense Schedule II, III, or IV controlled substances: Medical Board of California; Dental Board of California; Board of Pharmacy (including wholesalers non-resident wholesalers, and veterinary food-animal drug retailers); Veterinary Medical Board; Board of Registered Nursing; Physician Assistant Board; Osteopathic Medical Board of California; State Board of Optometry; California Board of Podiatric Medicine; and the Naturopathic Medicine Committee. This bill would make the money in the CURES Fund available for allocation to DOJ, upon appropriation by the Legislature, for the purposes of funding the CURES Program. This bill would specify that the fee increase shall be due at time of renewal and shall not exceed the reasonable costs associated with maintaining CURES.

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

In addition, it is important to note that this language is consistent with the language included in the Budget Bill (AB 73, Blumenfield), which will require all boards to provide funding to help maintain and upgrade the CURES system. For the Medical Board, this will be $848,000 for the FY 2013/14, and $790,000 for FY 2014/15. The Budget Bill states the legislative intent that the CURES system be jointly developed by DOJ and the Department of Consumer Affairs (DCA) and addresses the needs of the boards funding CURES and DOJ. The Budget Bill requires, before the funds are appropriated for CURES, for the Feasibility Study Report to be approved and mutually agreed upon by DOJ and DCA, and that an interagency agreement be developed between DOJ and DCA on behalf of each board or committee funding the system that includes the roles and responsibilities of each department as to the joint development, implementation, and utilization of CURES.

This language is very important as it will ensure that the new CURES system will be developed with the regulatory boards' needs in mind and will ensure that input from all boards must be considered and accounted for in development of the new CURES system.

This bill would allow DOJ to seek private funds from qualified manufacturers, insurers, and health care service plans for the purpose of supporting CURES. Information on the private funds received would be made available to the public and reported annually to the Legislature.

This bill would also allow DOJ to invite stakeholders to assist, advise and make recommendations on the establishment of rules and regulations necessary to ensure proper administration and enforcement of the CURES database. This bill would require DOJ to consult with prescribers, regulatory boards, and other stakeholders to identify desirable capabilities and upgrades to the CURES system.

This bill would specify that CURES data shall only be provided to appropriate state, local, and federal public agencies for disciplinary, civil, or criminal purposes, and to other agencies or entities, as determined by DOJ, for the purpose of educating practitioners in lieu of disciplinary, civil, or criminal actions. This bill would allow data to be provided to public or private entities, as approved by DOJ, for educational, peer review, statistical, or research purposes, provided that patient identifying information is not compromised. This bill would specify that data disclosed to any individual or agency shall not be disclosed, sold, or transferred to any third party.

This bill would also require the Board to periodically develop and disseminate information and educational materials related to assessing a patient's risk of abusing or diverting controlled substances and information on CURES to each licensed physician and GACH. The Board must consult with the Department of Health Care Services and DOJ in developing the materials.

Once CURES is funded, upgraded, and able to handle inquiries from all eligible prescribers and dispensers in California, but not before June 1, 2015, this bill would require DOJ to notify all prescribers and dispensers who have submitted

applications to CURES that they are capable of accommodating this workload. DOJ would also be required to notify the Legislature and post the notification on DOJ's Web site. Once DOJ issues this notification, all prescribers and dispensers eligible to prescribe and dispense Schedule II, III, and IV controlled substances would be strongly encouraged, but not required, to access and consult the electronic history of controlled substances dispensed to a patient under his or her care, prior to prescribing or dispensing a Schedule II, III, or IV controlled substance.

Board staff is suggesting the fee increase not be a percentage and annual fee increase, but be a flat fee increase on all initial licenses and renewals. This bill also contains an urgency clause, which means it would take effect immediately once signed into law by the Governor. This bill should include a delayed implementation schedule, as the Board sends out renewal notices 90 days in advance and would need to give licensees appropriate notice of the renewal fee increase. The Board will continue to take part in the working group meetings on this bill and continue to address proposed amendments that the Board may have concerns with. It is important to note that manufacturers and insurers are no longer required to help contribute to the upgrading and funding of CURES; however, if that language would have remained in the bill, it is very likely that the bill would have died in the Senate.

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

FISCAL: This bill would result in an annual 1.16% licensing fee increase for physicians, which equates to a $18 increase for renewals and a $9 increase for initial licensing fees. There would be a minimal and absorbable fiscal impact associated with periodically developing and disseminating information and educational materials to all licensed physicians and GACHs.

SUPPORT: California Attorney General Kamala Harris (Sponsor); California American Cancer Society Cancer Action Network; American College of Emergency Physicians, California Chapter; American Medical Association; California Association for Nurse Practitioners; California Association of Oral and Maxillofacial Surgeons; California Department of Insurance; California Medical Association; California Labor Federation; California Narcotic Officers Association; California Pharmacists Association; California Primary Care Association; California Police Chiefs Association; California Society of Health-System Pharmacists; California State Board of Pharmacy; California State Sheriff's

Association; Center for Public Interest Law; City and County of San Francisco; County Alcohol and Drug Program Administrators Association of California; Deputy Sheriffs' Association of San Diego County; Healthcare Distribution Management Association; Health Officers Association of California; Kaiser Permanente; Medical Board of California (in concept); National Coalition Against Prescription Drug Abuse; South Orange County Coalition; Troy and Alana Pack Foundation; Western Occupational and Environmental Medical Association; University of California; and one private individual

OPPOSITION: None

POSITION: Recommended: Support if Amended to make the fee a flat fee for all initial licenses and renewals and to address an implementation schedule for the fee increase, as it is impossible to implement on the day the bill is signed.

Item | Amount

(30) Amount payable from the National Mortgage Special Deposit Fund (Item 0820-001-8071)..... −6,000,000

(31) Amount payable from the Legal Services Revolving Fund (Item 0820-001-9731)..... −208,246,000

(32) Amount payable from the Central Service Cost Recovery Fund (Item 0820-001-9740)..... −1,539,000

Provisions:

1. The Attorney General shall submit to the Legislature, the Director of Finance, and the Governor the quarterly and annual reports that he or she submits to the federal government on the activities of the Medi-Cal Fraud Unit.
2. Notwithstanding any other provision of law, the Department of Justice may purchase or lease vehicles of any type or class that, in the judgment of the Attorney General or his or her designee, are necessary to the performance of the investigatory and enforcement responsibilities of the Department of Justice, from the funds appropriated for that purpose in this item.
3. Of the amount included in Schedule (3), $3,000,000 is available for costs related to the Lloyd's of London (Stringfellow) litigation. Any funds not expended for this specific purpose as of June 30, 2014, shall revert immediately to the General Fund.
4. *It is the intent of the Legislature that the Controlled Substance Utilization Review and Evaluation System be jointly developed by the Department of Justice and the Department of Consumer Affairs and address the respective needs of the boards funding the system and the Department of Justice.*
5. *Notwithstanding any other provision of law, of the funds appropriated in Schedule (6) for reimbursements of this item, up to $3,941,000 shall only be used to fund the cost of maintaining and upgrading the Controlled Substance Utilization Review and Evaluation System and is available for expenditure or encumbrance until June 30, 2015. Reimbursements provided pursuant to this provision are available upon completion of both of the following:*

Item | Amount

(a) Department of Technology approval of a Feasibility Study Report that has been mutually agreed upon by both the Department of Justice and the Department of Consumer Affairs.

(b) An interagency agreement between the Department of Justice and the Department of Consumer Affairs on behalf of each board or committee funding the system that includes, but is not limited to, the roles and responsibilities of each department as to the joint development, implementation, and utilization of the system.

0820-001-0012—For support of Department of Justice, for payment to Item 0820-001-0001, payable from the Attorney General Antitrust Account..... 2,410,000

0820-001-0017—For support of Department of Justice, for payment to Item 0820-001-0001, payable from the Fingerprint Fees Account, pursuant to subdivision (e) of Section 11105 of the Penal Code..... 70,261,000

Provisions:

1. The Attorney General may augment the amount appropriated in the Fingerprint Fees Account up to an aggregate of 10 percent above the amount approved in this act for the Division of Criminal Justice Information Services for unanticipated workload associated with this fund. The Attorney General shall notify the chairpersons of the budget committees of both houses of the Legislature, the Joint Legislative Budget Committee, and the Department of Finance within 15 days after the augmentation is made as to the amount and justification of the augmentation.

0820-001-0032—For support of Department of Justice, for payment to Item 0820-001-0001, payable from the Firearm Safety Account..... 343,000

0820-001-0044—For support of Department of Justice, for payment to Item 0820-001-0001, payable from the Motor Vehicle Account, State Transportation Fund..... 25,528,000

0820-001-0142—For support of Department of Justice, for payment to Item 0820-001-0001, payable from the Department of Justice Sexual Habitual Offender Fund..... 2,362,000

Provisions:

1. The amount appropriated in this item includes revenues derived from the assessment of fines

AMENDED IN ASSEMBLY JUNE 26, 2013

AMENDED IN SENATE MAY 28, 2013

AMENDED IN SENATE MAY 24, 2013

AMENDED IN SENATE MAY 14, 2013

AMENDED IN SENATE MAY 1, 2013

SENATE BILL No. 809

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

February 22, 2013

An act to add Sections 805.8 and 2196.8 to the Business and Professions Code, and to amend Sections 11164.1, 11165, and 11165.1 of, and to add Section 11165.4 to, the Health and Safety Code, relating to controlled substances, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

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

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

Existing law requires dispensing pharmacies and clinics to report, on a weekly basis, specified information for each prescription of Schedule

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

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

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

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

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

1 SECTION 1. The Legislature finds and declares all of the
2 following:
3 (a) The Controlled Substance Utilization Review and Evaluation
4 System (CURES) is a valuable preventive, investigative, and
5 educational tool for health care providers, regulatory boards,
6 educational researchers, and law enforcement. Recent budget cuts
7 to the Attorney General's Division of Law Enforcement have
8 resulted in insufficient funding to support the CURES Prescription
9 Drug Monitoring Program (PDMP). The PDMP is necessary to
10 ensure health care professionals have the necessary data to make
11 informed treatment decisions and to allow law enforcement to
12 investigate diversion of prescription drugs. Without a dedicated
13 funding source, the CURES PDMP is not sustainable.
14 (b) Each year CURES responds to more than 800,000 requests
15 from practitioners and pharmacists regarding all of the following:

Medical Board of California, the Naturopathic Medicine Committee of the Osteopathic Medical Board of California, the State Board of Optometry, and the California Board of Podiatric Medicine shall charge each licensee authorized pursuant to Section 11150 of the Health and Safety Code to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances a fee of up to 1.16 percent of the renewal fee that the licensee was subject to as of July 1, 2013, to be assessed annually. This fee shall be due and payable at the time the licensee renews his or her license and shall be submitted with the licensee's renewal fee. In no case shall this fee exceed the reasonable costs associated with operating and maintaining CURES for the purpose of regulating prescribers and dispensers of controlled substances licensed or certificated by these boards.

(2) In addition to the fees charged for licensure, certification, and renewal, at the time those fees are charged, the California State Board of Pharmacy shall charge wholesalers and nonresident wholesalers of dangerous drugs, licensed pursuant to Article 11 (commencing with Section 4160) of Chapter 9, a fee of up to 1.16 percent of the renewal fee that the wholesaler or nonresident wholesaler was subject to as of July 1, 2013, to be assessed annually. This fee shall be due and payable at the time the wholesaler or nonresident wholesaler renews its license and shall be submitted with the wholesaler's or nonresident wholesaler's renewal fee. In no case shall this fee exceed the reasonable costs associated with operating and maintaining CURES for the purpose of regulating wholesalers and nonresident wholesalers of dangerous drugs licensed or certificated by that board.

(3) In addition to the fees charged for licensure, certification, and renewal, at the time those fees are charged, the California State Board of Pharmacy shall charge veterinary food-animal drug retailers, licensed pursuant to Article 15 (commencing with Section 4196) of Chapter 9, a fee of up to 1.16 percent of the renewal fee that the drug retailer was subject to as of July 1, 2013, to be assessed annually. This fee shall be due and payable at the time the drug retailer renews its license and shall be submitted with the drug retailers' renewal fee. In no case shall this fee exceed the reasonable costs associated with operating and maintaining CURES for the purpose of regulating veterinary food-animal drug retailers licensed or certificated by that board.

(b) Pharmacies may dispense prescriptions for Schedule III, Schedule IV, and Schedule V controlled substances from out-of-state prescribers pursuant to Section 4005 of the Business and Professions Code and Section 1717 of Title 16 of the California Code of Regulations.

(c) This section shall become operative on January 1, 2005.

SEC. 5. Section 11165 of the Health and Safety Code is amended to read:

11165. (a) To assist health care practitioners in their efforts to ensure appropriate prescribing, ordering, administering, furnishing, and dispensing of controlled substances, law enforcement and regulatory agencies in their efforts to control the diversion and resultant abuse of Schedule II, Schedule III, and Schedule IV controlled substances, and for statistical analysis, education, and research, the Department of Justice shall, contingent upon the availability of adequate funds in the CURES accounts within the Contingent Fund of the Medical Board of California, the Pharmacy Board Contingent Fund, the State Dentistry Fund, the Board of Registered Nursing Fund, the Naturopathic Doctor's Fund, the Osteopathic Medical Board of California Contingent Fund, the Veterinary Medical Board Contingent Fund, the Optometry Fund, the Board of Podiatric Medicine Fund, and the CURES Fund, maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of, and Internet access to information regarding, the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe, order, administer, furnish, or dispense these controlled substances.

(b) The reporting of Schedule III and Schedule IV controlled substance prescriptions to CURES shall be contingent upon the availability of adequate funds for the Department of Justice for the purpose of funding CURES.

(c) The Department of Justice may seek and use grant funds to pay the costs incurred by the operation and maintenance of CURES. The department shall annually report to the Legislature and make available to the public the amount and source of funds it receives for support of CURES. Grant funds shall not be appropriated from the Contingent Fund of the Medical Board of California, the Pharmacy Board Contingent Fund, the State

the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the ultimate user.

(2) The prescriber's category of licensure and license number, the federal controlled substance registration number, and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility.

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

(4) National Drug Code (NDC) number of the controlled substance dispensed.

(5) Quantity of the controlled substance dispensed.

(6) International Statistical Classification of Diseases, 9th revision (ICD-9) or 10th revision (ICD-10) Code, if available.

(7) Number of refills ordered.

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

(9) Date of origin of the prescription.

(10) Date of dispensing of the prescription.

(f) The Department of Justice may invite stakeholders to assist, advise, and make recommendations on the establishment of rules and regulations necessary to ensure the proper administration and enforcement of the CURES database. All prescriber invitees shall be licensed by one of the boards or committees identified in subdivision (a) of Section 805.8 of the Business and Professions Code, in active practice in California, and a regular user of CURES.

(g) The Department of Justice shall, prior to upgrading CURES, consult with prescribers licensed by one of the boards or committees identified in subdivision (a) of Section 805.8 of the Business and Professions Code, one or more of the regulatory boards or committees identified in subdivision (a) of Section 805.8 of the Business and Professions Code, and any other stakeholder identified by the ~~department~~ *department,* for the purpose of identifying desirable capabilities and upgrades to the CURES Prescription Drug Monitoring Program.

(h) The Department of Justice may establish a process to educate authorized subscribers of CURES on how to access and use CURES.

(i) The CURES Fund is hereby established within the State Treasury. The CURES Fund shall consist of all funds made

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

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

(2) Upon the Department of Justice issuing the notification described in paragraph (3), licensed health care practitioners eligible to prescribe Schedule II, Schedule III, or Schedule IV controlled substances and pharmacists shall be strongly encouraged to access and consult the electronic history of controlled substances dispensed to an individual under his or her care prior to prescribing or dispensing a Schedule II, Schedule III, or Schedule IV controlled substance.

(3) The Department of Justice shall notify licensed health care practitioners and pharmacists who have submitted the application required pursuant to subdivision (a) when the department determines that CURES is capable of accommodating all users, but not before June 1, 2015. The department shall provide a copy of the notification to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel, and shall post the notification on the department's Internet Web site.

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

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

1 SEC. 8. This act is an urgency statute necessary for the
2 immediate preservation of the public peace, health, or safety within
3 the meaning of Article IV of the Constitution and shall go into
4 immediate effect. The facts constituting the necessity are:
5 In order to protect the public from the continuing threat of
6 prescription drug abuse at the earliest possible time, it is necessary
7 that this act take effect immediately.

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MBC TRACKER II BILLS
7/9/2013

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 5	Ammiano	Homelessness	2-year	04/08/13
AB 12	Cooley	Standardized Regulatory Impact Analysis	Sen. Approps.	05/24/13
AB 18	Pan	Individual Health Care Coverage	2-year	06/24/13
AB 40	Mansoor	Substance Abuse: Recovery and Treatment Facilities	2-year	05/07/13
AB 58	Wieckowski	Medical Experiments: Human Subjects	Sen. 3rd Reading	04/02/13
AB 213	Logue	Healing Arts: Licensing Requirements: Military	2-year	04/18/13
AB 219	Perea	Health Care Coverage: Cancer Treatment	Sen. Approps.	07/02/13
AB 291	Nestande	California Sunset Review Commission	2-year	
AB 299	Holden	Prescription Drug Benefits	2-year	05/14/13
AB 357	Pan	California Healthy Child Advisory Task Force	2-year	
AB 369	Pan	California Health Benefit Exchange: Report	2-year	
AB 376	Donnelly	Regulations: Notice	2-year	
AB 395	Fox	Alcoholism and Drug Abuse Treatment Facilities	Sen. Approps.	06/24/13
AB 396	Fox	Prescriptions	2-year	
AB 411	Pan	Medi-Cal: Performance Measures	Sen. Approps.	07/02/13
AB 446	Mitchell	HIV Testing	Sen. Approps.	07/08/13
AB 473	Ammiano	Medical Marijuana: State Regulation and Enforcement	2-year	05/24/13
AB 506	Mitchell	HIV Testing: Infants	Assembly Conc.	07/02/13
AB 555	Salas	Social Security Numbers	Enrollment	04/30/13
AB 576	Perez, V.	Revenue Recovery and Collaborative Enforcement Team	Sen. Approps.	05/01/13
AB 591	Fox	Hospital Emergency Room: Geriatric Physician	2-year	
AB 596	Brown	Health Care Services Grants	2-year	
AB 599	Donnelly	Minors: Vaccinations: Parental Consent	2-year	
AB 620	Buchanan	Heath and Care Facilities: Missing Patients & Participants	Sen. Approps.	06/27/13
AB 623	Lowenthal	Inmates: Psychiatric Medication: Informed Consent	2-year	

MBC TRACKER II BILLS
7/9/2013

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 633	Salas	Emergency Medical Services: Civil Liability	Sen. 3rd Reading	07/08/13
AB 657	Nazarian	Women's Health	2-year	
AB 658	Calderon, I.	Personal Information: Disclosure	Sen. 3rd Reading	06/24/13
AB 670	Atkins	Pharmacy Law: Incentive Payments	2-year	04/30/13
AB 676	Fox	Health Care Coverage: Post discharge Care Needs	2-year	04/10/13
AB 678	Gordon	Health Care Districts: Community Health Needs Assessment	Sen. Approps.	04/15/13
AB 689	Bonta	Health Facilities: Influenza	2-year	04/08/13
AB 705	Blumenfield	Combat to Care Act	2-year	04/23/13
AB 710	Pan	California Health Benefit Exchange: Multiemployer Plans	2-year	03/11/13
AB 722	Lowenthal	Drivers License: Medical Examinations	Assembly Conc.	05/28/13
AB 771	Jones	Public Health: Wellness Programs	2-year	03/19/13
AB 808	Fong	Acupuncture: License Requirements	2-year	04/09/13
AB 810	Muratsuchi	Law Enforcement: Data Sharing	2-year	03/21/13
AB 827	Hagman	Department of Consumer Affairs	2-year	
AB 859	Gomez	Professions and Vocations: Military Medical Personnel	2-year	
AB 889	Frazier	Health Care Coverage: Prescription Drugs	Sen. Approps.	05/02/13
AB 894	Mansoor	Consumer Affairs	2-year	
AB 912	Quirk-Silva	Health Care Coverage: Fertility Preservation	Sen. Approps.	07/02/13
AB 926	Bonilla	Reproductive Health and Research	Enrollment	04/23/13
AB 975	Wieckowski & Bonta	Health Facilities: Community Benefits	2-year	05/24/13
AB 980	Pan	Primary Care Clinics: Abortion	Sen. Approps.	06/19/13
AB 1013	Gomez	Consumer Affairs	2-year	
AB 1045	Quirk-Silva	Sterile Compounding and Nonresident Pharmacies	Sen. 3rd Reading	06/19/13
AB 1057	Medina	Professions & Vocations: Licenses: Military Service	Sen. 3rd Reading	06/03/13
AB 1136	Levine	Pharmacists: Drug Disclosures	Sen. 3rd Reading	04/15/13

MBC TRACKER II BILLS
7/9/2013

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 1139	Lowenthal	Prescriptions: Biosimilar Products	2-year	
AB 1153	Eggman	Master Esthetician: License	2-year	04/16/13
AB 1180	Pan	Health Care Coverage: Federally Eligible Defined Individuals	Sen. Approps.	06/20/13
AB 1208	Pan	Medical Homes	Sen. 3rd Reading	07/02/13
AB 1231	Perez, V.	Regional Centers: Telehealth	Sen. Approps.	06/27/13
AB 1263	Perez, J.	Medi-Cal: Communical	Sen. Approps.	06/25/13
AB 1297	Perez, J.	Coroners: Organ Donation	Sen. 3rd Reading	06/04/13
AB 1310	Brown	Medi-Cal: Pediatric Subacute Care	Sen. Approps.	05/24/13
AB 1372	Bonilla	Health Insurance: Pervasive Developmental Disorder or Autism	2-year	
ABX1 2	Pan	Health Care Coverage	Sen. 3rd Reading	04/01/13
ACA 1	Donnelly	Administrative Regulations: Legislative Approval	Failed Passage	
ACA 5	Grove	Abortion: Parental Notification	Asm. Health	
ACR 1	Medina	UC Riverside School of Medicine	Sen. Education	
SB 18	Hernandez	California Health Benefits Review Program	Asm. Health	04/17/13
SB 22	Beall	Health Care Coverage: Mental Health Parity	Asm. Approps	07/02/13
SB 28	Hernandez	California Health Benefit Exchange	Asm. Health	05/13/13
SB 44	Yee	State Internet Web sties: online voter registration	Asm. Approps	
SB 126	Steinberg	Health Care Coverage: pervasive developmental disorder/autism	Asm. Approps	06/15/13
SB 138	Hernandez	Confidentiality of Medical Information	Asm. Approps	06/26/13
SB 158	Correa	Autism Services: Demonstration Program	Asm. Approps	05/28/13
SB 176	Galgiani	Administrative Procedures	Asm. A & AR	06/18/13
SB 189	Monning	Health Care Coverage: Wellness Programs	2-year	05/08/13
SB 198	Price	Physical Therapy Board of California	Asm. Approps	06/18/13
SB 204	Corbett	Prescription Drugs: Labeling	Asm. Health	06/27/13
SB 205	Corbett	Prescription Drugs: Labeling	Asm. B&P	07/01/13

MBC TRACKER II BILLS
7/9/2013

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 218	Yee	Healing Arts	Asm. B&P	05/28/13
SB 248	Wyland	Professional Corporations	2-year	
SB 266	Lieu	Health Care Coverage: Out-of-Network Coverage	2-year	04/24/13
SB 270	Padilla	Underground Economy: Enforcement Actions	Asm. L&E	
SB 294	Emmerson	Sterile Drug Products	Asm. Health	07/03/13
SB 306	Torres	Pharmacy: Dangerous Drugs and Devices	Asm. B&P	06/20/13
SB 351	Hernandez	Health Care Coverage: Hospital Billing	2-year	04/23/13
SB 353	Lieu	Health Care Coverage: Language Assistance	Asm. Health	04/16/13
SB 357	Correa	Elective Percutaneous Coronary Intervention Pilot Program	Asm. Consent	06/14/13
SB 381	Yee	Healing Arts: Chiropractic Practice	2-year	
SB 393	Walters	Prescription Drugs: Procurement: False Representation	2-year	
SB 394	Walters	Prescription Drugs	2-year	
SB 439	Steinberg	Medical Marijuana	Asm. Health	06/27/13
SB 445	Price	Pharmacies: Advertising: Controlled Substances	Asm. B&P	
SB 460	Pavley	Prenatal Testing Program: Education	Asm. Health	05/28/13
SB 494	Monning	Health Care Providers	Asm. Health	05/28/13
SB 495	Yee	Postsecondary Education Employees: Physicians	Assembly	05/21/13
SB 528	Yee	Dependents: Care and Treatment	Asm. Approps	06/26/13
SB 532	De Leon	Professions and Vocations: Military Spouses: Temporary Licenses	2-year	
SB 534	Hernandez	Health and Care Facilities	Asm. A & LTC	07/03/13
SB 577	Pavley	Autism & Other Developmental Disabilities: Employment	2-year	04/15/13
SB 588	Emmerson	Medical Records: Reproduction Fees	2-year	04/08/13
SB 598	Hill	Biosimilars	Asm. Approps	06/20/13
SB 631	Beall	Health Care Facilities: Observation	2-year	04/08/13
SB 639	Hernandez	Health Care Coverage	Asm. Health	05/28/13

MBC TRACKER II BILLS
7/9/2013

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 643	Price	Pharmacists: Identity	2-year	
SB 669	Huff	Emergency Medical Care: Epinephrine Auto Injectors	Asm. Judiciary	07/03/13
SB 709	Nielsen	Inmates: Mental Evaluations	2-year	
SB 799	Calderon	Health Care Coverage: Colorectal Cancer: Testing & Screening	2-year	05/08/13
SB 800	Lara	California Health Benefit Exchange: Outreach Services	Asm. Health	05/28/13
SBX1 2	Hernandez	Health Care Coverage	Asm. 3rd Reading	04/01/13
SBX1 3	Hernandez	Health Care Coverage: Bridge Plan	Enrolled	06/19/13

WORKLOAD REPORT
as of July 19, 2013

CONSUMER INFORMATION UNIT FY 12/13					
	FY 12/13	**Q1**	**Q2**	**Q3**	**Q4**
Total Calls Answered	**92,611**	26,022	20,578	22,607	23,404
Calls Requesting Call Back	**12,469**	2,850	2,516	3,493	3,610
Calls Abandoned	**11,068**	3,071	2,167	2,832	2,998
Address Changes Completed	**5,067**	2,046	1,373	835	813

CONSUMER INFORMATION UNIT FY 11/12					
	FY 11/12	**Q1**	**Q2**	**Q3**	**Q4**
Total Calls Answered	**89,497**	15,725	20,456	28,061	25,255
Calls Requesting Call Back	**14,923**	4,647	5,022	3,229	2,025
Calls Abandoned	**13,448**	4,356	4,616	2,657	1,819
Address Changes Completed	**8,894**	3,451	2,133	1,909	1,401

PHYSICIAN & SURGEON DATA FY 12/13					
	FY 12/13	**Q1**	**Q2**	**Q3**	**Q4**
Applications Received	**6,697**	1,722	1,715	1,708	1,552
Initial Reviews Completed	**6,671**	1,556	1,791	1,604	1,720
Total Pending	**N/A**	3,907	4,244	4,468	4,113
Reviewed	**N/A**	3,365	3,770	3,900	3,725
Not Reviewed	**N/A**	542	474	568	388
(SR2s Pending)	**N/A**	93	88	38	28
Licenses Issued	**5,440**	1,447	1,264	1,291	1,438
Renewals Issued	**62,924**	16,282	14,830	16,266	15,546

PHYSICIAN & SURGEON DATA FY 11/12					
	FY 11/12	**Q1**	**Q2**	**Q3**	**Q4**
Applications Received	**6,629**	1,711	1,666	1,862	1,390
Initial Reviews Completed	**6,729**	1,491	1,689	1,979	1,570
Total Pending	**N/A**	4,012	4,325	4,515	3,823
Reviewed	**N/A**	3,273	3,530	3,928	3,423
Not Reviewed	**N/A**	739	795	587	400
(SR2s Pending)	**N/A**	108	121	124	109
Licenses Issued	**5,351**	1,358	1,203	1,419	1,371
Renewals Issued	**64,351**	16,092	14,067	17,835	16,357

Unrecognized and Disapproved Medical School Applicants (2135.7) - FY 12/13					
	FY 12/13	**Q1**	**Q2**	**Q3**	**Q4**
Received	**N/A**	N/A	N/A	11	0
Reviewed	**N/A**	N/A	N/A	7	4
Not Eligible	**N/A**	N/A	N/A	3	4
Licensed	**N/A**	N/A	N/A	1	1

WORKLOAD REPORT
as of July 19, 2013

SR 2 - CATEGORIES FY 12/13					
	FY 12/13	**Q1**	**Q2**	**Q3**	**Q4**
Alcohol/Drugs	**41**	5	9	3	24
PG/Medical Knowledge	**89**	25	19	13	32
Convictions	**51**	15	5	2	29
Other	**111**	11	19	17	64

SR 2 - CATEGORIES FY 11/12					
	FY 11/12	**Q1**	**Q2**	**Q3**	**Q4**
Alcohol/Drugs	**86**	30	12	27	17
PG/Medical Knowledge	**188**	59	40	60	29
Convictions	**100**	43	18	16	23
Other	**179**	92	44	21	22

INTERNATIONAL MEDICAL SCHOOL APPLICATIONS FY 12/13					
	FY 12/13	**Q1**	**Q2**	**Q3**	**Q4**
Schools Pending Recognition at Beginning of Quarter	**N/A**	101	98	94	91
Pending Self-Assessment Reports (included above)	**N/A**	7	9	8	8
New Self-Assessment Reports Received	**2**	0	2	0	0
New Unrecognized Schools Received	**96**	27	24	17	28
School Recognized Pursuant to CCR 1314(a)(1)	**104**	30	33	19	22
School Recognized Pursuant to CCR 1314(a)(2)	**1**	0	0	1	0
TOTAL Schools Pending Recognition at End of Quarter	**N/A**	98	94	91	97

INTERNATIONAL MEDICAL SCHOOL APPLICATIONS FY 11/12					
	FY 11/12	**Q1**	**Q2**	**Q3**	**Q4**
Schools Pending Recognition at Beginning of Quarter	**N/A**	43	62	75	90
Pending Self-Assessment Reports (included above)	**N/A**	3	5	6	7
New Self-Assessment Reports Received	**4**	2	0	1	1
New Unrecognized Schools Received	**102**	22	15	18	47
School Recognized Pursuant to CCR 1314(a)(1)	**47**	4	2	4	37
School Recognized Pursuant to CCR 1314(a)(2)	**1**	1	0	0	0
TOTAL Schools Pending Recognition at End of Quarter	**N/A**	62	75	90	101

SPECIALTY BOARD APPLICATIONS FY 12/13					
	FY 12/13	**Q1**	**Q2**	**Q3**	**Q4**
Applications Received	**0**	0	0	0	0
Applications Pending	**N/A**	1	1	1	1

SPECIALTY BOARD APPLICATIONS FY 11/12					
	FY 11/12	**Q1**	**Q2**	**Q3**	**Q4**
Applications Received	**0**	0	0	0	0
Applications Pending	**N/A**	1	1	1	1

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

RESEARCH PSYCHOANALYST FY 11/12					
	FY 11/12	**Q1**	**Q2**	**Q3**	**Q4**
RP Applications Received	**2**	1	0	1	0
RP Licenses Issued	**4**	3	0	0	1

LICENSED MIDWIVES FY 12/13					
	FY 12/13	**Q1**	**Q2**	**Q3**	**Q4**
Applications Received	**33**	8	12	9	4
Applications Pending	**N/A**	5	6	8	3
Licenses Issued	**31**	5	12	5	9
Licenses Renewed	**126**	31	32	28	35

LICENSED MIDWIVES FY 11/12					
	FY 11/12	**Q1**	**Q2**	**Q3**	**Q4**
Applications Received	**33**	9	5	13	6
Applications Pending	**N/A**	6	3	5	4
Licenses Issued	**31**	4	8	10	9
Licenses Renewed	**125**	24	31	33	37

FICTITIOUS NAME PERMITS FY 12/13					
	FY 12/13	**Q1**	**Q2**	**Q3**	**Q4**
P&S - FNP Received	**1251**	363	230	309	349
P&S - FNP Issued	**1,277**	284	343	293	357
P&S - FNP Pending	**N/A**	55	116	98	93
P&S - FNP Renewed	**5,045**	1,202	1,180	1,342	1,321
Podiatric FNP Received	**21**	6	4	4	7
Podiatric FNP Issued	**20**	6	7	2	5
Podiatric FNP Pending	**N/A**	18	8	2	2
Podiatric FNP Renewed	**167**	38	37	44	48

FICTITIOUS NAME PERMITS FY 11/12					
	FY 11/12	**Q1**	**Q2**	**Q3**	**Q4**
P&S - FNP Issued	**1,397**	384	380	315	318
P&S - FNP Pending	**N/A**	59	63	72	94
Podiatric FNP Issued	**23**	3	9	7	4
Podiatric FNP Pending	**N/A**	0	0	0	2

WORKLOAD REPORT
as of July 19, 2013

OPTICAL REGISTRATIONS FY 12/13					
	FY 12/13	**Q1**	**Q2**	**Q3**	**Q4**
RDO - Business Registrations Issued	**41**	0	9	15	17
RDO - Pending Applications Business	**N/A**	1	20	28	32
CLS - Out-of-State - Business Registrations Issued	**0**	0	0	0	0
CLS - Pending Out of State Applications -Business	**N/A**	1	1	1	1
Spectacle Lens Registrations Issued	**204**	66	32	42	64
Spectacle Lens - Pending Applications	**N/A**	59	24	30	36
Contact Lens Registrations Issued	**90**	33	14	11	32
Contact Lens - Pending Applications	**N/A**	20	7	9	11
Spectacle Lens Registrations Renewed	**919**	230	212	226	251
Contact Lens Registrations Renewed	**410**	94	110	106	100

OPTICAL REGISTRATIONS FY 11/12					
	FY 11/12	**Q1**	**Q2**	**Q3**	**Q4**
Business Registrations Issued	**48**	10	9	8	21
Pending Applications Business	**N/A**	30	30	18	23
Out-of-State Business Registrations Issued	**1**	0	0	0	1
Pending Applications Out of State Bus.	**N/A**	0	0	0	1
Spectacle Lens Registrations Issued	**192**	47	29	72	44
Pending Applications-Spectacle Lens	**N/A**	78	107	29	57
Contact Lens Registrations Issued	**85**	13	11	43	18
Pending Applications-Contact Lens	**N/A**	22	33	15	18
Spectacle Lens Registrations Renewed	**991**	216	217	276	282
Contact Lens Registrations Renewed	**420**	95	79	112	134

POLYSOM FY 12/13					
	FY 12/13	**Q1**	**Q2**	**Q3**	**Q4**
Polysomnographic Trainee Applications Received	**20**	2	9	7	2
Polysomnographic Trainee Registrations Pending	**N/A**	2	9	16	25
Polysomnographic Trainee Registrations Issued	**9**	0	6	1	2
Polysomnographic Technician Applications Received	**96**	20	68	7	1
Polysomnographic Technician Registrations Pending	**N/A**	21	33	37	51
Polysomnographic Technician Registrations Issued	**40**	0	25	7	8
Polysomnogrpahic Technologist Applications Received	**518**	168	327	14	9
Polysomnogrpahic Technologist Applications Pending	**N/A**	208	130	142	154
Polysomnogrpahic Technologist Registrations Issued	**329**	0	197	56	76

POLYSOM FY 11/12 **					
	FY 11/12	**Q1**	**Q2**	**Q3**	**Q4**
Polysomnographic Trainee Applications Received	**0**	0	0	0	0
Polysomnographic Technician Applications Received	**1**	0	0	0	1
Polysomnogrpahic Technologist Applications Received	**29**	0	0	0	29

** Program began accepting applications April of 2012

SPECIAL PROGRAMS
FY 12/13

Permit	Applications Received				Applications Reviewed				Permits Issued				Permits Renewed				Total Pending				Applications Withdrawn or Denied			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2111	11	12	4	2	10	14	3	3	6	9	5	6	2	3	2	4	21	10	12	8	0	0	0	0
2112	0	1	0	0	0	1	0	0	0	2	0	0	0	0	0	0	1	0	0	0	0	0	0	0
2113	7	4	2	3	8	2	2	3	2	3	3	3	10	13	9	21	20	9	7	7	0	0	1	0
2168	0	0	1	0	0	0	1	0	2	1	0	1	3	2	0	6	1	0	1	0	0	0	0	0
2072	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1327	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0

SPECIAL PROGRAMS
FY 11/12

Permit	Applications Received				Applications Reviewed				Permits Issued				Permits Renewed				Total Pending				Applications Withdrawn or Denied			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2111	8	2	3	11	9	5	3	9	3	7	2	5	5	2	3	3	10	15	10	16	0	0	1	0
2112	0	0	0	1	0	0	0	1	1	0	0	1	0	0	0	0	1	1	1	1	0	0	0	0
2113	5	6	9	6	5	8	9	6	14	4	4	7	6	11	14	7	8	10	14	13	0	0	1	0
2168	3	0	1	1	1	1	1	1	0	2	0	0	3	0	1	1	3	1	2	3	0	0	0	0
2072	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1327	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0

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

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

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

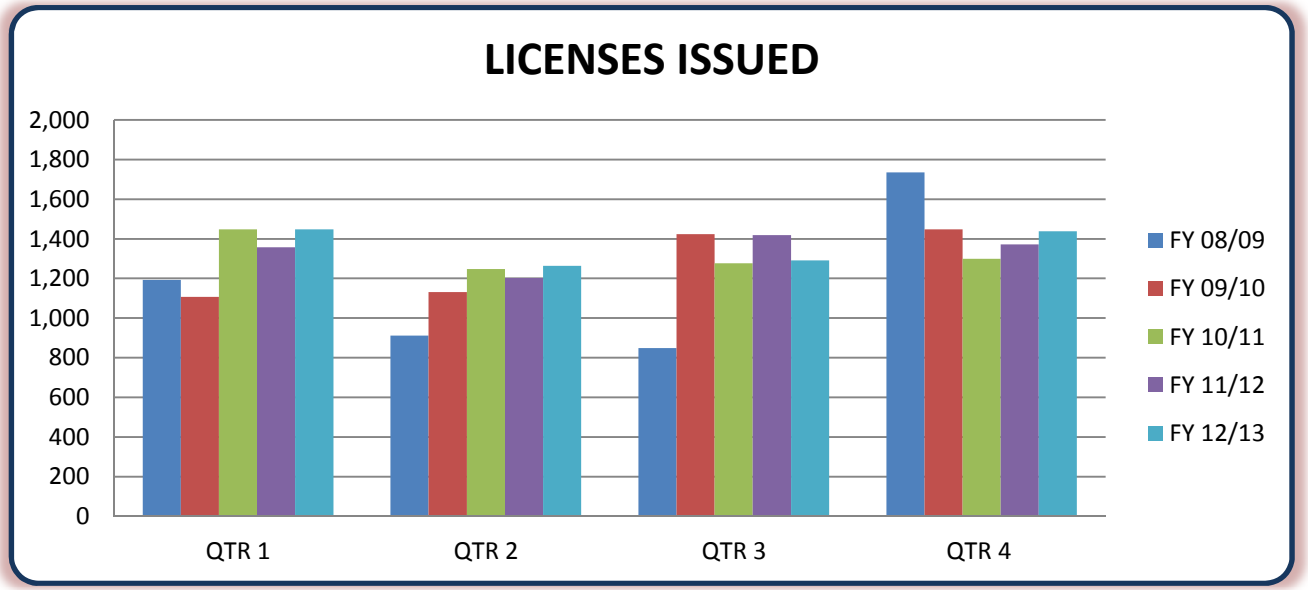
2168 - Special Faculty Permit (academically eminent; unrestricted practice within sponsoring medical school - not eligible for licensure)

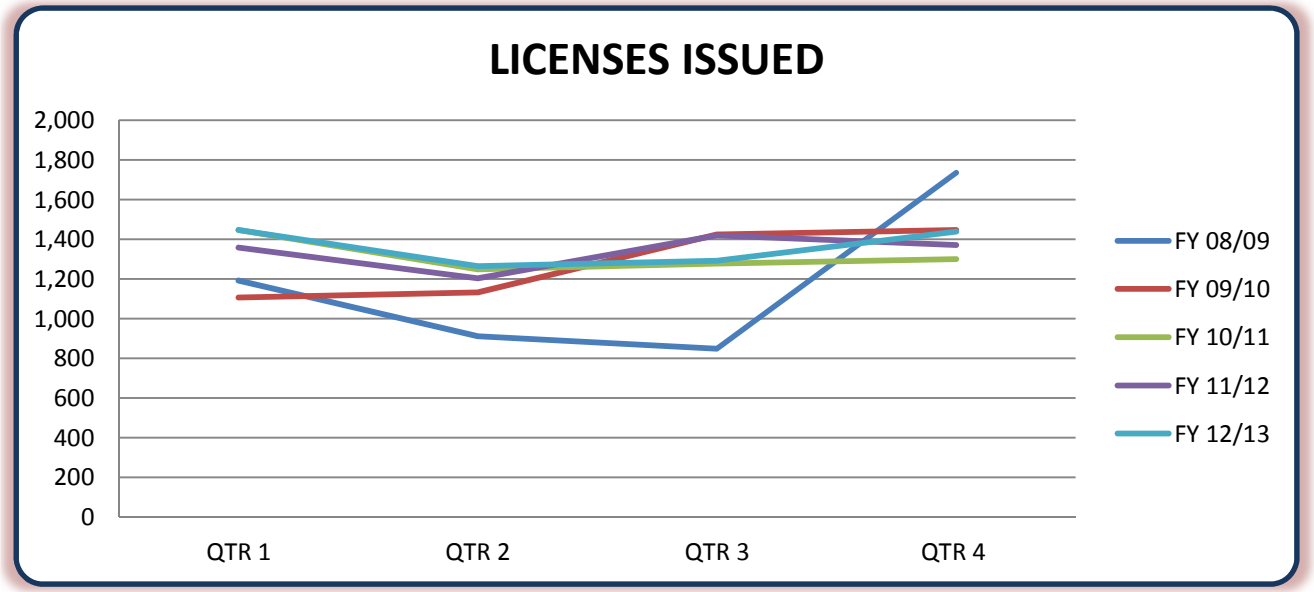
2072 - Special Permit - Correctional Facility

1327 - Medical Student Rotations - Non-ACGME Hospital Rotation

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

Fiscal Year	QTR 1	QTR 2	QTR 3	QTR 4	TOTAL
FY 12/13	1,447	1,264	1,291	1,438	***5,440***
FY 11/12	1,358	1,203	1,419	1,371	***5,351***
FY 10/11	1,447	1,248	1,277	1,300	***5,272***
FY 09/10	1,107	1,132	1,424	1,447	***5,110***
FY 08/09	1,192	912	849	1,735	***4,688***

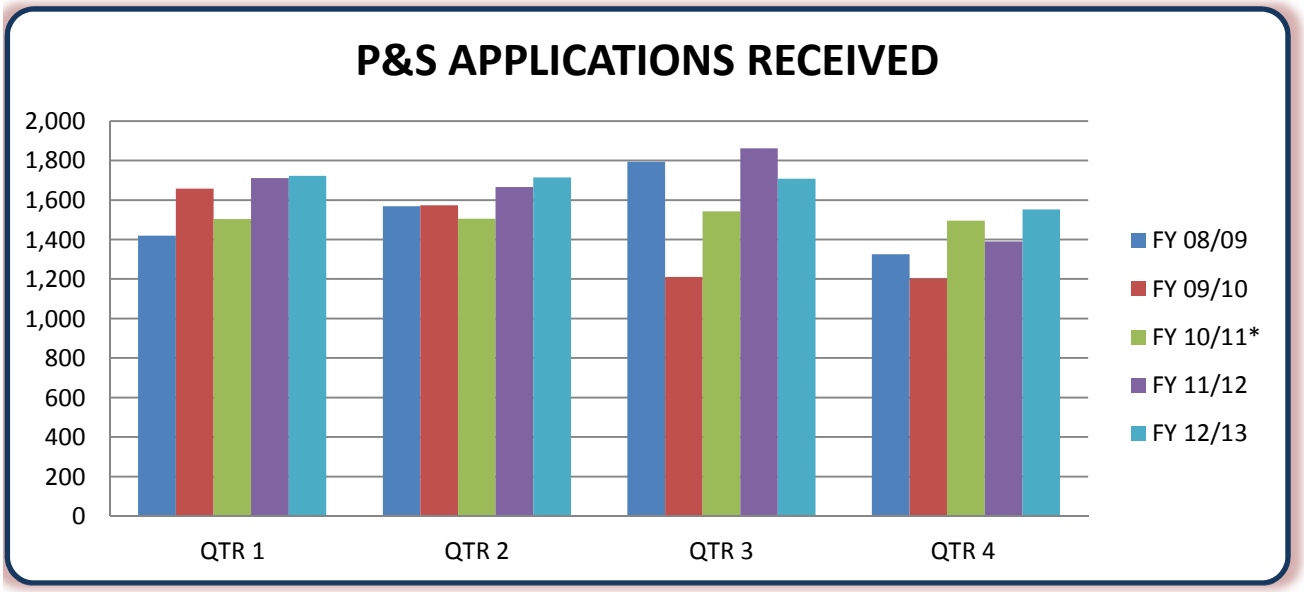


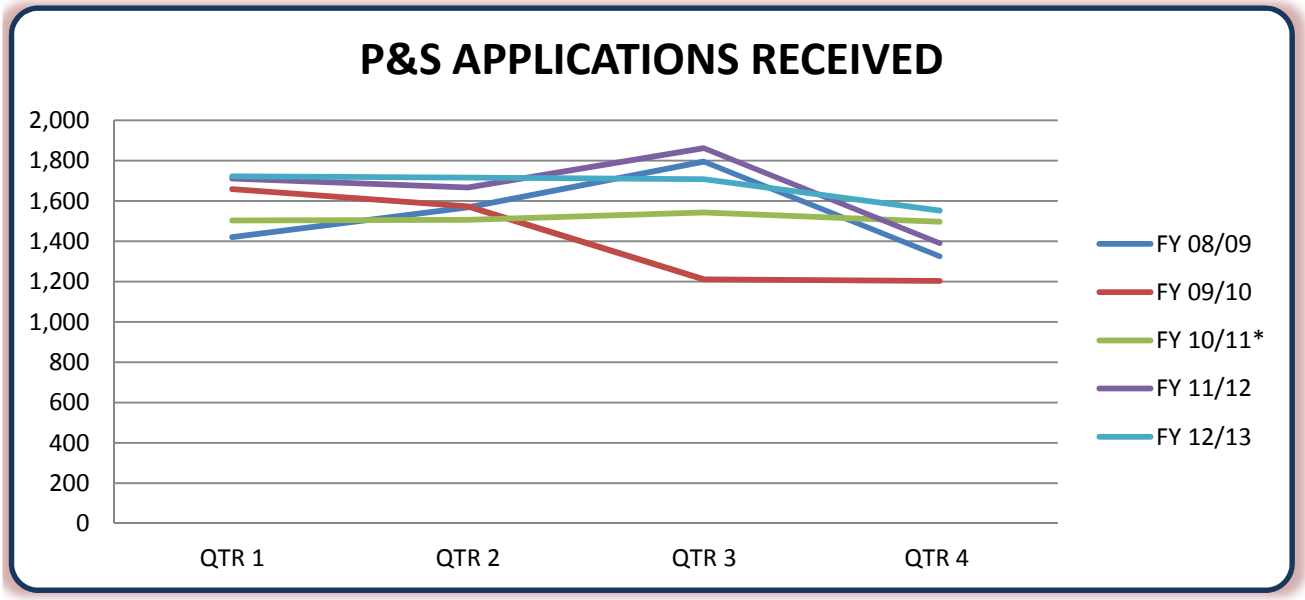


***PHYSICIAN'S AND SURGEON'S LICENSE AND PTAL APPLICATIONS RECEIVED**
Five Fiscal Year History

Fiscal Year	QTR 1	QTR 2	QTR 3	QTR 4	TOTAL
FY 12/13	1,722	1,715	1,708	1,552	***6,697***
FY 11/12	1,711	1,666	1,862	1,390	***6,629***
FY 10/11*	1,503	1,505	1,543	1496	***6,047***
FY 09/10	1,658	1,573	1,211	1,203	***5,645***
FY 08/09	1,420	1,568	1,794	1,325	***6,107***

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





WORKLOAD REPORT
as of July 19, 2013

Fiscal Year - 2012/2013

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

	FY 12/13	Q1	Q2	Q3	Q4
Number of Weeks 45 Day Initial Review Goal Not Met	**0**	0	0	0	0
Number of Weeks Per Quarter / Total Weeks	**52**	13	13	13	13
Highest # of Days Initial Review Goal Exceeded	**N/A**	0	0	0	0

Fiscal Year - 2011/2012

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

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

WORKLOAD REPORT
as of July 19, 2013

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

Fiscal Year - 2012/2013

2012 - 2013 -->	Applications Received (License & PTAL)					Percentage				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
US/CAN	975	1,165	1,251	913	4,304	56.62%	67.93%	73.24%	58.83%	64.27%
IMG - License	269	270	291	287	1,117	15.62%	15.74%	17.04%	18.49%	16.68%
IMG - PTAL	478	280	166	352	1,276	27.76%	16.33%	9.72%	22.68%	19.05%
TOTAL	1,722	1,715	1,708	1,552	6,697	100.00%	100.00%	100.00%	100.00%	100.00%

2012 - 2013 -->	Licenses & PTAL Issued					Percentage				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
US/CAN	1,037	953	990	1,115	4,095	71.67%	75.40%	76.68%	77.54%	75.28%
IMG - License	239	198	220	270	927	16.52%	15.66%	17.04%	18.78%	17.04%
PTAL - License	171	113	81	53	418	11.82%	8.94%	6.27%	3.69%	7.68%
TOTAL	1,447	1,264	1,291	1,438	5,440	100.00%	100.00%	100.00%	100.00%	100.00%
Total PTAL Issued	427	326	246	311	1,310					

Fiscal Year - 2011/2012

2011 - 2012 -->	Applications Received (License & PTAL)					Percentage				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
US/CAN	984	1,196	1,300	794	4,274	57.51%	71.79%	69.82%	57.12%	64.47%
IMG - License	271	243	337	352	1,203	15.84%	14.59%	18.10%	25.32%	18.15%
IMG - PTAL	456	227	225	244	1,152	26.65%	13.63%	12.08%	17.55%	17.38%
TOTAL	1,711	1,666	1,862	1,390	6,629	100.00%	100.00%	100.00%	100.00%	100.00%

2011 - 2012 -->	Licenses & PTAL Issued					Percentage				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
US/CAN	969	888	1,131	1,023	4,011	71.35%	73.82%	79.70%	74.62%	74.96%
IMG - License	389	315	288	348	1,340	28.65%	26.18%	20.30%	25.38%	25.04%
TOTAL	1,358	1,203	1,419	1,371	5,351	100.00%	100.00%	100.00%	100.00%	100.00%
Total PTAL Issued	338	349	204	324	1,215					

REQUESTS FOR NEW SCHOOL CODES
IMG Applicants

COUNTRY	Medical School Name	Date Request Received	Letter Mailed to Medical School	Medical School Response	Status of Application	CCR 1314.1(a)(1)	Chief & Legal Approval (Per CCR 1314.1(a)(1)	Self Assessment Report Received	CCR 1314.1(a)(2)	Comments/Decision
Algeria	Universite Mouloud Mammeri de Tizi-Ouzou Faculty of Medicine	10/20/2011	3/14/2012 Resent on 6/27/2013		Pending	?			?	Letter sent on 3/14/12 and resent on 6/27/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Argentina	Instituto Universitario CEMIC Escual de Medicina	6/27/2013	7/2/2013		Pending	?			?	Letter sent on 7/2/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Argentina	Universidad Abierta Interamericana Facultad de Medicina y Ciencias de la Salud	2/18/2013	3/4/2013		Pending	?			?	Letter sent on 3/4/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Armenia	Yerevan State Medical Institute (now Yerevan State Medical University)	10/21/2012	10/22/2012	5/7/2013	Recognized	X	5/9/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Australia	Queensland University (QU) - Australia U.S. Branch Campus	10/29/2010	1/18/2013		Pending			1/17/2012	X	Medical Consultant completed review of SAR on 4/16/13. Recommendations to be made at 7/19/13 Board Meeting.
Bangladesh	University of Dhaka, Medical College for Women & Hospital	10/21/2011	3/12/2012 6/19/2012	5/29/2012	Pending	?			?	Letter sent on 6/19/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Belarus	Gomel State Medical University	4/25/2013	4/30/2013		Pending	?			?	Letter sent on 4/30/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Bolivia	Universidad Privada del Valle Facultad de Ciencias de la Salud	5/2/2012	5/9/2012 5/29/2012	5/18/2012	Pending				X	School informed on 5/29/12 they will need to submit Self-Assessment Report since the school is a private, for profit university.
Brazil	Faculdade de Ciencias Medicas de Minas Gerais (FCMMG)	8/21/2012	8/27/2012		Pending	?			?	Letter sent on 8/27/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Brazil	Faculdade de Medicina de Itajuba (FMIT)	7/1/2011	9/21/2011 1/13/2012		Pending	?			?	Letter sent on 1/13/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Brazil	Universidade Estacio de Sa (UNESA) Faculdade de Medicina	2/1/2012	3/27/2012 11/6/2012 12/14/2012	10/29/2012 11/26/2012	Pending				X	School informed on 12/14/12 they will need to submit Self-Assessment Report since the school is a private, for profit university.
Brazil	Universidade Estadual de Ciências da Saúde de Alagoas (UNCISAL) Faculdade de Medicina	3/21/2013	3/21/2013 6/7/2013	6/25/2013	Recognized	X	7/3/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Brazil	Universidade Federal de Alagoas (UFAL) Faculdade de Medicina	5/22/2013	5/22/2013		Pending	?			?	Letter sent on 5/22/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).

REQUESTS FOR NEW SCHOOL CODES
IMG Applicants

COUNTRY	Medical School Name	Date Request Received	Letter Mailed to Medical School	Medical School Response	Status of Application	CCR 1314.1(a)(1)	Chief & Legal Approval (Per CCR 1314.1(a)(1)	Self Assessment Report Received	CCR 1314.1(a)(2)	Comments/Decision
Brazil	Universidade Federal do Estado do Rio de Janeiro (UNIRIO) Escola de Medicina e Cirurgia	3/1/2013	3/20/2013		Pending	?			?	Letter sent on 3/20/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Brazil	Universidade Sao Francisco (USF) Faculdade de Ciencias Medicas	12/1/2011	4/13/2012		Pending	?			?	Letter sent on 4/13/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Bulgaria	Medical University - Pleven Faculty of Medicine	4/30/2013	4/30/2013	6/12/2013	Recognized	X	6/14/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Bulgaria	Medical University Prof. Dr. Paraskev Stoyanov Varna	6/10/2011	3/22/2012		Pending	?			?	Letter sent on 3/22/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Bulgaria	Medical University, Sofia Faculty of Medicine	1/20/2013	1/22/2013		Pending	?			?	Letter sent on 1/22/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
China	Anhui Medical University Faculty of Medicine	10/12/2011	3/20/2012		Pending	?			?	Letter sent on 3/20/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
China	Chengdu University of Traditional Chinese Medicine	4/15/2013	4/29/2013	6/20/2013	Recognized	X	7/3/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
China	Fujian Medical University Faculty of Medicine	2/21/2013	3/4/2013 resent on 5/9/2013	6/12/2013	Recognized	X	6/14/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
China	HuBei University of Medicine	6/19/2012	6/19/2012		Pending	?			?	Letter sent on 6/19/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
China	Jilin University, Norman Bethune College of Medicine	7/19/2012	7/25/2012		Pending	?			?	Letter sent on 7/25/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
China	Liaoning Medical University College of Clinical Medicine	3/19/2013	3/20/2013		Pending	?			?	Letter sent on 3/20/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
China	Peking University Health Science Center	6/15/2011	3/22/2012		Pending	?			?	Letter sent on 3/22/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
China	Shanxi Medical University	11/27/2012	1/22/2013		Pending	?			?	Letter sent on 1/22/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
China	Xi'an Jiaotong University College of Medicine	6/21/2010	4/9/2012		Pending	?			?	Letter sent on 4/9/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).

REQUESTS FOR NEW SCHOOL CODES
IMG Applicants

COUNTRY	Medical School Name	Date Request Received	Letter Mailed to Medical School	Medical School Response	Status of Application	CCR 1314.1(a)(1)	Chief & Legal Approval (Per CCR 1314.1(a)(1)	Self Assessment Report Received	CCR 1314.1(a)(2)	Comments/Decision
Colombia	Universidad de Ciencias Aplicadas y Ambientales	2/14/2013	3/4/2013		Pending	?			?	Letter sent on 3/4/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Czech Republic	Charles University 2nd Faculty of Medicine	12/17/2012			Pending			12/17/2012	X	Staff needs to review Self-Assessment Report
Dominican Republic	Pontificia Universidad Catolica Madre y Maestra Facultad de Ciencias de la Salud	8/1/2012	8/1/2012 Resent 4/5/2013 5/3/2013	4/23/2013	Recognized	X	5/21/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Dominican Republic	Universidad Católica Nordestana (UCNE) Escuela de Medicina	5/22/2013	5/22/2013		Pending	?			?	Letter sent on 5/22/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Dominican Republic	Universidad Iberoamericana (UNIBE)	08/22/2008	3/12/2012		Pending			8/22/2008	X	Additional information was requested from UNIBE on 3/12/12 based on medical consultant's review of self-assessment report.
Egypt	Beni Suef University Faculty of Medicine	6/24/2013	6/26/2013		Pending	?			?	Letter sent on 6/26/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Egypt	October 6 University, Faculty of Medicine	9/27/2011	5/8/2013		Pending			9/26/2011	X	New SAR requested from school on 5/8/13; original not numbered or organized according to SAR format.
Egypt	Tanta University Faculty of Medicine	6/8/2012	6/26/2012		Pending	?			?	Letter sent on 6/26/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
England	University of London,King's College London School of Medicine	2/26/2013	3/4/2013 4/29/2013	4/15/2013 5/9/2013	Recognized	X	5/9/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Georgia	Tbilisi Medical Institute 'Vita'	6/22/2011	4/11/2012 10/10/2012 11/15/2012	9/10/2012 11/15/2012	Pending				X	School informed on 11/15/12 they will need to submit Self-Assessment Report since the school is a private, for profit university.
Germany	Medizinische Hochschule Hannover	11/09/2012	11/13/2012		Pending	?			?	Letter sent on 11/13/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Germany	Otto-von-Guericke Universität Magdeburg Medizinische Facultät	4/29/2013	4/29/2013		Pending	?			?	Letter sent on 4/29/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Germany	Univeritaet Leipzig Faculty of Medicine	9/6/2012	9/12/2012 6/21/2013 (Email)	6/21/2013	Pending	?			?	School submitted handwritten response on Board's original correspondence. On 6/21/13, requested school to resubmit formal typed response on school letterhead.
Germany	Universität Rostock Medizinische Facultät	4/29/2013	4/29/2013		Pending	?			?	Letter sent on 4/29/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).

REQUESTS FOR NEW SCHOOL CODES
IMG Applicants

COUNTRY	Medical School Name	Date Request Received	Letter Mailed to Medical School	Medical School Response	Status of Application	CCR 1314.1(a)(1)	Chief & Legal Approval (Per CCR 1314.1(a)(1)	Self Assessment Report Received	CCR 1314.1(a)(2)	Comments/Decision
Ghana	Kwame Nkrumah University of Science & Technology	11/5/2012	11/8/2012		Pending	?			?	Letter sent on 11/8/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Haiti	Université Notre Dame d'Häiti Faculté de Médicine	9/06/2012	9/12/2012 10/10/2012	10/2/2012	Pending	?			?	School submitted handwritten response on Board's original correspondence. On 10/10/12 requested school to resubmit formal typed response on school letterhead.
India	Baba Farid University of Health Sciences, Government Medical College, Amritsar Guru Nanek Dev University, Government Medical College Amritsar	1/14/2011	3/20/2013		Recognized	X	5/2/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
India	Dr. Babasaheb Ambedkar Marathwada University, Government Medical College Aurangabad	10/31/2012	11/8/2012		Pending	?			?	Letter sent on 11/8/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Karnatak University, Karnataka Institute of Medical Sciences	10/7/2011	3/16/2012 Resent 4/5/2013	4/20/2013	Recognized	X	5/2/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
India	Kerala University of Health and Applied Sciences, Dr. Somervell Memorial CSI Medical College & Hospital	2/6/2013	3/4/2013	7/3/2013	Recognized	X	7/3/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
India	Maharashtra University of Health Sciences, JMF's A.C.P.M. Medical College	8/28/2012	9/12/2012		Pending	?			?	Letter sent on 9/12/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Maharashtra University of Health Sciences, Rajarshi Chhatrapati Shau Maharaj Government Medical College Kolhapur	8/9/2012	8/9/2012		Pending	?			?	Letter sent on 8/9/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Maharashtra University of Health Sciences, Shri Bhausahab Hire Government Medical College	5/1/2012	5/1/2012		Pending	?			?	Letter sent on 5/1/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Mahatma Gandhi University, Malankara Orthodox Syrian Church Medical College	2/24/2011	3/16/2012		Pending	?			?	Letter sent on 3/16/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	NTR University of Health Sciences, Rangaraya Medical College, Kakinada	11/5/2012	11/8/2012	6/28/2013	Recognized	X	7/3/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
India	Pt. B.D. Sharma University, Maharaja Agrasen Medical College (previously affilicated with Maharshi Dayanand University)	5/2/2013	5/3/2013		Pending	?			?	Letter sent on 5/3/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Rajiv Gandhi University of Health Sciences, Al-Ameen Medical College	3/28/2012	4/30/2012		Pending	?			?	Letter sent on 4/30/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Rajiv Gandhi University of Health Sciences, Dr. B.R. Ambedkar Medical College	2/5/2013	3/4/2013 3/18/2013 (resent via email)	5/2/2013	Recognized	X	5/9/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).

REQUESTS FOR NEW SCHOOL CODES
IMG Applicants

COUNTRY	Medical School Name	Date Request Received	Letter Mailed to Medical School	Medical School Response	Status of Application	CCR 1314.1(a)(1)	Chief & Legal Approval (Per CCR 1314.1(a)(1)	Self Assessment Report Received	CCR 1314.1(a)(2)	Comments/Decision
India	Rani Durgavati Vishwavidyalaya University (formerly Jabalpur University), Netaji Chandra Bose Medical College	11/26/2012	11/27/2012 Resent 2/26/2013		Pending	?			?	Letter sent on 11/27/12 and 2/26/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Tamil Nadu Dr. M.G.R. Medical University, K.A.P. Vishwanathan Government Medical College	6/2/2011	3/15/2012 Resent on 1/22/2013		Pending	?			?	Letter sent on 3/15/12 and 1/22/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Tamil Nadu Dr. M.G.R. Medical University, Institute of Road Transport Perundurai Medical College	4/18/2013	4/24/2013		Pending	?			?	Letter sent on 4/24/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Tamil Nadu Dr. M.G.R. University, Stanley Medical College	8/28/2012	9/12/2012		Pending	?			?	Letter sent on 9/12/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	University of Kashmie, Jehlum Valley College of Medical Sciences	8/10/2011	3/20/2012 Resent 6/27/2013		Pending	?			?	Letter sent on 3/20/12 and 6/27/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
India	Vinayaka Mission's University, Vinayaka Mission's Kirupananda Variyar Medical College, Salem	4/1/2013			Recognized	X	4/4/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
India	Vinayaka Mission's University, Aarupadai Veedu Medical College, Pondicherry	4/1/2013			Recognized	X	4/4/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
India	West Bengal University of Health Sciences, Kolkata Medical College & Hospital	4/8/2013	4/11/2013		Pending	?			?	Letter sent on 4/11/13 to the medical school requesting information to determine eligibility for recogntion pursuant to CCR 1314.1(a)(1).
India	West Bengal University of Health Sciences, Nilratan Sircar Medical College	7/19/2011	4/5/2012		Pending	?			?	Letter sent on 4/5/12 to the medical school requesting information to determine eligibility for recogntion pursuant to CCR 1314.1(a)(1).
Iran	Golestan University of Medical Education & Health Services	6/9/2011	3/26/2012		Pending	?			?	Letter sent on 3/26/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Iran	Islamic Azad University, Ardabil Branch Faculty of Medicine	8/20/2012	8/27/2012 5/3/2013	3/19/2013	Pending	?			?	Letter sent on 5/3/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Iraq	Al-Anbar University College of Medicine	10/19/2011	4/5/2012		Pending	?			?	Letter sent on 4/5/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Iraq	Kufa University College of Medicine	3/7/2013	3/21/2013		Pending	?			?	Letter sent on 3/21/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).

REQUESTS FOR NEW SCHOOL CODES
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Iraq	University of Tikrit College of Medicine	3/20/2013	3/21/2013		Pending	?			?	Letter sent on 3/21/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Ireland	University of Dublin, Trinity College Dublin School of Medicine	9/17/2012	10/12/2012 2/26/2013	5/15/2013	Recognized	X	5/28/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Israel	Bar-Ilan University Faculty of Medicine in Galilee	6/3/2013	6/6/2013		Pending	?			?	Letter sent on 6/6/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Japan	Ehime University School of Medicine	6/8/2012	6/19/2012		Pending	?			?	Letter sent on 6/19/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Japan	Faculty of Medicine, University of Miyazaki	10/6/2010	3/20/2012		Pending	?			?	Letter sent on 3/20/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Japan	Kansai Medical University	6/23/2010	3/22/2012 9/7/2012 1/18/2013 4/14/2013	8/23/2012 11/20/2012	Pending	?			?	Initial review completed by staff 9/6/12. Additional information requested from school on 9/7/12, 1/18/13, and 4/14/13.
Japan	Kawasaki Medical School	8/9/2012	8/9/2012		Pending	?			?	Letter sent on 8/9/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Japan	Kyorin University School of Medicine	2/17/2012	3/13/2012 7/13/2012	7/6/2012 4/1/2013	Recognized	X	4/4/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Kazakhstan	Karaganda State Medical Academy	8/25/2010	3/9/2012		Pending	?			?	Letter sent on 3/9/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Libya	Benghazi Medical University	6/20/2012	6/26/2012		Pending	?			?	Letter sent on 6/26/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Libya	University of Tripoli (formerly Al Fateh Faculty of Medicine)	2/1/2013	2/5/2013	3/11/2013	Recognized	X	4/4/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Malaysia	Manipal University, Melaka-Manipal Medical College	6/10/2011	4/11/2012		Pending	?			?	Letter sent on 4/11/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Mexico	Benemerita Universidad Autonoma de Puebla Escuela de Medicina	10/1/2012	10/11/2012 3/5/2013	12/12/12	Pending	?			?	Recognition rescinded as of 6/29/13 based on school's refusal to provide requested information.
Nepal	Universal College of Medical Sciences, Paklihawa Campus	7/15/2011	10/29/2012		Pending			7/15/2011	X	Additional information requested from school on 10/29/12 based on staff's initial review of Self-Assessment Report.

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COUNTRY	Medical School Name	Date Request Received	Letter Mailed to Medical School	Medical School Response	Status of Application	CCR 1314.1(a)(1)	Chief & Legal Approval (Per CCR 1314.1(a)(1)	Self Assessment Report Received	CCR 1314.1(a)(2)	Comments/Decision
Neves	Medical University of the Americas	3/19/2012	3/19/2013	4/9/2013	Pending			3/19/2012	X	Initial review completed by staff. Medical consultant review of Self-Assessment Report to commence on 8/1/13.
Pakistan	Foundation University Medical College	5/29/2012	6/26/2013		Pending			5/29/2012	X	Additional information requested from school on 6/26/13 based on staff's initial review of Self Assessment Report.
Pakistan	University of Health Sciences Lahore, Nishtar Medical College and Hospital (NMCH)	9/1/2010	5/17/2011 5/21/2012	7/19/2011	Pending	?			?	Letter sent on 5/21/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Pakistan	University of Karachi, Jinnah Medical and Dental College	2/13/2013	3/4/2013	3/11/2013	Recognized	X	4/4/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Pakistan	University of the Punjab, Fatima Jinnah Medical College for Women	6/26/2012	6/26/2012		Pending	?			?	Letter sent on 6/26/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Peru	Universidad Nacional Mayor de San Marcos Facultad de Medicina	7/26/2012	8/2/2012		Pending	?			?	Letter sent on 8/2/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Peru	Universidad Peruana de Ciencias Aplicadas Escuela de Medicina	6/7/2013	6/10/2013		Pending	?			?	Letter sent on 6/10/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Peru	Universidad Privada de Tacna Facultad de Ciencias de la Salud	4/22/2013	4/29/2013		Pending	?			?	Letter sent on 4/29/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Philippines	Ateneo De Manila University School of Medicine and Public Health	4/23/2013	4/29/2013		Pending	?			?	Letter sent on 4/29/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Philippines	Silliman University Medical School	11/28/2012	6/28/2013		Pending			11/28/2012	X	Additional information requested from school on 6/28/13 based on staff's initial review of Self Assessment Report.
Philippines	University of the Philippines Manila College of Medicine	3/4/2013	3/20/2013		Pending	?			?	Letter sent on 3/20/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Russia	Far Eastern State Medical University (Previously known at Khabarovsk State Medical Insitute)	10/15/2012	11/8/2012	5/17/2013	Recognized	X	6/14/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Russia	Saint Petersburg I.P. Pavlov State Medical University of the Federal Agency of Health and Human Development	5/9/2013	5/14/2013		Pending	?			?	Letter sent on 5/14/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Russia	Smolensk State Medical Academy	6/11/2013	6/11/2013		Pending	?			?	Letter sent on 6/11/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Russia	Ural State Medical Academy / Sverdlovsk State Medical Institute	10/2/2012	10/12/2012		Pending	?			?	Letter sent on 10/12/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).

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Saudi Arabia	University of Dammam College of Medicine	12/14/2012	1/22/2013	3/20/2013	Recognized	X	4/4/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Senegal	Cheikh Anta Diop University, Faculty of Medicine, Pharmacy and Odontology	3/27/2012	5/18/2012 5/14/2013	5/6/2013 6/7/2013	Recognized	X	6/14/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Serbia	University of Nis Faculty of Medicine	11/26/2012	11/27/2012	2/1/2013	Recognized	X	5/2/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Sierra Leone	University of Sierra Leone College of Medicine & Allied Health Sciences	10/6/2010	3/9/2012		Pending	?			?	Letter sent on 3/9/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Slovak Republic	Jesseniova Lekárska Fakulta v Martine, Univerzita Komenského	6/14/2013	6/26/2013		Pending	?			?	Letter sent on 6/26/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
South Korea	Inha University College of Medicine	2/29/2012	4/5/2012 Resent on 4/11/2013	06/06/2013	Recognized	X	6/14/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
South Korea	Konkuk University College of Medicine	10/31/2011	4/5/2012 6/19/2012 Resent on 3/14/2013	6/13/2012 4/30/2013	Recognized	X	5/28/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
South Korea	Konyang University College of Medicine	6/21/2013	6/26/2013		Pending	?			?	Letter sent on 6/26/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
South Korea	Sungkyunkwan University School of Medicine	3/11/2013	4/20/2013	4/5/2013	Recognized	X	5/2/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Spain	Universidad Miguel Hernández Facultad de Medicina	9/12/2012	9/12/2012 Resent on 12/7/2012	5/6/2013	Recognized	X	5/9/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Sudan	International University of Africa Faculty of Medicine & Health Sciences	11/19/2012	11/27/2012		Pending	?			?	Letter sent on11/27/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Syria	Al-Baath University Faculty of Medicine	3/10/2011	4/12/2012 Resent on 2/26/2013	4/15/2013	Recognized	X	5/2/2013			Chief/Legal Counsel verified medical school is eligible for recognition pursuant to CCR 1314.1(a)(1).
Tajikstan	Avicenna Tajik State Medical University	5/10/2013	5/14/2013		Pending	?			?	Letter sent on 5/14/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Taiwan	National Yang-Ming University School of Medicine	4/25/2013	4/29/2013		Pending	?			?	Letter sent on 4/29/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).

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Turkey	Gulhane Askeri Tip Akademisi (Gulhane Medical Military Academy)	4/12/2012	4/13/2012		Pending	?			?	Letter sent on 4/13/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Ukraine	M. Gorky Donetsk National Medical University	7/8/2011	4/9/2012		Pending	?			?	Letter sent on 4/9/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Ukraine	O.O. Bogomolets National Medical University	4/29/2013	4/29/2013		Pending	?			?	Letter sent on 4/29/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Ukraine	Zaporozhye State Medical University	2/25/2013	3/4/2013		Pending	?			?	Letter sent on 3/4/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
United Arab Emirates	Gult Medical University	4/15/2013			Pending			4/15/2013	X	Staff needs to review Self-Assessment Report
Uzbekistan	M.I. Kalinin Andizhan State Medical Institute	6/12/2012	6/26/2012		Pending	?			?	Letter sent on 6/26/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Venezuela	Universidad Central de Venezuela Escuela de Medicina Luis Razetti	3/22/2012	3/22/2012 1/22/2013 2/26/2013		Pending	?			?	Letter sent on 3/22/12 and resent on 1/22/13 and 2/26/13 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1)
Vietnam	Can Tho University School of Medicine and Pharmacy	7/30/2010	4/16/2012		Pending	?			?	Letter sent on 4/16/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).
Zimbabwe	University of Zimbabwe College of Health Sciences, Godfrey Huggins School of Medicine	8/28/2012	8/28/2012		Pending	?			?	Letter sent on 8/28/12 to the medical school requesting information to determine eligibility for recognition pursuant to CCR 1314.1(a)(1).

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: July 2, 2013
ATTENTION: Board Members
SUBJECT: Outpatient Surgery Setting Task Force Update and Requested Action
STAFF CONTACT: Curt Worden/Kimberly Kirchmeyer

REQUESTED ACTION:
Approve the Task Force's recommendation for a legislative proposal to require accredited outpatient surgery settings to submit adverse event reports to the Medical Board of California (Board) and authorize the Board the authority to issue a penalty to the outpatient surgery setting that does not submit the required report.

BACKGROUND AND ANALYSIS:
On June 25, 2013 the Outpatient Surgery Setting (OSS) Task Force met in Sacramento to: review and discuss the Board's Web site, specifically the OSS section; to discuss the core standards and additional standards required by the accreditation agencies and determine if additional standards are needed; and to discuss the adverse event reporting as required in law. The Board's OSS Task Force consists of Board Members Janet Salomonson, M.D. and Dev Gnanadev, M.D.

The OSS Task Force provided several suggested edits to the Board's Web site, including making edits and clarifications to the initial page for the OSS Program, requesting the ability to search for an OSS by city, and other minor changes that will enhance the Web site and make it more understandable. The Board staff will be working on these changes and those that do not require programmatic changes will be completed prior to the next OSS Task Force meeting and programmatic changes should be done before the Board Meeting in October.

The OSS Task Force also reviewed the list of core standards required by the accreditation agencies. Overall, the Members felt the core standards, as required in the Board's laws and regulations, provide the necessary consumer protection. However, the Members did feel that a few changes need to be made to existing statutes. The Members had some clarifying questions that they requested be provided by the accreditation agencies. Staff will be working to obtain that additional information prior to the next Task Force meeting. Once this information is received, the Members will be able to meet and make a recommendation to the Board on changes to the current laws and regulations.

Lastly, the Task Force discussed the adverse event reporting as required by Health and Safety (H&S) Code section 1248.15(h). This section subjects each OSS to the reporting requirements of H&S Code section 1279.1 and to penalties for failure to report specified in H&S Code section 1280.4. These sections, which are under the authority of the California Department of Public Health (CDPH), require the adverse event reports be submitted to the CDPH and authorize the CDPH to issue a citation for failing to report. OSSs that are only accredited by the Board have no relationship with the CDPH, and these sections of law do not authorize the Board to receive these reports.

Although the Board has been in discussion with the CDPH to try and obtain the information that has been submitted to it, the Board has been unsuccessful in procuring any information that could be used to initiate an investigation. The CDPH, in conjunction with the Center for Medicare and Medicaid Services (CMS), has stated that the information cannot be submitted to the Board. Although there is a process whereby the Board could petition CMS for the necessary information, such as patient name,

physician name, etc., the Board would have to submit a request for each report, would not receive the information until after the CDPH investigation is completed (which could take a significant amount of time), and the request may be denied by CMS.

Reports that are submitted to CDPH for facilities that are not licensed by CDPH or certified by CMS currently are not being investigated, as the CDPH has no authority over these facilities. Therefore, the Board believes it is necessary to change the law to require adverse event reports on accredited OSSs be submitted to the Board, and not CDPH. Additionally, due to H&S Code section 1280.4 only authorizing the CDPH to issue a civil penalty, the Board would need to have authority to issue penalties to entities that do not report to the Board.

The Task Force Members have reviewed this issue and support the proposal to seek legislation to require accredited OSSs to submit adverse event reports to the Board and to authorize the Board to issue a penalty to the OSS for failing to report.

Required and Additional Accreditation Standards by Approved Accreditation Agency

	California Health and Safety Code	Medical Board of California - Accreditation Standards	AAAASF	AAAHC	IMQ	JC
1	HSC 1248.15(a)(1)	Outpatient setting allied health staff shall be licensed or certified to the extent required by state or federal law.	X	X	X	X
2	HSC 1248.15(a)(2)(A)	Outpatient settings shall have a system for facility safety and emergency training requirements.	X	X	X	X
3	HSC 1248.15(a)(2)(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.	X	X	X	X
4	HSC 1248.15(a)(2)(C)(i)	Have a written transfer agreement with a local accredited or licensed acute care hospital, approved by the facility's medical staff	X	X	X	X
5	HSC 1248.15(a)(2)(C)(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.	X	X	X	X
6	HSC 1248.15(a)(2)(C)(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.	X	X	X	X
7	HSC 1248.15(a)(2)(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:	X	X	X	X
8	HSC 1248.15(a)(2)(D)(i)	Notify the individual designated by the patient to be notified in case of an emergency.	X	X	X	X
9	HSC 1248.15(a)(2)(D)(ii)	Ensure that the mode of transfer is consistent with the patient's medical condition.	X	X	X	X
10	HSC 1248.15(a)(2)(D)(iii)	Ensure that all relevant clinical information is documented and accompanies the patient at the time of transfer.	X	X	X	X
11	HSC 1248.15(a)(2)(D)(iv)	Continue to provide appropriate care to the patient until the transfer is effectuated	X	X	X	X

	California Health and Safety Code	Medical Board of California - Accreditation Standards	AAAASF	AAAHC	IMQ	JC
12	HSC 1248.15(a)(2)(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.	X	X	X	X
13	HSC 1248.15(a)(4)	Outpatient settings shall have a system for maintaining clinical records.	X	X	X	X
14	HSC 1248.15(a)(5)	Outpatient settings shall have a system for patient care and monitoring procedures.	X	X	X	X
15	HSC 1248.15(a)(6)(A)	Outpatient settings shall have a system for quality assessment and improvement.	X	X	X	X
16	HSC 1248.15(a)(6)(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.	X	X	X	X
17	HSC 1248.15(a)(6)(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.	X	X	X	X
18	HSC 1248.15(a)(7)	Outpatient settings regulated by this chapter that have multiple service locations shall have all of the sites inspected.	X	X	X	X
19	HSC 1248.15(a)(8)	Outpatient settings shall post the certificate of accreditation in a location readily visible to patients and staff.	X	X	X	X
20	HSC 1248.15(a)(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.	X	X	X	X
21	HSC 1248.15(a)(10)	Outpatient settings shall have a written discharge criteria.	X	X	X	X

	California Health and Safety Code	Medical Board of California - Accreditation Standards	AAAASF	AAAHC	IMQ	JC
22	HSC 1248.15(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.	X	X	X	X
23	HSC 1248.15(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.	X	X	X	X
24	HSC 1248.15(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.	X	X	X	X
25	HSC 1248.15(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.	X	X	X	X

Required and Additional Accreditation Standards by Approved Accreditation Agency

		Additional Accreditation Standards	AAAASF	AAAHC	IMQ	JC
1a	Patient Rights and Responsibilities	Patients are treated with respect, consideration, dignity, and provided appropriate privacy.	X	X	X	X
2a	Patient Rights and Responsibilities	There is a process for patients to express their concerns and report problems.	X	X	X	X
3a	Patient Rights and Responsibilities	When the need arises, reasonable attempts are made for health care professionals and other staff to communicate in the language or manner primarily used by patients.		X	X	X
4a	Patient Rights and Responsibilities	Patients are provided, to the degree known, information concerning their diagnosis, evaluation, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.	X	X	X	X
5a	Patient Rights and Responsibilities	Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.	X	X	X	X
6a	Patient Rights and Responsibilities	Information is available to patients concerning their rights and responsibilities.	X	X	X	X
7a	Administration	Administrative policies, procedures and controls are established and implemented to ensure the orderly and efficient management of the organization.	X	X	X	X
8a	Administration	Personnel policies are established and implemented to facilitate attainment of the mission, goals, and objectives of the organization.	X	X	X	X
9a	Administration	Records of work injuries or illnesses are maintained, consistent with reporting requirements, and employee health records are managed appropriately.	X	X	X	X
10a	Administration	The physician must report to the accreditation agency within 15 days any transfer to a hospital or emergency center for medical treatment that exceeds 24 hours, any subsequent admission to the hospital, and any occurrence of a death within seven days of a procedure performed at the surgery center.			X	

11a	Administration	Facility must report, within 10 days, any adverse action taken against it by other entities, such as: state departments of public health or other state agencies, the Centers for Medicare & Medicaid Services or other federal entities, and other private accreditation entities.	X (policy)		X	
12a	Administration	Facility must report to the accreditation agency, within 15 days, any significant event.		X		

		Additional Accreditation Standards	AAAASF	AAAHC	IMQ	JC
13a	Administration	Accredited organizations are required to notify the accreditation agency within twenty-four hours of the death of a patient that occurs within 7 days of a procedure, regardless of where the death occurred.			X	
14a	Administration	Any death occurring in an accredited facility, or any death occurring within thirty (30) days of a surgical procedure performed in an accredited facility, must be reported within five (5) business days after the facility is notified or otherwise becomes aware of that death. In addition to this notification, the death must also be reported as an unanticipated operative sequela in the semi-annual Peer Review report. In the event of a death occurring within thirty (30) days of an operation done in an accredited facility, an unannounced inspection may be done by a senior inspector.	X			
15a	Personnel and Credentialing	Physicians using registry nurses or technicians have a responsibility to: a) Confirm identity with a picture ID and keep a copy of the clinical license and ID verification on file; and b) Ensure that verification of licensure, credentials, and competency has been performed by the registry company. The registry contract should specify that the registry has performed these verification responsibilities. Registry staff should also receive orientation. Note: Some registries use “self-assessment” as a means to determine competency. This is not an acceptable form of competency determination.		X	X	X
16a	Personnel and Credentialing	The organization has a fair hearing and appeal process for addressing adverse decisions.	X (policy)	X		X

17a	Personnel and Credentialing	All individuals using the facility must meet one of the following criteria: 1. A Doctor of Medicine certified or eligible for certification by one of the member boards of the American Board of Medical Specialties (ABMS). 2. A Doctor of Osteopathy certified or eligible for certification by the American Osteopathic Association Bureau of Osteopathic Specialists (AOABOS). 3. A podiatrist certified or eligible for certification by the American Board of Podiatric Surgery (ABPS). 4. An oral and maxillofacial surgeon certified or eligible for certification by the American Board of Oral and Maxillofacial Surgery (ABOMS)	X			

		Additional Accreditation Standards	AAAASF	AAAHC	IMQ	JC
18a	Personnel and Credentialing	The Medical Director must be a physician certified or eligible for certification by either an American Board of Medical Specialties (ABMS medical or surgical specialty certifying boards), or by The American Osteopathic Association Bureau of Osteopathic Specialists (AOABS).	X			
19a	Quality of Care	Processes to reduce and avoid medication errors.	X	X	X	X
20a	Quality of Care	The organization has policies and procedures for identifying, storing, and transporting laboratory specimens and biological products. The policies and procedures include logging and tracking to ensure that results for each specimen are obtained and have been reported to the ordering physician in a timely manner.	X	X	X	X
21a	Facilities and Environment	Provide a functionally safe and sanitary environment for its patients, personnel, and visitors.	X	X	X	X
22a	Surgical and Related Services	Policies and procedures should be established and implemented for Laser, Light-Based Technologies, and Other Energy-Emitting Equipment.	X	X	X	X
23a	Surgical and Related Services	Extraction and post-operative care standards governing body liposuction procedures performed in a non-hospital setting.	X		X	X

24a	Surgical and Related Services	Renal lithotripsy services made available by the organization meet the needs of the patients and are provided in accordance with ethical and professional practices as well as legal requirements.		X	X	X
25a	Pharmaceutical Services	Pharmaceutical services provided or made available by an accreditable organization meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements.		X	X	X
26a	Pathology and Medical Laboratory Services	Pathology and medical laboratory services provided or made available by an accreditable organization meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements.	X	X	X	X
27a	Diagnostic and Other Imaging Services	Imaging services, including those used for diagnosing, monitoring, or assisting with procedures provided or made available by an accreditable organization, meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements.	X	X	X	X
28a	Dental Services	Dental services provided or made available by an accreditable organization meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements.	X	X	X	X

		Additional Accreditation Standards	AAAASF	AAAHC	IMQ	JC
29a	Other Professional and Technical Services	Professional and technical services provided or made available by an accreditable organization, even though they are not specifically mentioned, meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements. Services may include, but are not limited to: various medical services, rehabilitation services (physical, occupational, vocational therapy), massage therapy, acupuncture, registered dieticians, aestheticians, audiologists, and other individuals who provide services to patients and may submit separate charges for their services.		X	X	X
30a	Other Professional and Technical Services	Organizations providing travel medicine services will ensure that these services are appropriate to the needs of the patient and are adequately supported by the organization's clinical capabilities.		X	X	
31a	Transplant Safety	The organization uses standardized procedures for managing tissues.		X	X	X
32a	Heath Education and Health Promotion	All health education and health promotion services provided or made available by the organization are appropriate to the needs of the population served.		X	X	X
33a	Behavioral Health Services	Behavioral health services are provided or made available by an accreditable organization to meet the needs of its clients and the population served.		X	X	X

34a	Teaching and Publication Activities	If staff is involved in teaching or publishing, an accreditable organization has policies governing those activities that are consistent with its mission, goals, and objectives.		X		
35a	Research Activities	If research is conducted, an accreditable organization establishes and implements policies governing research that are consistent with its mission, goals and objectives, and with its clinical capabilities.		X		X
36a	Overnight Care and Services	If an accreditable organization provides overnight care (i.e., has patients that are not discharged from the facility on the day they were admitted to the facility) and related services, such care and services meet the needs of the patients served and are provided in accordance with ethical and professional practices and legal requirements.	X	X	X	X
37a	Occupational Health Services	Occupational health services are accurately portrayed to patients, employees and purchasers of the services.		X	X	X
38a	Immediate/Urgent Care Services	If an accreditable organization implies by its activities, advertising, or practices that its primary mission is to provide medical care of an urgent or immediate nature on a non-appointment basis, such care meets the needs of the patients it intends to serve. Such immediate care and urgent care is provided in accordance with ethical and professional practices and adheres to applicable local, state, and federal requirements.		X	X	X
		Additional Accreditation Standards	**AAAASF**	**AAAHC**	**IMQ**	**JC**
39a	Emergency Services	If an accreditable organization implies by its activities, advertising, or practice that it provides emergency services on a regular basis to meet life-, limb-, or function-threatening conditions, such services meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements.		X	X	X
40a	Radiation Oncology Treatment Services	Radiation oncology treatment services provided or made available by an accreditable organization meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements.		X	X	X
41a	Medical Home	The services provided by an accreditable Medical Home are patient-centered, physician, nurse practitioner or physician assistant directed, comprehensive, accessible, continuous, and organized to meet the needs of the individual patients served.		X		X

AGENDA ITEM 26

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	July 11, 2013
ATTENTION:	Medical Board of California
SUBJECT:	Review and Consideration of Request for Approval as an Outpatient Surgery Setting Accreditation Agency; American Osteopathic Association / Healthcare Facilities Accreditation Program
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing

REQUESTED ACTION AND RECOMMENDATION:

The Medical Board of California (Board) Members approve the American Osteopathic Association/Healthcare Facilities Accreditation Program (AOA/HFAP) as a Board approved Outpatient Surgery Setting Accreditation Agency.

AOA/HFAP APPLICATION REVIEW ANALYSIS:

AOA/HFAP submitted an "Application for Approval as an Outpatient Surgery Setting Accreditation Agency" (Attachment 1- Application) with supporting documentation to the Board in late December 2012.

AOA/HFAP has been providing medical facilities with an objective, standards-based review of their services since 1945. In 2003, AOA/HFAP was granted "Deeming Authority" by the Center for Medicare and Medicaid Services (CMS) to conduct accreditation surveys of Ambulatory Surgical Centers, (Outpatient Surgery Settings) for CMS. In addition, AOA/HFAP is a CMS "Deeming Authority" to survey Acute Care Hospitals, Critical Care Hospitals, and hospital and facility laboratories.

Board Staff performed a preliminary review of the AOA/HFAP application and supporting documents for compliance with the criteria established in the Board's statutes and regulations. Board Staff then submitted the AOA/HFAP application and supporting documents, along with Staff's findings for executive level review. Following that review, additional information was requested from AOA/HFAP (Attachment 2).

On July 10, 2013, the Board received AOA/HFAP's response to the Board's request for clarification and additional information (Attachment 3). This new information was reviewed, and as part of that review process, the attached comparison chart (Attachment 4) was prepared substantiating AOA/HFAP's compliance with the established criteria.

STATUTORY/REGULATORY BACKGROUND:

Accreditation Agencies may submit to the Board an "Application for Approval as an Outpatient Surgery Setting Accreditation Agency" to be a Board approved Outpatient Surgery Setting Accreditation Agency with the appropriate application fee. Accreditation Agencies that apply for the Board's approval shall meet the criteria established pursuant to California Health and Safety Code section 1248.15.

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

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

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

FISCAL CONSIDERATIONS:

AOA/HFAP submitted the applicable "Approved Outpatient Surgery Setting Accreditation Agency" application fee. If the Board grants approval to AOA/HFAP, it would be subject to the applicable renewal requirements.

If you have any questions concerning this memorandum, please contact me at (916) 263-2389.

ATTACHMENTS:

1. AOA/HFAP – Redacted Copy of "Application for Approval as an Outpatient Surgery Setting Accreditation Agency," Supporting Documentation Not Included

2. Board Correspondence to AOA/HFAP Requesting Clarification and Additional Information Dated July 1, 2013

3. AOA/HFAP's Response to the Board's Request for Clarification and Additional Information Received July 10, 2013

4. HSC §1248.15 and AOA/HFAP Responses Comparison Chart

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(916) 263-2382 Fax: (916) 263-2487
www.mbc.ca.gov

APPLICATION FOR APPROVAL AS AN OUTPATIENT SURGERY SETTING ACCREDITATION AGENCY

$5000.00 Fee
Please print or type.
All illegible applications will be returned.

FOR OFFICE USE ONLY

Fee Pd _____ Rcpt. No. _____

Date Filed _____ RC No. _____

Date Approved _____

Date Denied _____

Name of Organization applying for approval as Outpatient Surgery Setting Accreditation Agency	American Osteopathic Association/Healthcare Facilities Accreditation Program (AOA/HFAP)	
Address of Organization applying for approval as Outpatient Surgery Setting Accreditation Agency	142 East Ontario Street, Chicago, Illinois 60611	
Telephone and Fax Numbers:	Telephone 312.202.8258	Fax 312.202.8361
Date Organization began to operate as an Accreditation Agency:	1945	
The Organization is a(n): (Check ✓ one box only)	☐ Individual (Sole Proprietor) ☐ Partnership	☐ Group of Individuals ☑ Corporation
Contact Person's Full Name and Title	Joseph L. Cappiello, Chief Operating Officer	
Applicants Social Security Number or Federal Employer ID Number	Federal Employer ID	
Telephone and Fax Numbers: (Contact Person)	Telephone	Fax

Please answer each question listed below by checking either "Yes" or "No". Attach an explanation for any question answered "No". Documentation may be required upon request by the Licensing Program.

Question	Yes	No	Documentation To Be Made Available Upon Request
Does your Organization have accreditation standards for outpatient settings as well as the standards for patient care and safety at the setting?	✓		2 Sets of accreditation standards.
Are your Organization's standards for accreditation developed with the input of the medical community and the ambulatory surgery industry?	✓		2 copies of the Development Process.
Does your Organization have a process by which its accreditation standards are reviewed and revised no less than every three years?	✓		2 copies of the Review Process.
Does your Organization maintain internal management programs to ensure the quality of its outpatient setting accreditation process?	✓		2 copies of the Quality Control Program(s) process.
Does your Organization require outpatient settings that it accredits, to notify it of certain changes (e.g., operation, services, ownership, etc.) with respect to the setting?	✓		2 copies of the Notification Requirements.
Does the Organization maintain an available pool of allied health care practitioners to serve on accreditation review (survey) teams in California?	✓		
Are reviewers (Surveyors) screened and credentialed by your Organization?	✓		2 copies of the Screening and Credentialing Processes.
Does your Organization provide formal education training programs in the evaluation of certification standards that each reviewer (Surveyor) must attend at least every three years?	✓		2 Sets of current Evaluation Training Manuals, and Training Schedule.
Does the composition of each of your Organizations review (survey) team(s) consist of at least one physician and surgeon who practices in an outpatient setting?	✓		2 copies of the Physician & Surgeon Surveyors' Roster (Must include each physician's name, license number, telephone number, field of medical practice, the number of on-site inspections completed, and the date each last attended surveyor training.)

Question	Yes	No	Documentation To Be Made Available Upon Request
Does the composition of your Organization's review (survey) team(s) consist of other allied health care practitioners actively practicing in outpatient setting?	✓		2 copies of the Allied Health Care Practitioners' Roster (must include each individual's name, license number (if applicable), telephone number, field of medical practice, the number of on-site inspections completed, and the date each last attended surveyor training.)
Does your Organization provide its reviewers (surveyors) with printed material to use in the on-site inspection of an outpatient surgery setting?	✓		2 Sets of the Surveyor inspection material, and surveyor instructions for completing an on-site inspection.
Does your Organization issue any type of accreditation certificate to an outpatient surgery setting that passes its on-site inspection and meets with your Organization standards?	✓		2 copies of each type accreditation certificate issued, and accreditation decision process.

California state law precludes an accreditation agency from having an ownership interest in or being involved in the operation of a freestanding outpatient setting or in the delivery of health care services to patients.

1. Does your Organization have an ownership interest in any freestanding outpatient setting?		Yes	x	No
2. Is your Organization involved in the operation of any freestanding outpatient setting?		Yes	x	No
3. Is your Organization involved the delivery of any health care services to patients?		Yes	x	No

If you answered "YES" to questions 1, 2, or 3, please attach an explanation

The applying accreditation agency must agree, as part of the approval, to submit the following items with the application per Health and Safety Code section 1248.4(b): a list of each outpatient setting to which it has granted a certificate of accreditation, as well as settings that have lost accreditation or were denied accreditation.

DECLARATION

I hereby declare under the penalty of perjury under the laws of the State of California that all information contained in this application, and all attachments thereto, submitted to the Medical Board of California in support of this application are true and correct to the best of my knowledge, and that I have the legal authority to sign this application on behalf of the applicant.

Executed at Chicago (City), Illinois (State), this 20th day of December, 2012

By: Joseph L. Cappiello
Type or Print Full Name

Chief Operating Officer
Type or Print Title

Signature

Submit the completed application with fee and requested documentation to:

Medical Board of California, Licensing Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

Questions regarding the completion of this application may be directed to the Outpatient Surgery Settings Unit at the aforementioned address or by telephone at (916) 263-2393.

The Information Practices Act, Section 1798.17 Civil Code, requires the following information be provided when collecting information from individuals. Agency Name: Medical Board of California, Licensing Program, 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815; Telephone: (916) 263-2382. The official responsible for information maintenance is the Program Manager. The authority which authorizes the maintenance of this information is Business and Professions Code. Public Law 94-455(42 U.S.C.A. 405(c)(2)(C)) authorizes collection of your Social Security Number (SSN) and/or federal employer identification number (FEIN). Your SSN and/or FEIN will be used exclusively for tax enforcement purposes and for purposes of compliance with any judgment or order for family support in accordance with Section 11350.6 of the Welfare & Institutions Code. If you fail to disclose your SSN or FEIN, you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you. Failure to provide all or any part of the requested information will result in this form being rejected as incomplete. The principal purpose(s) for which the information is to be used is to determine your eligibility. Any known or foreseeable interagency or intergovernmental transfer which may be made of the information, when necessary, is to other federal, state and local law enforcement agencies. Each individual has the right to review the files or records maintained on them by the agency, except for information exempt from disclosure, pursuant to Section 6254 of the government Code or Section 1798.40 of the Civil Code.

ACCREDITATION AGENCY COMPARISON

CERTIFICATION PROGRAM – HEALTH AND SAFETY CODE **§1248.15**			
		To be completed by accreditation agency	To be completed by Medical Board Staff
H & S Code Section	Summary of Requirement	List agency standard that applies and where applicable standards is located.	Does agency meet requirements?
Part 1 – Staff Privileges			
1248.15(2)(C)(ii)	An outpatient setting may 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.	**06.00.02 Medical Staff Membership & Clinical Privileges.** Members of the Medical Staff must be legally and professionally qualified for the positions to which they are appointed and for performance of privileges granted. The ASC grants privileges in accordance with recommendations from qualified medical personnel. **06.00.04 Other Practitioners** If the ASC assigns patient care responsibilities to practitioners other than physicians, it must have established policies and procedures, approved by the governing body, for overseeing and evaluating their clinical activities. Allied Health Practitioners (AHP) privileges must be consistent with federal and state regulations applicable to their specific profession. **01.00.04 Hospitalization** The ASC must have an effective procedure for the immediate transfer, to a hospital, of patients requiring emergency medical care beyond the capabilities of the ASC. This hospital must be a local, Medicare-participating hospital or a local, nonparticipating hospital that meets the requirements for payment for emergency services under 482.2 of 42 Code of Federal Regulation. **01.00.05 Transfer Agreement** The ASC must satisfy one of the following: Have a written transfer agreement with a hospital that meets the requirements of Federal Regulation. Ensure that all physicians performing surgery in the ASC have admitting privileges at a hospital that meets the requirements of paragraph (b)(2).	
1248.15(6)(B)	Medical staff and other practitioners granted clinical privileges shall be professionally qualified and appropriately credentialed for the	**06.00.02 Medical Staff Membership & Clinical Privileges.** Members of the Medical Staff must be legally and professionally qualified for the positions to which	

	privileges granted. Additionally, an outpatient setting shall grant privileges in accordance with recommendations from qualified health professionals, and credentialing standards established by the outpatient setting.	they are appointed and for performance of privileges granted. The ASC grants privileges in accordance with recommendations from qualified medical personnel. **06.00.04 Other Practitioners** If the ASC assigns patient care responsibilities to practitioners other than physicians, it must have established policies and procedures, approved by the governing body, for overseeing and evaluating their clinical activities. Allied Health Practitioners (AHP) privileges must be consistent with federal and state regulations applicable to their specific profession.	
1248.15(a)(1)	An outpatient setting's allied health staff shall be appropriately licensed or certified.	**06.00.04 Other Practitioners** If the ASC assigns patient care responsibilities to practitioners other than physicians, it must have established policies and procedures, approved by the governing body, for overseeing and evaluating their clinical activities. Allied Health Practitioners (AHP) privileges must be consistent with federal and state regulations applicable to their specific profession.	
1248.15(10)(b)	Outpatient settings shall 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 shall constitute unprofessional conduct.	**07.00.02 Organization & Staffing** Patient care responsibilities must be delineated for all nursing service personnel. Nursing services must be provided in accordance with recognized standards of practice. There must be a registered nurse available for emergency treatment whenever there is a patient in the ASC. **05.01.08 Emergency Personnel** Personnel trained in the use of emergency equipment and in cardiopulmonary resuscitation must be available whenever there is a patient in the ASC.	
Part 2 – Medical Services			
1248.15(0)(3)	An outpatient setting shall permit surgery by a dentist, physician and surgeon, or podiatrist acting within his or her scope of practice pursuant to the governing the licensee. Additionally, at the discretion of the outpatient setting, a certified registered nurse anesthesia may be permitted to provide anesthesia services within his or her scope of practice pursuant to the laws governing the licensee.	**03.05.01 Anesthesia** Administrator's Qualifications Only physicians, dentists or podiatrists who are qualified by education, training and licensure to administer moderate sedation (conscious sedation) should supervise the administration of moderate sedation (conscious sedation). **03.00.05 Administration of Anesthesia** Anesthetics must be administered by only: 1. A qualified anesthesiologist 2. A physician qualified to administer anesthesia, a certified registered nurse anesthetist (CRNA) or an anesthesiologist's assistant as defined 410.69(b) of 42 Code of Federal Regulation, or a supervised trainee in an approved educational program. In	

		those cases in which a nonphysician administers the anesthesia, unless exempted in accordance with paragraph [(c)} of 42 Code of Federal Regulation, the anesthetist must be under the supervision of the operating physician, and in the case of an anesthesiologist's assistant, under the supervision of an anesthesiologist. **03.00.06 State Exemption** An ASC may be exempted from the requirement for physician supervision of CRNAs as described in paragraph (b)(2) of 42 Code of Federal Regulation, if the state in which the ASC is located submits a letter to CMS signed by the Governor, following consultation with the State's Boards of medicine and Nursing, requesting exemption from physician supervision of CRNAs. The letter from the Governor must attest that he or she has consulted with State Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt-out of the current physician supervision requirement, and that the opt-out is consistent with state law.	
1248.15(2)(B)	An outpatient setting shall have onsite equipment, medication, and trained personnel to facilitate handling the services sought or provided, and any medical emergency that may arise in the connection with those services.	**05.00.01 Environment** The ASC must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients. **05.00.03 Operating Room Design** Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area. **05.00.04 Recovery Room & Waiting Area** The ASC must have a separate recovery room and waiting area. **05.01.01 Safety from Fire** Except as otherwise provided in this section, the ASC must meet the provisions applicable to Ambulatory Health Care Centers of the 2000 edition of the Life Safety Code of the National Fire Protection Association, regardless of the number of patients served. **05.01.05 Emergency Lighting** An ASC must be in compliance with Chapter 21.2.9.1, Emergency Lighting, beginning on March 13, 2006. **05.01.07 Emergency Equipment**	

		The ASC medical staff and governing body of the ASC coordinates, develops, and revises ASC policies and procedures to specify the types of emergency equipment required for use in the ASC's operating room. The equipment must meet the following requirements: (1) Be immediately available for use during emergency situations; (2) Be appropriate for the facility's patient population; (3) Be maintained by appropriate personnel. **05.01.08 Emergency Personnel** Personnel trained in the use of emergency equipment and in cardiopulmonary resuscitation must be available whenever there is a patient in the ASC. **07.00.01 Nursing Services** The nursing services of the ASC must be directed and staffed to assure that the nursing needs of all patients are met. **07.00.02 Organization & Staffing** Patient care responsibilities must be delineated for all nursing service personnel. Nursing services must be provided in accordance with recognized standards of practice. These must be a registered nurse available for emergency treatment whenever there is a patient in the ASC. **09.00.01 Pharmaceuticals** The ASC must provide drugs and biologicals in a safe and effective manner, in accordance with accepted professional practice and under the direction of the individual responsible for pharmaceutical services. **09.00.02 Administration of Drugs** Drugs must be prepared and administered according to established policies and acceptable standards of practice. **09.00.03 Adverse Reactions** Adverse reactions must be reported to the physician responsible for the patient and must be documented in the record.	
Part 3 – Patient Care			
1248.15(2)(C)(i)	An outpatient setting must have a written transfer agreement with a local accredited or licensed acute care hospital, approved by the facility's medical staff. A written transfer agreement shall include a – mechanism for patient transport; a	**01.00.04 Hospitalization** The ASC must have an effective procedure for the immediate transfer, to a hospital, of patients requiring emergency medical care beyond the capabilities of the ASC. This hospital must be a local, Medicare-participating	

	plan for transfer of the patient's records; policies defining the role of each person handling an emergency; and a plan for continuity of the patient's care upon transfer of that care.	hospital or a local, nonparticipating hospital that meets the requirements for payment for emergency services under 482.2 of 42 Code of Federal Regulation.	
1248.15(D)	All physicians and surgeons transferring patients from an outpatient setting shall agree to cooperate with the medical staff peer review process in those transferred cases.	**01.00.02 Governing Body & Management** The ASC must have a Governing Body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the ASC total operation. The governing body has oversight and accountability for the quality assessment and performance improvement program, ensures that facility policies and programs are administered so as to provide quality health care in a safe environment, and develops and maintains a disaster preparedness plan. Any quality related issues will be forwarded to the QAPI committee, the CEO and the Governing Body (this can include transfers, burns, falls, deaths, SSI). **01.02.02 Medical Staff Appointments** The Governing Body must appoint and reappoint the medical staff. The ASC establishes criteria for initial and reappointment to staff membership which includes current supporting documents of: a. License (including narcotics registration, if applicable) b. Training/education c. Current competence including current peer evaluation **01.02.03 Information for Medical Staff Applications.** In addition to the completed application and current supporting documentation, the Governing Body and competent authority must use additional available information when taking action on applications for appointment and reappointment and in awarding current privileges, including: a. Documentation of relevant continuing education. b. Current information obtained from the National Practitioner Data Bank. c. Documentation of changes in board eligibility or certification status. d. ASC quality information and peer review evaluations. e. Voluntary or involuntary reductions or limitations in privileges or membership at any hospital, or the ASC. f. Procedure logs from other ASC(s) to support	

		privilege requests for procedures not attested to in the past.	
48.15(2)(C)(iii)	An outpatient setting is required to submit for approval to the accrediting agency, a detailed procedural plan for handling medical emergencies.	**01.00.03 Governing Body & Management** The ASC must have a Governing Body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the ASC total operation. The governing body has oversight and accountability for the quality assessment and performance improvement program, ensures that facility policies and programs are administered so as to provide quality health care in a safe environment, and develops and maintains a disaster preparedness plan. **01.00.06 Disaster Preparedness Plan** The ASC must maintain a written disaster preparedness plan that provides for the emergency care of patients, staff and others in the facility in the event of fire, natural disaster, functional failure of equipment, or other unexpected events or circumstances that are likely to threaten the health and safety of those in the ASC.	
1248.15(10)	Outpatient settings shall have written a discharge criteria.	**03.00.01 Evaluation for Anesthesia Recovery** Before discharge from the ASC, each patient must be evaluated by a physician or by an anesthetist as defined at 410.69(b) of 42 Code of Federal Regulation, in accordance with applicable state health and safety laws, standards of practice, and ASC policy, for proper anesthesia recovery. An evaluation of the patient's recovery from anesthesia, to determine whether the patient is recovering appropriately, must be completed and documented before the patient is discharged from the ASC. American Society of Anesthesiology (ASA) guidelines do not define moderate or conscious sedation as anesthesia. While current practice dictates that the patient receiving conscious sedation be monitored and evaluated before, during, and after the procedure by trained practitioners, a postanesthesia evaluation is not required. The evaluation must be completed and documented by a physician or anesthetist, as defined at 42 CFR 410.69(b), i.e., a certified registered nurse anesthetist (CRNA) or an anesthesiologist's assistant. See the discussion of §416.42(b) for more discussion of CRNA and anesthesiologist's assistant requirements. ASCs would be well advised in developing their policies and procedures for postanesthesia care to consult recognized guidelines. For example, Practice	

		Guidelines for Postanesthetic Care, Anesthesiology, Vol 96, No 3, March, 2002, provides the recommendations of the American Society of Anesthesiologists for routine postanesthesia assessment and monitoring, including monitoring/assessment of: o Respiratory function, including respiratory rate, airway patency, and oxygen saturation o Cardiovascular function, including pulse rate and blood pressure o Mental status o Temperature o Pain o Nausea and vomiting o Postoperative hydration Depending on the specific surgery or procedure performed, additional types of monitoring and assessment may be necessary. **03.13.01 Discharge** The ASC Must: 1. Provide each patient with written discharge instructions. 2. Ensure the patient has a safe transition to home and that the post surgical needs are met. 3. Ensure each patient has a discharge order, signed by a physician or the qualified practitioner who performed the surgery or procedure unless otherwise specified by state law. The discharge order must indicate that the patient has been evaluated for proper anesthesia and medical recovery. • Postoperative assessment **03.13.02 Discharge Assessment** Assessment and evaluation for discharge must be documented by a physician. Rules and regulations approve by the Governing body, define the discharge criteria from PACU. These, if used in lieu of a practitioner assessment/order, are consistently applied whenever postanesthesia recovery occurs. Even when the above rules are used. **03.13.03 Discharge & Transportation** All patients are discharged in the company of a responsible adult, except those exempted by the attending physician. **03.13.04 Discharge Instructions** Ambulatory surgery patients and their families - companions as appropriate, are provided with instructions regarding post procedure management in language that the patient or accompanying responsible person can understand.	

		06.01.10 Discharge Criteria The Medical Staff periodically reviews and makes recommendations to the Governing Body, on discharge criteria, if any, for discharge from post-anesthesia observation. **08.05.01 Discharge Planning** Prior to discharge from the current session of care, the physician must determine the advisability and safety of the patient's discharge destination make arrangements for follow-up care and provide for appropriate transportation to their home. **08.05.02 Evaluation of Patient's Condition** All ASC(s) must have a process for evaluating and re-evaluating the patient's condition upon arrival and throughout their stay.	
1248.15(D)(5)	An outpatient setting shall have a system for patient care and monitoring procedures.	**03.01.01 Invasive Procedures Performed in Appropriate Environment.** ASC invasive procedures must be performed in an operating room. The Governing Body, based upon recommendation of competent medical authority, must define for each location where invasive procedures are performed: 1. The type of procedure(s) that may be performed in that location. **03.02.04 Monitoring Patients under Moderate Sedation (Conscious Sedation)** When only moderate sedation (conscious sedation) is implemented, a RN or other provider licensed by the state must monitor the patient. Check the state law requirements. **03.04.01 Adequate Instrumentation in Operating Rooms** Instruments, supplies and equipment must be in sufficient quantity and located so that movement is minimized during cases. Processed instruments are protected from surface/airborne contamination. **06.01.08 Patient Monitoring Frequency** The Medical Staff periodically reviews and makes recommendations to the Governing Body on the minimum frequency of monitoring and recording of critical physiological measures of patients before, during and after permitted procedures. **03.05.03 Intra-operative/Procedural Anesthesia (Time-Based Record of Events)** When a topical anesthetic or local block is used: Immediately prior to initiation of the topical anesthetic or local block, the patient will be assessed.	

		After initial administration and prior to initiation of the laser/surgical procedure or treatment, determination of the effectiveness of the topical anesthetic or local block. When moderate sedation (conscious sedation) through general anesthesia is used: There is an anesthesia event which reflects the management of the patient during the anesthetic administration including the following parameters: A. Immediate review prior to initiation of anesthetic procedures: • Patient re-evaluation • Check of equipment, drugs and gas supply B. Monitoring of the patient** (e.g., recording of vital signs). C. Amounts of drugs and agents used, and times of administration. D. The type and amounts of intravenous fluids administered if administered, including blood and blood products, and times of administration. E. The techniques(s) used. F. Unusual events during the administration of anesthesia. G. The status of the patient at the conclusion of anesthesia. **03.05.04 Post-anesthesia Evaluation** When a topical anesthetic or local block is used: A. Patient assessment for pain and range of motion if appropriate. When moderate sedation (conscious sedation) through general anesthesia is used: A. Patient evaluation on admission and discharge from the postanesthesia care unit. B. A time-based record of vital signs and level of consciousness. C. A time-based record of drugs administered their dosage and route of administration. D. Type and amounts of intravenous fluids administered, if administered, including blood and blood products. E. Any unusual events including post anesthesia or post procedural complications. F. Postanesthesia visits. **07.00.01 Nursing Services** The nursing services of the ASC must be directed and staffed to assure that the nursing needs of all patients are met. **07.00.02 Organization & Staffing** Patient care responsibilities must be delineated for	

		all nursing service personnel. Nursing services must be provided in accordance with recognized standards of practice. These must be a registered nurse available for emergency treatment whenever there is a patient in the ASC. **07.01.04 Administration of Medications** Medications must be administered only by individuals licensed to do so or under the direct supervision of a licensed provider. The ASC shall have policies and procedures to administer medications that are current.	
1248.15(D)(4)	An outpatient setting shall have a system for maintaining clinical records.	**08.00.01 Medical Record for Each Patient** The ASC must maintain complete, comprehensive, and accurate medical records to ensure adequate patient care. **08.00.02 Organization** The ASC must develop and maintain a system for the proper collection, storage, and use of patient records. **08.00.03 Form & Content of Record** The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following: 1. Patient identification 2. Significant medical history and results of physical examination 3. Preoperative diagnostic studies (entered before surgery), if performed 4. Findings and techniques of the operation including a pathologist's report on all tissues removed during surgery, except those exempted by the Governing Body 5. Any allergies and abnormal drug reactions 6. Entries related to anesthesia administration 7. Documentation of properly executed informed patient consent 8. Discharge diagnosis **08.01.02 Record Storage** Clinical records must be stored in secure locations, away from access by unauthorized individuals and secure from destruction by fire or disaster. **08.02.03 Medical Record Distinct Identifier** Each medical record must have a distinct identifier, unique for each patient, and documentation on each patient must be consolidated into one clinical record. Each page within the record will contain patient identification. **08.02.04 Medical Records Accurate, Organized &**	

		Accessible All ASC medical records must be arranged in a consistent manner, appropriate to the scope and complexity of services offered. The medical records must be accurate, readily accessible and systematically organized. **08.03.01 Medical Record Content** The medical record must also include: 1. A record of all medications, treatments, advice, or evaluations ordered or provided. 2. A legible, chronological record of care given, which must be authenticated by the provider of that care, with the date care was provided and the time care was provided when appropriate. 3. As appropriate, each visit will include the Subjective complaint, the Objective findings, an Analysis and a Treatment Plan with follow-up instructions. **08.03.02 Medical Record Content (cont'd)** For patients seen more than once, the clinical record must contain a list of chronic conditions, including chronic medications, and an updated list of appropriate preventive medicine evaluations and treatments. **08.03.03 Time Frame for Completion of Physical Examination** The ASC, in conjunction with the professional staff, must define the scope and time for completion of any physical examination (PE) required based upon the care to be provided or procedure to be performed. **08.03.04 Scope of Medical Record Defined** The ASC must define the scope of the medical, dental, family, work, drug or alcohol use, psychosocial history(s) to be obtained and documented and the time frame when the history(s) must be completed. **08.03.05 Documentation Requirements Defined** The ASC must establish or implement evaluation and documentation requirements for specific conditions or care in accordance with professional recommendations and standards. **08.03.06 Medical Record – Drugs** Medical records entries for prescribed drugs must include at least: a. Drug name b. Dosage c. Amount prescribed d. Directions for taking or using e. Frequency of usage	

		f. Patient's name g. Patient's number	
Part 4 – Additional Standards			
1248.15(b)(c)	An accreditation agency may include additional standards in its determination to accredit outpatient settings, if these are approved by the division to protect the public health and safety. An accreditation agency shall send to the division any change in its accreditation standards within 30 calendar days after making the change. (16 CCR 113.4 (b)) An accreditation agency shall, within fourteen calendar says after issuance, provide to the division a copy of any certificates of accreditation it issues and any denial or revocation of a certificate of accreditation. For each setting whose accreditation agency it denies or revokes, the accreditation agency shall also provide to the division in writing the reasons for its action. (16 CCR 1313.4 (c))	See attached accreditation manual: **Accreditation Requirements for Ambulatory Surgical Centers.**	
Part 5 – Safety and Emergency Training			
1248.15 (2)(A)	An outpatient setting shall have a system for facility safety and emergency training requirements.	**08.04.04 Required Emergency Training** The ASC in conjunction with the medical director must determine the level of initial and recurrent emergency training required for each level of staff. **01.00.06 Disaster Preparedness Plan** The ASC must maintain a written disaster preparedness plan that provides for the emergency care of patients, staff and others in the facility in the event of fire, natural disaster, functional failure of equipment, or other unexpected events or circumstances that are likely to threaten the health and safety of those in the ASC. **02.01.14 ASC Provides OSHA Training as Appropriate** The ASC must comply with training requirements and documentation as required by the Occupational Health and Safety Administration (OSHA) for all personnel whose duties involve occupational exposure to	

		Bloodborne Pathogens. **02.01.15 ASC Provides HAZMAT Training as Appropriate** All personnel, whose workplace exposure requires it, must have documented initial and periodic Hazardous materials (HAZMAT) training. Material Safety Data Sheets (MSDS) for each hazardous material/chemical will be maintained in each workplace. **05.01.08 Emergency Personnel** Personnel trained in the use of emergency equipment and in Cardiopulmonary resuscitation must be available whenever there is a patient in the ASC.	
Part 6 – Quality Control			
1248.15(6)(A)	An outpatient setting shall have a system for quality assessment and improvement. The required system for quality assessment and improvement shall include, in addition to chart review, actins that utilize information derived through quality assessment to improve systems to maximize patient protection. (16 CCR 1314(a)(2))	**01.00.02 Governing Body & Management** The ASC must have a Governing Body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the ASC total operation. The governing body has oversight and accountability for the quality assessment and performance improvement program, ensures that facility policies and programs are administered so as to provide quality health care in a safe environment, and develops and maintains a disaster preparedness plan. **02.00.08 CEO & Executive Team Serve as QAPI Committee** The CEO and/or selected members of the executive team, or the group as a whole serve on the Quality Assessment Performance Improvement (QAPI) committee. **04.00.01 Quality Assessment Performance Improvement.** The ASC must develop, implement and maintain an ongoing, data-driven Quality Assessment Performance Improvement (QAPI) program. **04.00.03 Track Quality Indicators** The ASC must measure, analyze, and track quality indicators, adverse patient events, infection control and other aspects of performance that	

		includes care and services furnished in the ASC.	
Part 7- Periodic Review			
1248.15(6)(C)	An outpatient setting shall periodically reappraise its clinical privileges, and review and amend as appropriate, the scope of procedures it performs.	**06.00.03 Reappraisals** Medical staff privileges must be periodically reappraised by the ASC. The scope of procedures performed in the ASC must be periodically reviewed and amended as appropriate. The medical staff, as a body or as a committee, will review and make recommendations to the governing body on all applications for reappointment to the professional staff. The ASC must have a policy on this function. **06.00.04 Other Practitioners** If the ASC assigns patient care responsibilities to practitioners other than physicians, it must have established policies and procedures, approved by the governing body, for overseeing and evaluating their clinical activities. Allied Health Practitioners (AHP) privileges must be consistent with federal and state regulations applicable to their specific profession. **06.00.03 Reappraisals** Medical staff privileges must be periodically reappraised by the ASC. The scope of procedures performed in the ASC must be periodically reviewed and amended as appropriate. The medical staff, as a body or as a committee, will review and make recommendations to the governing body on all applications for reappointment to the professional staff. The ASC must have a policy on this function.	
Part 8 – Posting of Accreditation Agency Information			
1248.15(8)	Outpatient settings shall post the certificate of accreditation readily visible to patients and staff.	See Section II. The Bureau of Healthcare Facilities Accreditation (page ix) A. Bureau Authority and Procedure - Health Care Facilities 1. The Bureau has been delegated authority by the American	

		Osteopathic Association Board of Trustees: a. To conduct accreditation surveys of health care facilities. b. To evaluate the survey reports, and on the basis of the survey findings, to grant, deny, or withdraw accreditation to those health care facilities seeking accreditation. 2. Accreditation actions that may be taken for health care facilities are: a. Preliminary Accreditation – The organization demonstrates compliance with selected standards in surveys conducted under the Early Option Survey Policy. b. Accredited – indicates that a healthcare facility meets the HFAP accreditation requirements and, based on the decision of the Executive Committee, accreditation may be granted for one, two, or three years. c. Interim Accreditation – (not applicable for organizations seeking initial accreditation) indicates that a facility generally meets the standards, but that certain areas have been identified which require additional work to be compliant. The facility is required to complete the additional work within a specified period of time, as defined by the Executive Committee that will not exceed twelve months, in order to remain accredited. d. Denial of Accreditation – indicates that a healthcare facility has been denied accreditation because it does not meet HFAP requirements. 3. A random sample of five (5) percent of accredited ASCs will receive a mid-cycle review in order to demonstrate that facilities maintain their compliance with the HFAP requirements throughout the three-year accreditation period. 4. A health care facility that has been granted accreditation is provided with an HFAP Certificate	

		of Accreditation. 5. The Bureau may alter the accreditation status of a health care facility for just cause. Just cause includes, but is not limited to, failure to maintain compliance with HFAP accreditation requirements.	
1248.15(9)	Outpatient settings shall post the name and telephone numbers of the accrediting agency with instructions on the submission of complaints in a location readily visible to patients and staff.	**11.00.05 Notice of Rights** The ASC must, prior to the start of the surgical procedure, provide the patient, the patient's representative, or the patient's surrogate with verbal and written notice of the patient's rights in a language and manner that ensures the patient, the patient's representative, or the surrogate understand all of the patient's rights as set forth in this section. The ASC's notice of rights must include the address and telephone number of the State agency to which patients may report complaints, as well as the Website for the Office of the Medicare Beneficiary Ombudsman.	
rt 9 – Certificates of Approval			
1248.15(7)	Outpatient settings regulated by Chapter 1.3 – Outpatient Settings that have multiple service locations governed by the same standards may elect to have all service sites surveyed on any (one) accreditation (agency) survey. An organization that elects not to have all its service sites surveyed shall have at a maximum no more than 20 percent of the sites surveyed. The actual sample size shall be determined by the accreditation agency. The accreditation agency shall determine the location of the sites to be surveyed. Outpatient settings that have 5 or fewer sites shall have at least 1 site surveyed. An organization that elects to have a sample of its sites surveyed and is approved for accreditation, all of the organization's sites shall be automatically accredited.	See HFAP Surveyor Handbook under TEAM COMPOSITION, beginning at page (7).	

CERTIFICATES OF ACCREDITATION – HEALTH & SAFETY CODE 1248.3			
10 – Certificates of Approval			
1248.3(a)	Certificates of accreditation issued to outpatient settings by an accreditation agency shall be valid for not more than three years.	A health care facility that has been granted accreditation by the Healthcare Facilities Accreditation Program is awarded a Certificate of Accreditation for a three year period. **See page ix of the Accreditation Requirements of Ambulatory Surgical Centers.** D. Survey Procedures 1. Health care facility surveys will be unannounced and conducted on a three-year cycle by a combination of the following approved surveyor categories: physician, health care facility administrator, registered nurse, and a life safety code specialist. The number of surveyors, the combination of surveyors, and the survey days will vary based on the size and complexity of the health care facility. The fee for each survey will take into account the complement of the survey, i.e., the length of the survey and the number of surveyors assigned to the survey. **See page x of the Accreditation Requirements for Ambulatory Surgical Centers.** **II. The Bureau of Healthcare Facilities Accreditation** A. Bureau Authority and Procedure - Health Care Facilities 1. The Bureau has been delegated authority by the American Osteopathic Association Board of Trustees: a. To conduct accreditation surveys of health care facilities. b. To evaluate the survey reports, and on the basis of the survey findings, to grant, deny, or withdraw accreditation to those health care facilities seeking accreditation. 2. Accreditation actions that may be taken for health care facilities are: **a. Preliminary Accreditation** – The organization demonstrates compliance with selected	

		standards in surveys conducted under the Early Option Survey Policy. **b. Accredited** – indicates that a healthcare facility meets the HFAP accreditation requirements and, based on the decision of the Executive Committee, accreditation may be granted for one, two, or three years.	
ACCREDITATION PROGRAM – HEALTH & SAFETY CODE 1248.4 (C)			
Part 11 – Agency Standards			
1248.4(c)(1)	An accreditation program, at a minimum, must include the standards for accreditation of outpatient settings approved by the division as well as standards for patient care and safety at the outpatient setting.	See BUREAU OF HEALTHCARE FACILITIES ACCREDITATION (BHFA) (see pages (3) & (4) of Surveyor Handbook. The AOA Bureau of Healthcare facilities Accreditation (BHFA) is the body, which makes accreditation decisions. The committee provides a wide-spread representation of healthcare professionals, including: •Surgery •Obstetrics •Gynecology •Medical education •Medical administration •Osteopathic manipulation •Internal medicine •Family practice •Pathology •Hospital administration pharmacy •Nursing The BHFA meets three times per year to review accreditation policy issues, and proposed additions, changes, and deletions to accreditation requirements. The BHFA takes accreditation actions based on the results of the accreditation surveys and the corrective actions taken by the health care facility, in response to any cited deficiencies. When called, the BHFA's Executive Committee convenes monthly to review policies, procedures, additions to standards, deletions of standards, updates to standards, and make accreditation decisions.	

1248.4(c)(2)	An accreditation agency must submit its current accreditation standards to the division every three years, or upon request for continuing approval by the division.	See Current HFAP Accreditation ASC Manual for 2013.	
1248.4(c)(4)	An accreditation agency must have a process by which accreditation standards can be reviewed and revised no less than every three years.	The HFAP accreditation standards are reviewed annually – Please see 2013 ASC HFAP manual.	
1248.4(c)(8)	Standards for accreditation shall be developed with the input of the medical community and the ambulatory surgery industry.	Please refer to HFAP references such as CMS/ CfC/ NQF/ AORN/ APIC & CDC. Ambulatory also participates in the ASC Quality Collaboration regarding quality outcome measurements. Standards are reviewed by the Bureau specialty disciplines for current content and best practices.	
Part 12 – Review Teams			
1248.4(c)(5) & 1248.4(c)(6)	An accreditation agency must maintain an available pool of allied health care practitioners to serve on accreditation review teams as appropriate. The accreditation review teams shall do all of the following:	See application requirements	
1248.4(c)(6)(A)	Accreditation review teams must consist of at least one physician and surgeon who practices in an outpatient setting; any other members shall be practicing actively in these settings.	See application requirements	
1248.4(c)(6)(B)	Accreditation review teams must participate in formal education training programs provided by the accreditation agency in evaluation of the certification standards at least every three years.	See application requirements	
1248.4(c)(7)	An accreditation agency shall demonstrate that professional members of its review team have experience in conducting review activities of freestanding outpatient settings.	See application requirements	
1248.4(c)(9)	Accreditation reviewers shall be credentialed and screened by the accreditation agency.	See application requirements	
Part 13 – Quality Control			
1248.4(c)(3)	An accreditation agency must maintain internal quality management programs to ensure quality of the accreditation	See attached HFAP policy. "The Quality Management Program"	

	process.		
14 – Conflict of Interest			
1248.4(c)(10)	An accreditation agency shall not have an ownership interest in nor be involved in the operation of a freestanding outpatient setting, nor in the delivery of health care services to patients.	NA- HFAP does not participate in this type of practice or ownership.	
Part 15 - Comments			

MEDICAL BOARD OF CALIFORNIA
Licensing Program

July 1, 2013

Sent Via Email: JCappiello@HFAP.org

Joseph L. Cappiello
Chief Operating Officer
American Osteopathic Association /
Healthcare Facilities Accreditation Program
142 East Ontario Street
Chicago, IL 60611

RE: APPLICATION FOR APPROVAL AS AN OUTPATIENT SURGERY SETTING ACCREDITATION AGENCY

Dear Mr. Cappiello:

The Medical Board of California (Board) has reviewed the information you have provided in your "Application for Approval as an Outpatient Surgery Setting Accreditation Agency" and request additional information or clarification on the following items:

Questions one through four are also being asked of all approved Accreditation Agencies and as part of your request for approval. The additional questions are regarding AOA/HFAP's request for approval by the Board:

1) California Business and Professions Code §2216.2 requires a physician and surgeon to provide adequate security by liability insurance, or by participation in an interindemnity trust, for claims by patients arising out of surgical procedures performed outside of a general acute care hospital as defined in subdivision (a) of Section 1250 of the Health and Safety Code. B&P §2216.2(d) further requires that the security required by this section shall be acceptable only if provided by any one of the following: (1) An insurer admitted pursuant to Section 700 of the Insurance Code to transact liability insurance in this state. (2) An insurer that is eligible pursuant to Section 1765.1 of the Insurance Code. (3) A cooperative corporation authorized by Section 1280.7 of the Insurance Code. (4) An insurer licensed to transact liability insurance in at least one state of the United States.

    a. Title 16 of the California Code of Regulations §1304 defines "adequate security" to mean that a physician has coverage of the type prescribed in Section 2216.2 of the code in the amount of not less than one million dollars per incident and not less than three million dollars per year.

b. Please provide information on AOA/HFAP's standards regarding liability insurance for physicians and surgeons performing surgery outside of general acute care hospitals. Please indicate how these standards are evaluated by AOA/HFAP.

2) California Health and Safety Code §1248.15(a)(2)(b) requires that there shall be on-site 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.

   a. Please provide information on AOA/HFAP's standards regarding on-site equipment, medication, and trained personnel to facilitate handling of service provided and medical emergencies.

3) California Health and Safety Code §128.15(a)(6)(B) requires that members of the medical staff and other practitioners who are granted clinical privileges shall be professionally qualified and appropriately credentialed for the performance of the privileges granted. Members of the Medical Board's Outpatient Surgery Setting Task Force have requested additional information on how this provision is implemented by accreditation agencies.

   a. Please provide information on the safeguards within the credentialing process to prevent an untrained and/or limited trained physician from performing procedures they are not qualified to perform.

4) California Health and Safety Code §1248.15(c) allows an accreditation agency to include additional standards in its determination to accredit outpatient settings if these are approved by the board to protect the public health and safety.

   a. Please provide a complete list of any and all standards required by AOA/HFAP that are not specifically required by California law. This information will be presented to the members of the Medical Board of California at an upcoming quarterly Board meeting as a "side-by-side" comparison of the additional standards required by each of the accreditation agencies that have been approved by the Board.

   b. Please provide the answers to following questions and/or request for additional information:

5) When is the first site visit for the Outpatient Surgery Setting facility that is currently applying for accreditation?

6) The Board has asked each of the approved Accreditation Agencies to provide information regarding the Outpatient Surgery Settings that they have certified for CMS as Medicare facilities. Will AOA/HFAP also provide the Board with these CMS certified facilities for includion on the Board's Web site in our efforts to assist California consumers?

7) Has AOA/HFAP formally adopted all of the draft Policy/Procedures that were initially provided to the Board at the time of application for approval as a Board-approved Accreditation Agency?

8) Page 3 of 4 of the Quality Management Plan states ...."No disclosure of any reports...". Will these reports be provided to the Board?

9) Does AOA/HFAP use the Medicare/Medicaid standards to accredit non-CMS certified Outpatient Surgery Settings?

10) Are Non-CMS certified Outpatient Surgery Settings required to have a formal and posted transfer plan to a hospital that accepts Medicare?

11) Does HFAP require peer review processes for physician & surgeons? This information is not referenced in the Governing Body & Management section, 0100.02. California regulation code 1248.15 (D) references physicians and surgeons who transfer patients from an Outpatient Surgery Setting shall agree to cooperate with the medical staff peer review process in those transferred cases.

12) HFAP performs on-site inspections within 120 days of expiration dates for re-accreditation. How often do Outpatient Surgery Settings undergo regular and routine on-site inspections? Are on-site inspections performed for initial and/or renewal accreditations?

13) Are Outpatient Surgery Settings required to post the certificate of accreditation to be readily visible and accessible to patients and staff at the facility?

14) Inspection teams must comply with the following criteria:
    - Accreditation reviewers must be credentialed and screened by the accreditation agency.
    - Professional members of the accreditation review team must have experience in conducting review activities of free-standing outpatient settings.
    - Participation in formal education training programs provided by the accreditation agency.

Please provide information identifying where these requirements are specifically addressed in the HFAP manual.

15) The Board is required to post the following information to the Board's Web site pursuant to California Health and Safety Code (HSC) Section 1248.2:
    - Whether an outpatient setting is accredited; or whether the setting's accreditation has been revoked, suspended, or placed on probation; or whether the setting has received a reprimand by the Accreditation Agency.
    - The list of outpatient settings shall include all of the following:
        - Name, address, and telephone number of any owners, and their corresponding medical license numbers.
        - Facility ownership percentage for each owner.

- Name and address of the facility.
- The name and telephone number of the accreditation agency.
- The approval 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.

16) Is AOA/HFAP planning to provide the Board with the above information for the Outpatient Surgery Settings accredited by your organization?

Pursuant to HSC Section 1248.15(7), Outpatient Surgery Settings regulated by this chapter with multiple service locations shall have all of the sites inspected. Each and all facility locations are to be identified and must undergo individual separate on-site reviews.

17) Does the HFAP require on-site reviews for each facility seeking initial accreditation or reaccreditation?

18) Please identify where this information is located in your manual.

Pursuant to HSC Section 148.35, approved Accreditation Agencies are required to submit documents to the Board within specific timeframes. These documents include, but are not limited to electronic copies of inspection reports and corrective action reports with specific timeframes identified to correct all facility deficiencies.

19) Will AOA/HFAP provide the required documents to the Board within the specified timeframes?

Please provide AOA/HFAP's response to each of the above items in *both a paper and electronic format* by July 5, 2013. The Board also requests an electronic copy of AOA/HFAP's initial submission of the table comparing AOA/HFAP's standards and policies to those required in California law.

Thank you for your assistance in this matter.

Sincerely,

Curtis J. Worden
Chief of Licensing

Medical Board of California Licensing Program Response
ASC Application for Approval

1) California Business and Professions Code 2216.2 requires a physician and surgeon to provide adequate security by liability insurance, or by participation in an inter-indemnity trust for claims by patients arising out of surgical procedures performed outside of a general acute care hospital as defined in subdivision (a) of Section 1250 of the Health and Safety Code. B&P 2216.2(d) further requires that the security required by this section shall be acceptable only if provided by any one of the following: (1) An insurer admitted pursuant to Section 700 of the Insurance Code to transact liability insurance in this state. (2) An insurer that is eligible pursuant to Section 1765.1 of the Insurance Code. (3) A cooperative corporation authorized by Section 1280.7 of the Insurance Code. (4) An insurer licensed to transact liability insurance in at least one state of the United States.
    a. Title 16 of the California Code of Regulations 1304 defines "adequate security" to mean that a physician has coverage of the type prescribed in Section 2216.2 of the code in the amount of not less than one million dollars per incident and not less than three million dollars per year.
    b. Please provide information on AOA/HFAP's standards regarding liability insurance for physicians and surgeons performing surgery outside of general acute care hospitals. Please indicate how these standards are evaluated by AOA/HFAP.

HFAP Standard: 01.00.01 *Compliance with state licensure law. The ASC must comply with state licensure requirements (416.40). ASC must also conform to state, local and accreditation laws, regulations and/or standards.*

Explanation: *The standard addresses the requirements to conform to all state licensure requirements that may include adequate security for liability insurance or participation in an inter-indemnity trust, as specified within the state-specific licensure law. Facilities must outline in their administrative policies of their intent to conform to laws and standards and take appropriate, expeditious, remedial actions when noncompliance is noted. Failure of the facility to meet state licensure law may be cited when the authority having jurisdiction (AHJ) has made a determination of noncompliance and has also taken a final adverse action as a result. If the surveyor identifies a situation that indicates the provider may not be in compliance with state licensure law, the information may be referred to the AHJ for follow-up.*

2) California Health and Safety Code 1248.15(a)(2)(b) requires that there shall be on-site 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.

a. Please provide information on AOA/HFAP's standards regarding on-site equipment, medication, and trained personnel to facilitate handling of service provided and medical emergencies.

HFAP Standards: 05.01.07 *Emergency equipment. The ASC medical staff and governing body of the ASC coordinates, develops, and revises ASC policies and procedures to specify the types of emergency equipment required for use in the ASC's operating room. The equipment must meet the following requirements: (1) Be immediately available for use during emergency situations; (2) Be appropriate for the facility's patient population; and (3) Be maintained by appropriate personnel.* ***05.01.08*** *Emergency personnel. Personnel trained in the use of emergency equipment and in cardiopulmonary resuscitation must be available whenever there is a patient in the ASC (416.44(d)).* ***09.02.01*** *Emergency drugs storage. When provided, emergency drugs maintained in patient care areas must be securely stored and are in quantities as established by the medical staff. Storage units must not be locked to facilitate access in case of emergency; however, security must be such that violation of that security is readily evident.*

Explanation: *The facility must meet the current acceptable standards of practice, and incorporate the identified emergency equipment, supplies and medications that are most suitable for the potential emergencies associated with the procedures performed in the ASC, and the population the ASC serves. Personnel should be current in CPR and depending on the type and extent of surgery current in ACLS. Personnel who are CPR trained should be free of other duties.*

3) California Health and Safety Code 128.15(a)(6)(B) requires that members of the medical staff and other practitioners who are granted clinical privileges shall be professionally qualified and appropriately credentialed for the performance of the privileges granted. Members of the Medical Board's Outpatient Surgery Setting Task Force have requested additional information on how this provision is implemented by accreditation agencies.
    a. Provide information on the safeguards within the credentialing process to prevent an untrained/limited trained physician from performing procedures they are not qualified to perform.

HFAP Standards: 06.00.02 *Medical staff membership & clinical privileges. Members of the Medical Staff must be legally and professionally qualified for the positions to which they are appointed and for performance of privileges granted. The ASC grants privileges in accordance with recommendations from qualified medical personnel (416.45(a)).* ***06.00.03*** *Reappraisals. Medical staff privileges must be periodically reappraised by the ASC. The scope of procedures performed in the ASC must be periodically reviewed and amended as appropriate (416.45(b)).*

Explanation*: The ASC's governing body must have a process for granting clinical privileges that would safeguard prevention of untrained/limited trained physicians from performing procedures that they are not qualified to perform. The credentialing process must also include reappraisal every 24 months and documentation of reappraisals being performed in a timely manner. Granting of privileges must*

be supported by recommendations. The medical staff personnel file should contain records of personnel qualifications, privileges granted, and other appropriate records/documents.

4) California Health and Safety Code 1248.15(c) allows an accreditation agency to include additional standards in its determination to accredit outpatient settings if these are approved by the board to protect the public health and safety.
    a. Please provide a complete list of any and all standards required by AOA/HFAP that are not specifically required by California law. This information will be presented to the members of the Medical Board of California at an upcoming quarterly Board meeting as a "side-by-side" comparison of the additional standards required by each of the accreditation agencies that have been approved by the Board.

HFAP Response: *You may download the link below to the ASC standards manual.*

Download Link:
https://www.dropbox.com/s/y7yzougliihg2ny/Accreditation%20Requirements%20for%20Ambulatory%20Surgical%20Centers%202012-2013.pdf

    b. Please provide the answers to following questions and/or request for additional information:

5) When is the first site visit for the Outpatient Surgery Setting facility that is currently applying for accreditation?

HFAP Response: *Currently, there are no new (initial) ASC facilities in California scheduled for a site visit. Two currently accredited facilities will have site visits scheduled before the end of 2013.*

6) The Board has asked each of the approved Accreditation Agencies to provide information regarding the Outpatient Surgery Settings that they have certified for CMS as Medicare facilities. Will AOA/HFAP also provide the Board with these CMS certified facilities for inclusion on the Board's website in our efforts to assist California consumers?

HFAP Response: *The following ASCs are certified for CMS as Medicare facilities.*

	Facility Name	***Facility ID***	***Expiration Date/Status***
1	*Prescott Eye Car & Surgery Center*	*327737*	*11/28/14*
2	*Pain MDS*	*195764*	*07/12/16*
3	*Newport Bay Surgery Center, LLC*	*181507*	*11/26/13*
4	*Evansville Surgery Center-Deaconess Campus*	*188632*	*06/13/14*
5	*Evansville Surgery Center Associates, LLC*	*181668*	*06/13/14*
6	*Mooresville Endoscopy Center, LLC*	*189867*	*12/16/15*
7	*St Francis Mooresville Surgery Center, LLC*	*189742*	*01/18/16*
8	*Hammond Community Ambulatory Care Center*	*189290*	*06/19/16*

9	*Epic Surgery Center, LLC*	*191225*	*11/02/15*
10	*Coastal Eye Surgery Center*	*182440*	*07/07/14*
11	*Mackinaw Surgery Center, LLC*	*175480*	*10/15/15*
12	*Chu Surgery Center, LLC*	*188733*	*04/07/15*
13	*Murphy Watson Burr Surgery Center*	*199609*	*12/10/13*
14	*Freeman Surgical Center*	*196683*	*07/20/16*
15	*Eltra LLC*	*181339*	*01/21/14*
16	*Delphos ASC*	*164119*	*03/10/12 (withdrawal)*
17	*Meridian Center for Surgical Excellence, LLC*	*182576*	*07/30/14*
18	*Guaynabo Ambulatory Surgical Group, Inc.*	*188610*	*04/28/15*
19	*Babcock Surgical Center, LLC*	*328562*	*08/29/14*
20	*Eye Surgery of Edmonds*	*189166*	*06/30/15*
21	*Spokane Valley Ambulatory Surgery Center*	*191933*	*03/09/16*
22	*Seattle Spine Institute*	*195463*	*03/12/16*
23	*The Retina Surgery Center*	*196689*	*06/09/14*
24	*Tri-State Surgical Center*	*163330*	*04/07/14*

7) Has AOA/HFAP formally adopted all of the draft Policy/Procedures that were initially provided to the Board at the time of application for approval as a Board-approved Accreditation Agency?

HFAP Response: *Yes. All draft policies/procedures have been submitted to our Executive Committee and were approved on January 23, 2013.*

8) Page 3 of 4 of the Quality Management Plan states…."No disclosure of any reports…". Will these reports be provided to the Board?

HFAP Response*: The statement states "No disclosure of any reports, records, statements, memoranda, findings, or data shall be made without the authorization of the Quality Improvement Committee." Once the Board approves our application, that will provide the basis for us to authorize release of reports required under the regulations.*

9) Does AOA/HFAP use the Medicare/Medicaid standards to accredit non-CMS certified Outpatient Surgery Settings?

HFAP Response: *The Medicare/Medicaid standards apply to those who choose to be CMS certified as Ambulatory Surgery Centers (ASC). Outpatient Surgery Settings, such as Office Based Surgery (OBS), that are not seeking deemed status is not required to be surveyed under the Medicare/Medicaid standards.*

10) Are non-CMS certified Outpatient Surgery Settings required to have a formal and posted transfer plan to a hospital that accepts Medicare?

HFAP Response: *Currently, non-CMS certified Outpatient Surgery Settings are not required to have a formal and posted transfer plan to a hospital that accepts Medicare.*

11) Does HFAP require peer review processes for physician & surgeons? This information is not referenced in the Governing Body & Management chapter, **01.00.02**. California regulation code 1248.15(D) references physicians and surgeons who transfer patients from an Outpatient Surgery Setting shall agree to cooperate with the medical staff peer review process in those transferred cases.

HFAP Standards: 01.00.02 *Governing Body & Management. The ASC must have a Governing Body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the ASC total operation. The governing body has oversight and accountability for the quality assessment and performance improvement program, ensures that facility policies and programs are administered so as to provide quality health care in a safe environment, and develops and maintains a disaster preparedness plan.*

01.00.05 *Transfer agreement. The ASC must satisfy one of the following: Have a written transfer agreement with a hospital that meets the requirements of paragraph (b)(2) of 42 Code of Federal Regulation (416.41(b)(3)(i)); or, ensure that all physicians performing surgery in the ASC have admitting privileges at a hospital that meets the requirements of paragraph (b)(2) (416.41(b)(3)(ii)).*

Explanation: *HFAP's standard does not explicitly require participation in peer review processes for physicians & surgeons who transfer patients from an Outpatient Surgery Setting. The requirement is implicit in the requirement that the physician have admitting privileges. Generally, transfer agreements establish the respective responsibilities of each party to the agreement. If the ASC does not have a transfer agreement, then it must maintain documentation of the current admitting privileges of all physicians who perform surgery at the ASC at local hospitals that satisfy the regulatory requirements in 416.41(b)(2).*

12) HFAP performs on-site inspections within 120 days of expiration dates for re-accreditation. How often do Outpatient Surgery Settings undergo regular and routine on-site inspections? Are on-site inspections performed for initial and/or renewal accreditations?

HFAP Response: *Onsite inspections are performed for initials and/or renewal accreditations. HFAP's accreditation cycle is three (3) years for Outpatient Surgery Settings. At mid-cycle (18 months), 5% of facilities will undergo a random unannounced validation survey. Facilities that are due for renewal, the inspection will occur within 120 days before the expiration date. Accreditation award for renewals is three (3) years from prior expiration date and not based on last survey date.*

13) Are Outpatient Surgery Settings required to post the certificate of accreditation to be readily visible and accessible to patients and staff at the facility?

HFAP Response: *The facility is not required to post the certificate of accreditation. However, it may choose to do so as a statement of their accomplishment to the public. What is suggested is that the facility may notify the public of their upcoming accreditation survey; and if any members of the public*

have any quality-of-care or safety concerns, they are to notify HFAP of the complaint process by one of two methods: 1) Completion of the Complaint Form online at www.hfap.org; or 2) Contact HFAP's Quality Specialist by phone at 312-202-8067.

14) Inspection teams must comply with the following criteria:
    a. Accreditation reviewers must be credentialed and screened by the accreditation agency.
    b. Professional members of the accreditation review team must have experience in conducting review activities of free-standing outpatient settings.
    c. Participation in formal education training programs provided by the accreditation agency.

HFAP Response: *HFAP's policies require all surveyors to be credentialed and screened prior to seeking approval from the Executive Committee. Surveyors' performances are also evaluated and presented to the Executive Committee for appointment and re-appointment each year. Professional members of the surveyor cadre are appropriately selected for the type of setting(s) based on their education and experiences. Regular training is provided to all surveyors on an ongoing basis, and at least annually.*

Please provide information identifying where these requirements are specifically addressed in the HFAP manual.

15) The Board is required to post the following information to the Board's website pursuant to California Health and Safety Code (HSC) Section 1248.2:
    a. Whether an outpatient setting is accredited; or whether the setting's accreditation has been revoked, suspended, or placed on probation; or whether the setting has received a reprimand by the Accreditation Agency.
    b. The list of outpatient settings shall include all of the following:
        i. Name, address, and telephone number of any owners and their corresponding medical license numbers.
        ii. Facility ownership percentage for each owner.
        iii. Name and address of the facility
        iv. The name and telephone number of the accreditation agency
        v. The approval and expiration dates of the accreditation
        vi. Accrediting agencies approved by the board shall notify the board and update the board on all outpatient settings that are accredited.

HFAP Standard: 01.00.01 *Compliance with state licensure law. The ASC must comply with state licensure requirements (416.40). ASC must also conform to state, local and accreditation laws, regulations and/or standards.*

HFAP Response*: The ASC's compliance to the accreditation standard will also involve compliance with state-specific licensure requirements. Therefore, the applicant facility (ASC) as well as the approved accreditor (HFAP) will be required to report any necessary information in accordance with the California Health and Safety Code (HSC) Section 1248.2 as part of the application agreement.*

16) Is AOA/HFAP planning to provide the Board with the above information for the Outpatient Surgery Settings accredited by your organization?

HFAP Response: *If permitted and required, HFAP will comply with providing the necessary information for the Outpatient Surgery Settings, in the state of California, that are accredited by HFAP to the Board.*

Pursuant to HSC Section 1248.15(7), Outpatient Surgery Settings regulated by this chapter with multiple service locations shall have all of the sites inspected. Each and all facility locations are to be identified and must undergo individual separate on-site reviews.

17) Does the HFAP require on-site reviews for each facility seeking initial accreditation or reaccreditation?

HFAP Response: *Yes. All ASC facilities will undergo an on-site inspection whether seeking initial accreditation or re-accreditation. In cases where an applicant is seeking accreditation under one application with multiple sites, all ASC sites will be visited at 100%.*

18) Please identify where this information is located in your manual.

Pursuant to HSC Section 148.35, approved Accreditation Agencies are required to submit documents to the Board within specific timeframes. These documents include, but are not limited to electronic copies of inspection reports and corrective action report with specific timeframes identified to correct all facility deficiencies.

HFAP Response: *State-specific requirements are not specified within the accreditation manual. The requirement between the state, the ASC, and approved accreditation agency (HFAP) may be outlined in an agreement between the specified parties or, absent an agreement, part of the HFAP standard operating procedures.*

19) Will AOA/HFAP provide the required documents to the Board within the specified timeframes?

HFAP Response: *HFAP will comply with providing the necessary information for the Outpatient Surgery Settings that are accredited by HFAP within the specified timeframes to the Board.*

ATTACHMENT 4

AOA/HFAP
ACCREDITATION REVIEW CHART

CA - STATUTORY REQUIREMENT	ACCREDITATION CRITERIA	INITIAL MEETS REQUIREMENT Y/N/?	FOLLOW-UP MEETS REQUIREMENT Y/N/?	COMMENTS
HSC 1248.15(a)(1)	Outpatient setting allied health staff shall be licensed or certified to the extent required by state or federal law.	Y		
HSC 1248.15(a)(2)(A)	Outpatient settings shall have a system for facility safety and emergency training requirements.	Y		
HSC 1248.15(a)(2)(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.	?	Y	Sent AOA/HFAP request for clarification. AOA/HFAP submitted clarification substaniating compliance. HFAP Standard 05.01.07
HSC 1248.15(a)(2)(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:			
HSC 1248.15(a)(2)(C) (i)	Have a written transfer agreement with a local accredited or licensed acute care hospital, approved by the facility's medical staff	Y		
HSC 1248.15(a)(2)(C) (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.	Y		
HSC 1248.15(a)(2)(C) (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.	?	Y	Sent AOA/HFAP request for clarification. AOA/HFAP submitted clarification substaniating compliance. HFAP Standard 01.00.05

AOA/HFAP
ACCREDITATION REVIEW CHART

CA - STATUTORY REQUIREMENT	ACCREDITATION CRITERIA	INITIAL MEETS REQUIREMENT Y/N/?	FOLLOW-UP MEETS REQUIREMENT Y/N/?	COMMENTS
HSC 1248.15(a)(2)(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:	?	Y	Sent AOA/HFAP request for clarification. AOA/HFAP submitted clarification substaniating compliance. HFAP Standard 01.00.05
HSC 1248.15(a)(2)(D)(i)	Notify the individual designated by the patient to be notified in case of an emergency.	Y		
HSC 1248.15(a)(2)(D)(ii)	Ensure that the mode of transfer is consistent with the patient's medical condition.	Y		
HSC 1248.15(a)(2)(D)(iii)	Ensure that all relevant clinical information is documented and accompanies the patient at the time of transfer.	Y		
HSC 1248.15(a)(2)(D)(iv)	Continue to provide appropriate care to the patient until the transfer is effectuated	Y		
HSC 1248.15(a)(2)(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.	?	Y	Sent AOA/HFAP request for clarification. AOA/HFAP submitted clarification substaniating compliance. HFAP Standard 01.00.05
HSC 1248.15(a)(4)	Outpatient settings shall have a system for maintaining clinical records.	Y		

AOA/HFAP
ACCREDITATION REVIEW CHART

CA - STATUTORY REQUIREMENT	ACCREDITATION CRITERIA	INITIAL MEETS REQUIREMENT Y/N/?	FOLLOW-UP MEETS REQUIREMENT Y/N/?	COMMENTS
HSC 1248.15(a)(5)	Outpatient settings shall have a system for patient care and monitoring procedures.	Y		
HSC 1248.15(a)(6)(A)	Outpatient settings shall have a system for quality assessment and improvement.	Y		
HSC 1248.15(a)(6)(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.	?	Y	Sent AOA/HFAP request for clarification. AOA/HFAP submitted clarification substaniating compliance. HFAP Standard 06.00.02
HSC 1248.15(a)(6)(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.	Y		
HSC 1248.15(a)(7)	Outpatient settings regulated by this chapter that have multiple service locations shall have all of the sites inspected.	Y		
HSC 1248.15(a)(8)	Outpatient settings shall post the certificate of accreditation in a location readily visible to patients and staff.	Y		
HSC 1248.15(a)(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.	Y		
HSC 1248.15(a)(10)	Outpatient settings shall have a written discharge criteria.	Y		

AOA/HFAP
ACCREDITATION REVIEW CHART

CA - STATUTORY REQUIREMENT	ACCREDITATION CRITERIA	INITIAL MEETS REQUIREMENT Y/N/?	FOLLOW-UP MEETS REQUIREMENT Y/N/?	COMMENTS
HSC 1248.15(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.	Y		
HSC 1248.15(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.	?	Y	Sent AOA/HFAP request for clarification. AOA/HFAP submitted clarification substaniating compliance.
HSC 1248.15(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.	Y		

AOA/HFAP
ACCREDITATION REVIEW CHART

CA - STATUTORY REQUIREMENT	ACCREDITATION CRITERIA	INITIAL MEETS REQUIREMENT Y/N/?	FOLLOW-UP MEETS REQUIREMENT Y/N/?	COMMENTS
HSC 1248.15(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.	Y		
HSC 1248.3(a)	Certificates of accreditation issued to outpatient settings by an accreditation agency shall be valid for not more than three years.	Y		
HSC 1248.3(b)	The outpatient setting shall notify the accreditation agency within 30 days of any significant change in ownership, including, but not limited to, a merger, change in majority interest, consolidation, name change, change in scope of services, additional services, or change in locations.	Y		

CA - STATUTORY REQUIREMENT	ACCREDITATION CRITERIA	INITIAL MEETS REQUIREMENT Y/N/?	FOLLOW-UP MEETS REQUIREMENT Y/N/?	COMMENTS
HSC 1248.3(c)	Except for disclosures to the division or to the Division of Medical Quality under this chapter, an accreditation agency shall not disclose information obtained in the performance of accreditation activities under this chapter that individually identifies patients, individual medical practitioners, or outpatient settings. Neither the proceedings nor the records of an accreditation agency or the proceedings and records of an outpatient setting related to performance of quality assurance or accreditation activities under this chapter shall be subject to discovery, nor shall the records or proceedings be admissible in a court of law. The prohibition relating to discovery and admissibility of records and proceedings does not apply to any outpatient setting requesting accreditation in the event that denial or revocation of that outpatient setting's accreditation is being contested. Nothing in this section shall prohibit the accreditation agency from making discretionary disclosures of information to an outpatient setting pertaining to the accreditation of that outpatient setting.	Y		
HSC 1248.4(c)	The division shall approve an accreditation agency that applies for approval on a form prescribed by the division, accompanied by payment of the fee prescribed by this chapter and evidence that the accreditation agency meets the following criteria:	Y		
HSC 1248.4(c)(1)	Includes within its accreditation program, at a minimum, the standards for accreditation of outpatient settings approved by the division as well as standards for patient care and safety at the setting.	Y		
HSC 1248.4(c)(2)	Submits its current accreditation standards to the division every three years, or upon request for continuing approval by the division.	Y		
HSC 1248.4(c)(3)	Maintains internal quality management programs to ensure quality of the accreditation process.	Y		

AOA/HFAP
ACCREDITATION REVIEW CHART

CA - STATUTORY REQUIREMENT	ACCREDITATION CRITERIA	INITIAL MEETS REQUIREMENT Y/N/?	FOLLOW-UP MEETS REQUIREMENT Y/N/?	COMMENTS
HSC 1248.4(c)(4)	Has a process by which accreditation standards can be reviewed and revised no less than every three years.	Y		
HSC 1248.(c)(5)	Maintains an available pool of allied health care practitioners to serve on accreditation review teams as appropriate.	Y		
HSC 1248.4(c)(6)	Has accreditation review teams that shall do all of the following:	Y		
HSC 1248.4(c)(6)(A)	Consist of at least one physician and surgeon who practices in an outpatient setting; any other members shall be practicing actively in these settings.	Y		
HSC 1248.4(c)(6)(B)	Participate in formal educational training programs provided by the accreditation agency in evaluation of the certification standards at least every three years.	Y		
HSC 1248.4(c)(7)	The accreditation agency shall demonstrate that professional members of its review team have experience in conducting review activities of freestanding outpatient settings.	Y		
HSC 1248.4(c)(8)	Standards for accreditation shall be developed with the input of the medical community and the ambulatory surgery industry.	Y		
HSC 1248.4(c)(9)	Accreditation reviewers shall be credentialed and screened by the accreditation agency.	Y		
HSC 1248.4(c)(10)	The accreditation agency shall not have an ownership interest in nor be involved in the operation of a freestanding outpatient setting, nor in the delivery of health care services to patients.	Y		
HSC 1248.4(d)	Accreditation agencies approved by the division shall forward to the division copies of all certificates of accreditation and shall notify the division promptly whenever the agency denies or revokes a certificate of accreditation.	Y		

Expert Reviewer Pay Information by State

State	What is the hourly rate for the Expert Reviewers?
Arizona	$150/hour for case review, $300/hour for hearing preparation, and $400/hour for hearing testimony (may pay higher in unusually large or complex cases)
California	$150/hour for case review and $200/hour for hearing testimony; approved to increase to $200/hour for case review and $300/hour for hearing testimony if the physician has attended expert reviewer program training; approved to increase costs for neurosurgery experts to $300/hour for case review and $400/hour for hearing testimony (will be seeking budget authority for this proposal)
Kansas	$150/hour (may pay higher in a particular specialty and have paid as high as $500/hour) and pay varies depending on if it is case review or hearing testimony
Maine	No set rate, pay what must to get good service
Mississippi	No set rate, use a reasonable rate, and some volunteer services
Nevada	$150/hour for case review plus CME credits up to 20 hours for a renewal period; $250/hour for hearing testimony
North Carolina	$150/hour (in discussion to increase rate for hearing testimony)
Oregon	$150/hour for case review and hearing testimony
Washington (Osteo)	Price varies but commonly pay $400-$500/hour and has paid up to $600/hour
West Virginia	$220/hour (infrequently higher in a particular specialty but no more than $400/hour)
Wyoming	$150/hour (may pay higher in a particular specialty - $500+/hour)

The Medical Board queried all 50 states through the Administrator's in Medicine Exec Net on 6/25/13, only 10 responses were received.

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY

June 28, 2013

SPECIALTY	Number of cases reviewed/ sent to Experts (Jan-Jun, 2013)	Number of Experts Utilized (Jan-Jun, 2013)	Active List Experts 936↓
ADDICTION	7	**6 EXPERTS** 5 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	15
ALLERGY & IMMUNOLOGY (A&I)			4
ANESTHESIOLOGY (Anes)	8	**10 EXPERTS** 10 LIST EXPERTS REVIEWED 1 CASE	66 ↑
COLON & RECTAL SURGERY (CRS)	3	**2 EXPERTS** 1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	3
COMPLEMENTARY/ALTERNATIVE MEDICINE	9	**4 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES	20 ↓
CORRECTIONAL MEDICINE			26
DERMATOLOGY (D)	1	**1 EXPERT** 1 LIST EXPERT	10
EMERGENCY (EM)	12	**10 EXPERTS** 6 LIST EXPERTS REVIEWED 1 CASE 4 LIST EXPERTS REVIEWED 2 CASES	49
FAMILY (FM)	62	**36 EXPERTS** 17 LIST EXPERTS REVIEWED 1 CASE 12 LIST EXPERTS REVIEWED 2 CASES 4 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES 1 LIST EXPERT REVIEWED 8 CASES	74 ↓
INTERNAL (General Internal Med)	48	**34 EXPERTS** 25 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES 3 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES 1 LIST EXPERT REVIEWED 6 CASES	182 ↓
Cardiovascular Disease (Cv)	8	**6 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES	31 ↓

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY

June 28, 2013

SPECIALTY	Number of cases reviewed/ sent to Experts (Jan-Jun, 2013)	Number of Experts Utilized (Jan-Jun, 2013)	Active List Experts 936↓
Gastroenterology (Ge)	3	**4 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE	18
Medical Oncology (Onc)	3	**3 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE	11
Nephrology (Nep)	1	**1 EXPERT** 1 LIST EXPERT	9
Rheumatology (Rhu)	1	**1 EXPERT** 1 LIST EXPERT	8
MIDWIFE REVIEWER	1	**1 EXPERT** 1 LIST EXPERT	6
NEUROLOGICAL SURGERY (NS)	5	**3 EXPERTS** 1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	9
NEUROLOGY (N)	8	**6 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES	25 ↓
NEUROLOGY with Special Qualifications in Child Neurology (N/ChiN)			2
NUCLEAR MEDICINE (NuM)			5
OBSTETRICS & GYNECOLOGY (ObG)	35	**23 EXPERTS** 12 LIST EXPERTS REVIEWED 1 CASE 8 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES	80 ↓
OPHTHALMOLOGY (Oph)	12	**8 EXPERTS** 6 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 6 CASES	32↑

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY

June 28, 2013

SPECIALTY	Number of cases reviewed/ sent to Experts (Jan-Jun, 2013)	Number of Experts Utilized (Jan-Jun, 2013)	Active List Experts 936↓
ORAL & MAXILLOFACIAL SURGERY	1	**1 EXPERT** LIST EXPERT	1
ORTHOPAEDIC SURGERY (OrS)	5	**4 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	26 ↓
OTOLARYNGOLOGY (Oto)	2	**2 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE	22
PAIN MEDICINE (PM)	31	**13 EXPERTS** 5 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 3 CASES 3 LIST EXPERT REVIEWED 4 CASES 2 LIST EXPERTS REVIEWED 5 CASES	21 ↑
PATHOLOGY (Path)	1	**1 EXPERT** 1 LIST EXPERT	9 ↓
PEDIATRICS (Ped)	4	**5 EXPERTS** 5 LIST EXPERTS REVIEWED 1 CASE	47 ↑
PHYSICAL MEDICINE & REHABILITATION (PMR)	2	**2 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE	10
PLASTIC SURGERY (PIS)	22	**10 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 2 LIST EXPERTS REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES	47 ↓
PSYCHIATRY (Psyc)	62	**37 EXPERTS** 23 LIST EXPERTS REVIEWED 1 CASE 8 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERT REVIEWED 3 CASES 3 LIST EXPERTS REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 10 CASES	81

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY

June 28, 2013

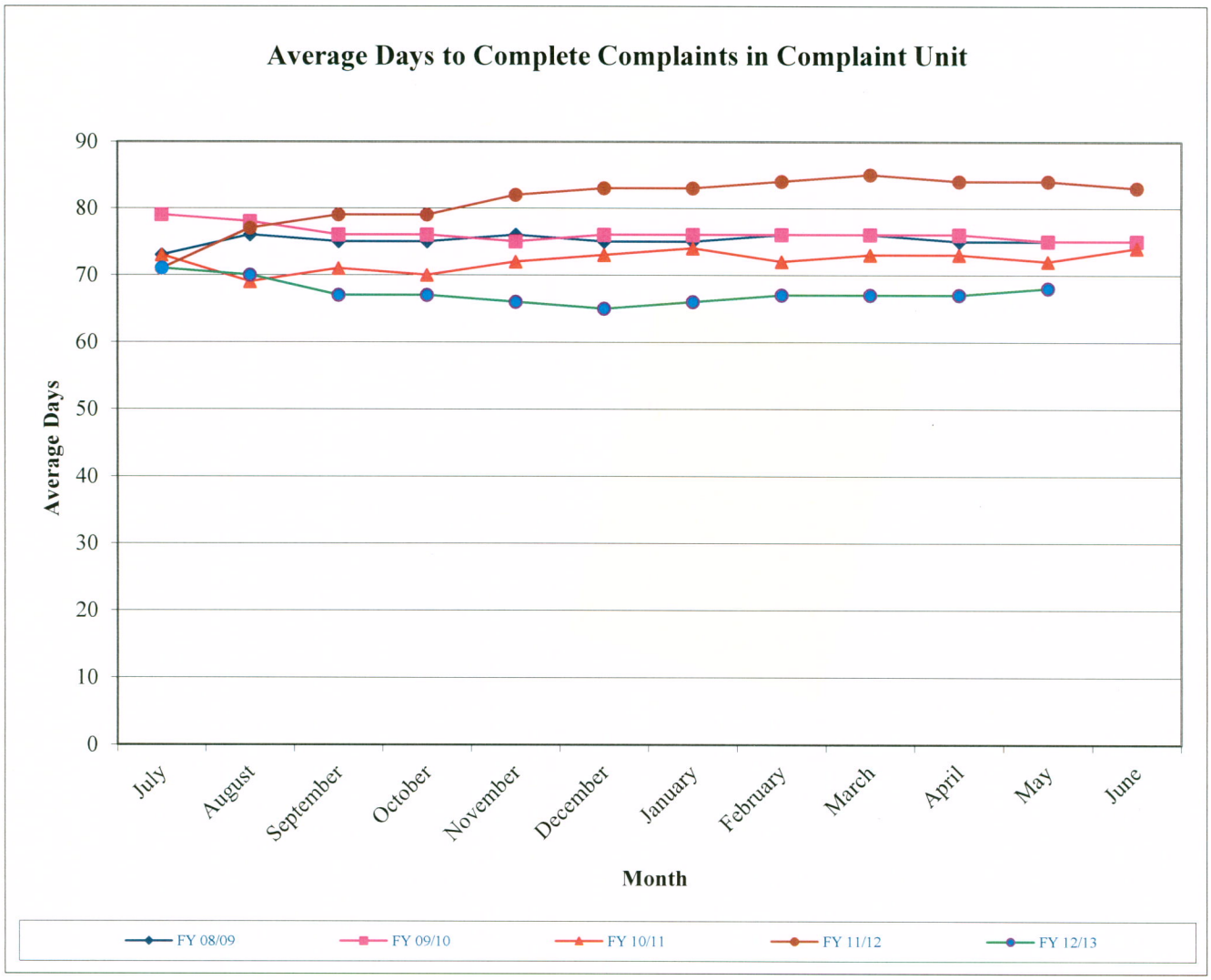
SPECIALTY	Number of cases reviewed/ sent to Experts (Jan-Jun, 2013)	Number of Experts Utilized (Jan-Jun, 2013)	Active List Experts 936↓
RADIOLOGY (Rad)	6	**6 EXPERTS** 6 LIST EXPERTS REVIEWED 1 CASE	33
SLEEP MEDICINE (S)			8
SURGERY (S)	22	**15 EXPERTS** 8 LIST EXPERTS REVIEWED 1 CASE 7 LIST EXPERTS REVIEWED 2 CASES	43 ↓
Vascular Surgery (VascS)	2	**1 EXPERT** 1 LIST EXPERT REVIEWED 2 CASES	9 ↑
THORACIC SURGERY (TS)			15 ↓
(MEDICAL) TOXICOLOGY			2 ↓
UROLOGY (U)	11	**7 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	15 ↑

TOTAL CASES SENT (2ND QUARTER)	**372**
TOTAL LIST EXPERTS UTILIZED (2ND QUARTER)	**258**
TOTAL ACTIVE LIST EXPERTS	**936**

/susan (6/27/13)

Medical Board of California Enforcement Program
Average Days to Complete Complaint in Complaint Unit

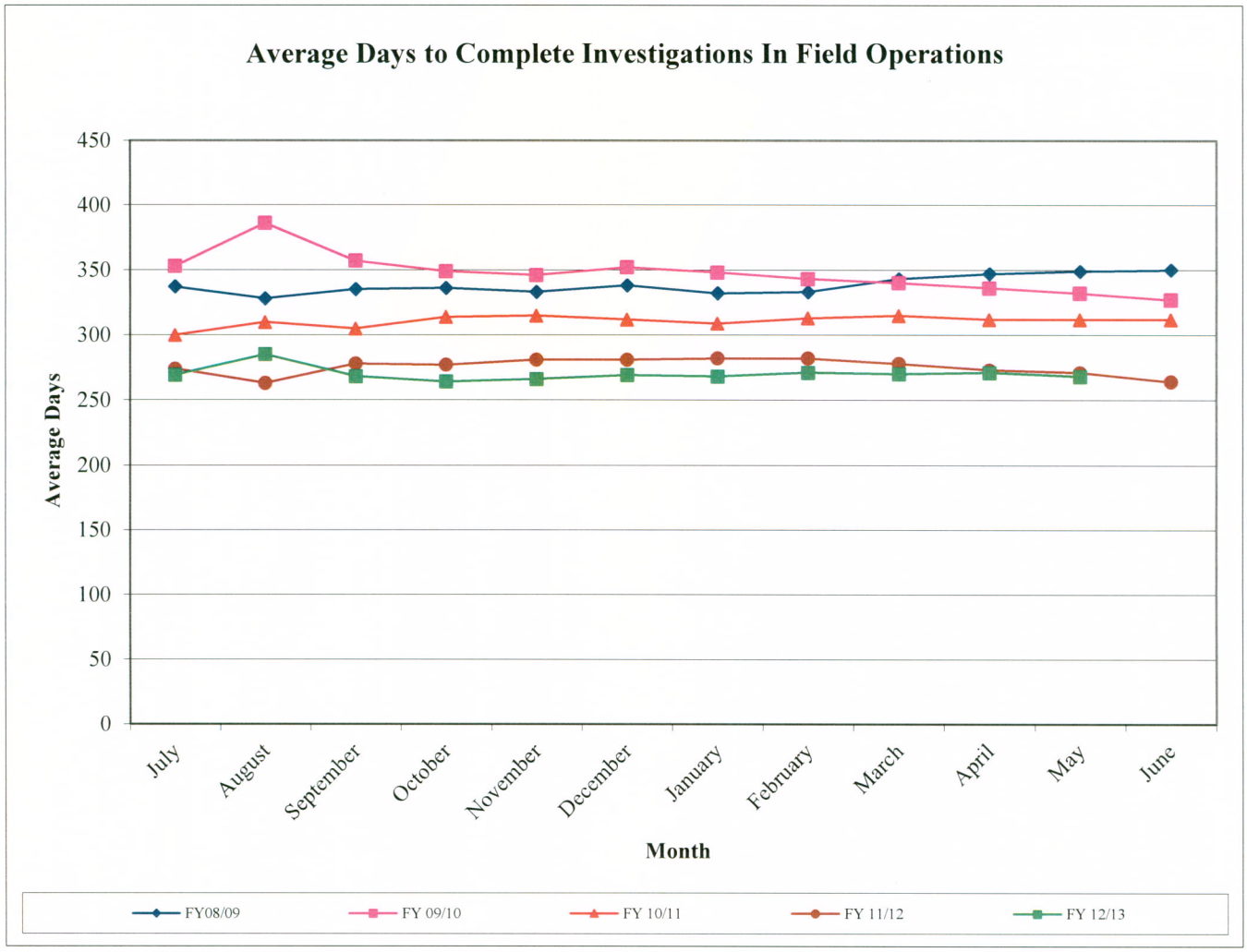
Month	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13
July	73	79	73	71	71
August	76	78	69	77	70
September	75	76	71	79	67
October	75	76	70	79	67
November	76	75	72	82	66
December	75	76	73	83	65
January	75	76	74	83	66
February	76	76	72	84	67
March	76	76	73	85	67
April	75	76	73	84	67
May	75	75	72	84	68
June	75	75	74	83	



Average Days to Complete Complaints in Complaint Unit includes complaints resolved by Complaint Unit and Complaint Unit processing days for cases completed at field investigation.

Medical Board of California Enforcement Program
Average Days to Complete Investigations in Field Operations

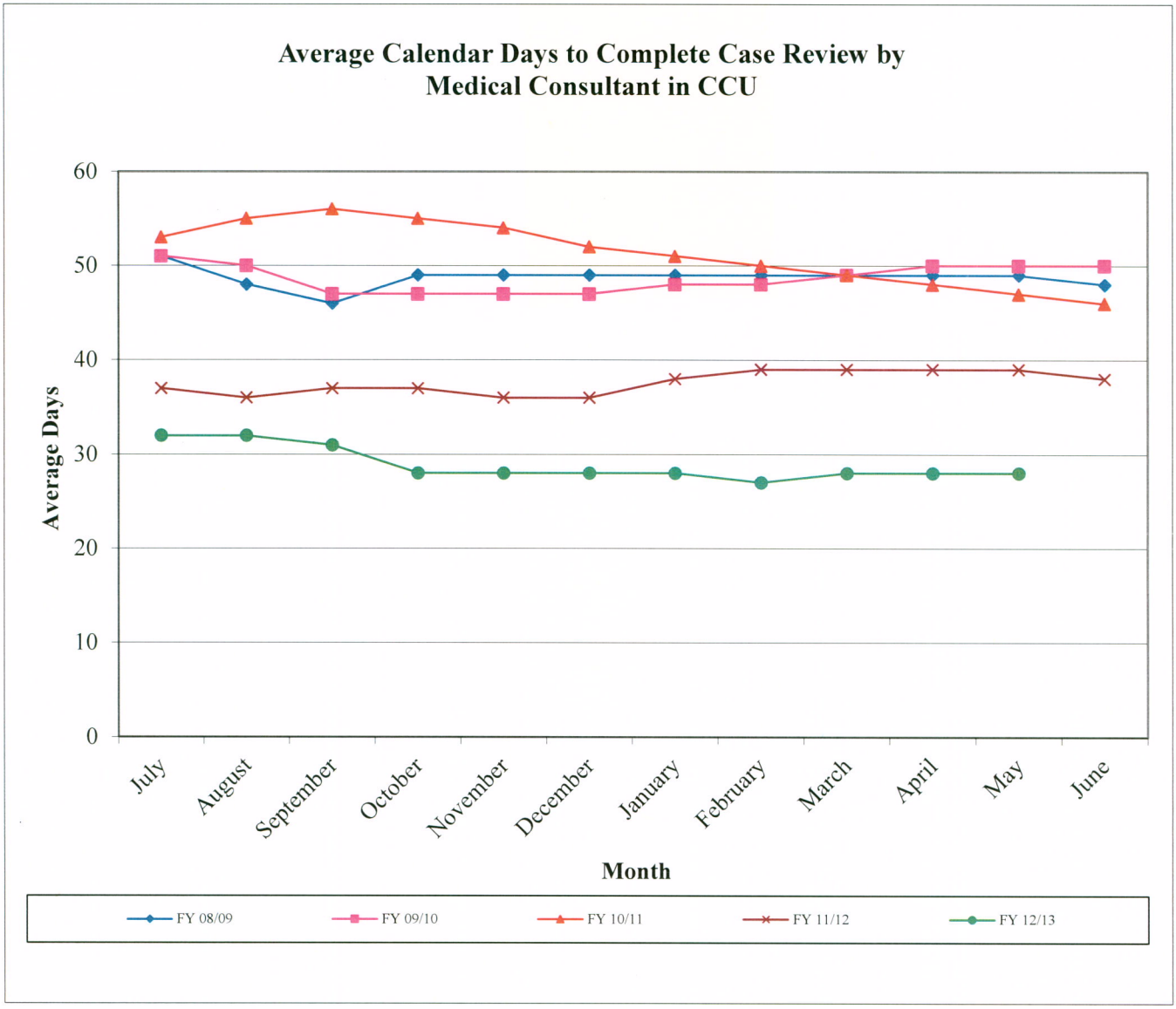
Month	Fiscal Year FY08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13
July	337	353	300	274	269
August	328	386	310	263	285
September	335	357	305	278	268
October	336	349	314	277	264
November	333	346	315	281	266
December	338	352	312	281	269
January	332	348	309	282	268
February	333	343	313	282	271
March	343	340	315	278	270
April	347	336	312	273	271
May	349	332	312	271	268
June	350	327	312	264	



Investigation processing days are from the date case was sent to field investigation by Complaint Unit until closure or referral (does not include Complaint Unit processing days for complaints completed at field investigation).

Medical Board of California Enforcement Program
Average Calendar Days to Complete Case Review by Medical Consultant in CCU

Month	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13
July	51	51	53	37	32
August	48	50	55	36	32
September	46	47	56	37	31
October	49	47	55	37	28
November	49	47	54	36	28
December	49	47	52	36	28
January	49	48	51	38	28
February	49	48	50	39	27
March	49	49	49	39	28
April	49	50	48	39	28
May	49	50	47	39	28
June	48	50	46	38	



Medical Board of California

Investigation Prosecution Timeframes*

	2005	2006		2007		2008		2009		2010		2011	2012	2013 Qtr 1	2013 Qtr 2
	Prior to VE	All	VE	All	VE	All	VE	All	VE	All	VE	All	All	All	All
Calendar Day Age from Case Assigned to Case Closed Not Resulting in Prosecution															
Average	271	299	138	330	268	374	358	383	381	333	333	296	263	266	269
Median	252	285	134	304	269	335	324	346	346	298	297	273	230	246	255
Record Count	827	703	192	648	539	609	588	673	672	664	663	857	794	222	201
Calendar Day Age from Request to Suspension Order Granted															
Average	51	44	4	34	38	19	19	52	39	40	40	43	73	33	36
Median	17	3	2	22	23	10	10	23	23	1	1	17	24	29	33
Record Count	24	21	11	17	13	21	17	17	16	27	27	31	51	9	12
Calendar Day Age from Request to Receipt of Medical Records															
Average	58	53	37	59	57	63	58	73	73	64	64	67	46	69	44
Median	32	31	26	31	31	28	28	32	32	29	29	30	28	34	29
Record Count	475	376	228	264	259	256	252	243	243	257	257	246	236	46	44
Calendar Day Age from Request to Physician Interview Completed															
Average	48	51	43	52	50	63	63	52	52	46	46	52	47	48	39
Median	36	42	38	37	36	41	42	37	37	34	34	38	35	37	31
Record Count	597	453	172	406	371	473	466	696	696	582	582	729	664	145	136
Calendar Day Age from Request to Receipt of Expert Opinion															
Average	51	47	35	51	43	50	50	48	48	47	47	58	57	47	48
Median	41	35	31	36	35	39	38	36	35	37	37	39	38	36	36
Record Count	519	424	82	344	270	374	359	426	424	415	415	599	447	142	151
Calendar Day Age from Case Assigned to Completed Investigation and Accusation Filed															
Average	556	554	140	543	340	565	493	584	578	589	588	552	495	558	499
Median	525	504	120	523	339	541	486	575	569	616	616	533	457	530	469
Record Count	187	149	17	198	95	157	131	189	186	200	199	239	231	54	65
Calendar Day Age from Accusation Filed to Disciplinary Outcome**															
Average	608	602	85	576	188	561	243	473	339	426	340	425	449	459	476
Median	526	466	99	426	182	384	238	351	309	326	304	391	367	422	440
Record Count	212	195	3	226	29	203	80	198	145	171	156	190	237	51	59

*Excludes Out of State and Headquarters Cases
**Excludes Outcomes where no Accusation Filed

Medical Board of California

Citations Issued & Civil Actions Filed by Calendar Year

	2005	2006	2007	2008	2009	2010	2011	2012	2013 Qtr 1	2013 Qtr 2
***Citations Issued**	80	81	76	109	124	100	98	122	21	19
Citations Issued for Failure to Produce Records	0	6	3	3	2	5	6	3	3	0
Civil Actions Filed	3	3	1	1	2	1	6	0	0	0
Civil Actions Filed for Failure to Produce Records	2	2	1	1	0	0	3	0	0	0

*Excludes citations issued for failure to comply with CME audit and for failure to notify Board of change of address

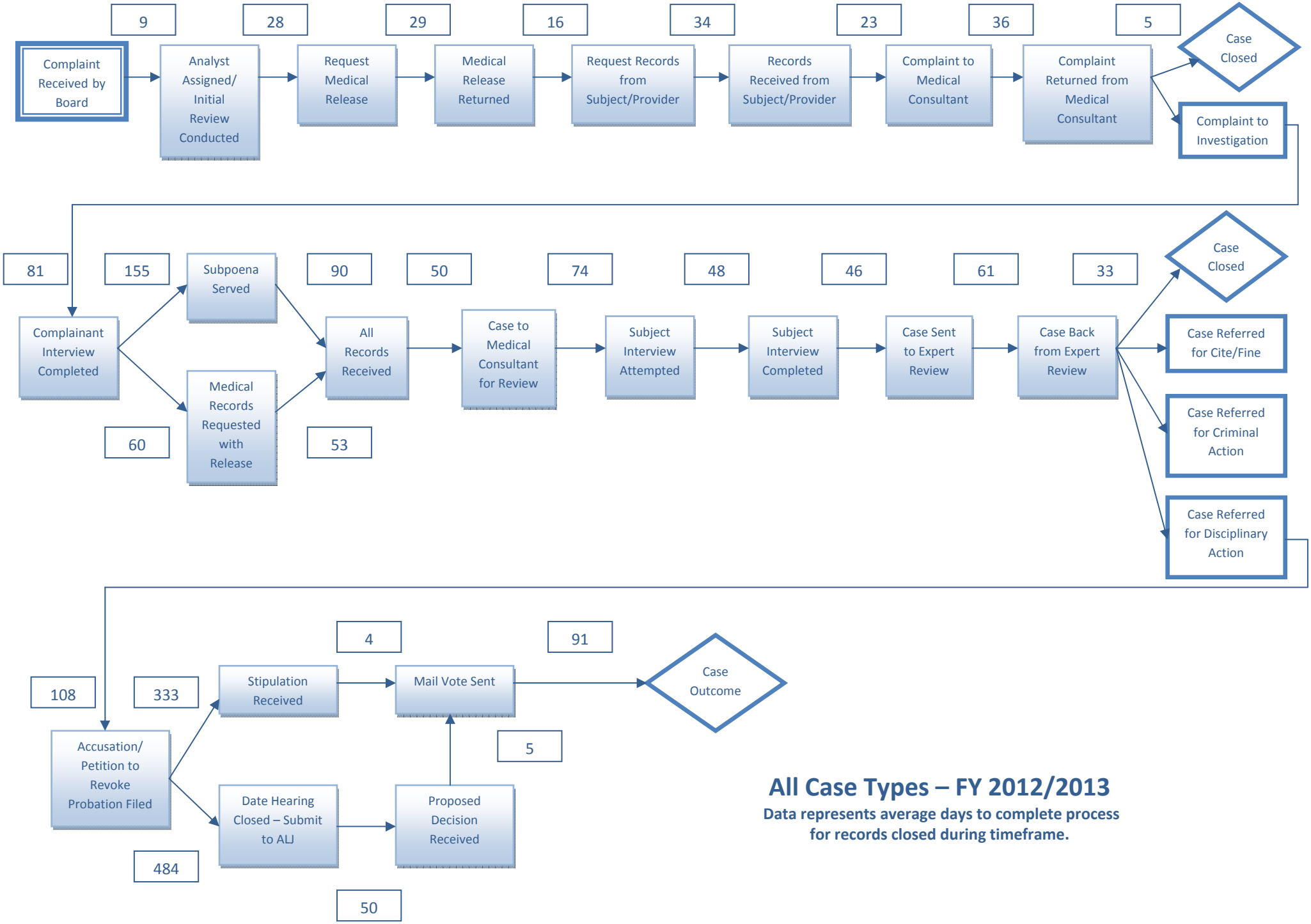
Enforcement Data Markers
All Case Types

Data represents average days to complete Complaint and Investigation processes for records closed during reported time frames.	FY 2008/2009		FY 2009/2010		FY 2010/2011		FY 2011/2012		FY 2012/2013	
	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records
Complaint Processes										
Complaint Received by Board → Analyst Assigned/Initial Review Conducted	10	6761	11	6869	9	7513	12	7699	9	7929
Analyst Assigned/Initial Review Conducted → Request Medical Release	25	1216	24	1360	28	1567	42	1557	28	1419
Request Medical Release → Medical Release Returned	29	1044	26	1166	25	1321	27	1281	29	1233
Medical Release Returned → Request Records from Subject/Provider	7	687	7	802	11	888	17	865	16	775
Request Records from Subject/Provider → Records Received from Subject/Provider	39	1759	38	1879	35	1906	35	2015	34	1953
Records Received from Subject/Provider → Complaint to Medical Consultant	15	1617	16	1865	17	1768	21	1798	23	1621
Complaint to Medical Consultant → Complaint Returned from Medical Consultant	54	1934	54	2120	52	2129	45	2164	36	1935
Complaint Returned from Medical Consultant → Case Closed/Complaint to Investigation	7	1932	4	2114	5	2126	4	2151	5	1928
Investigative Processes										
Complaint to Investigation → Complainant Interview Completed	103	349	102	424	110	490	89	531	81	513
Complainant Interview Completed → Subpoena Served	173	42	237	43	172	44	202	45	155	61
Complainant Interview Completed → Medical Records Requested with Release	76	141	88	170	59	194	87	203	60	213
Subpoena Served → All Records Received	124	120	100	178	88	166	82	146	90	151
Medical Records Requested with Release → All Records Received	95	372	92	406	85	420	64	416	53	418
All Records Received → Case to Medical Consultant for Review	78	227	84	318	70	369	59	322	50	313
Case to Medical Consultant for Review → Subject Interview Attempted	110	374	109	488	77	558	76	532	74	477
Subject Interview Attempted → Subject Interview Completed	66	712	53	880	53	961	51	1046	48	1014
Subject Interview Completed → Case Sent to Expert Review	97	412	81	511	72	580	57	626	46	614
Case Sent to Expert Review → Case Back from Expert Review	79	510	72	601	63	658	61	701	61	706
Case Back from Expert Review → Case Closed or Referred for Action	39	495	31	585	30	656	29	705	33	697

Enforcement Data Markers
All Case Types

Data represents average days to complete Disciplinary processes for records closed during reported time frames.	FY 2008/2009		FY 2009/2010		FY 2010/2011		FY 2011/2012		FY 2012/2013	
	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records
Case Referred for Action → Accusation/Petition to Revoke Probation Filed	121	239	113	237	103	219	129	284	108	304
Accusation/Petition to Revoke Probation Filed → Stipulation Received	330	159	291	173	318	142	329	202	333	198
Stipulation Received → Mail Vote Sent	6	136	6	132	4	124	5	153	4	141
Accusation/Petition to Revoke Probation Filed → Date Hearing Closed - Submit to ALJ	416	25	370	30	393	44	318	45	484	55
Date Hearing Closed - Submit to ALJ → Proposed Decision Received	28	35	98	43	39	58	40	63	50	86
Proposed Decision Received → Mail Vote Sent	5	54	5	53	6	60	6	72	5	88
Mail Vote Sent → Case Outcome	131	206	87	208	111	205	82	262	91	265

Data represents overall average days from Receipt to Closure for records closed during reported time frames.	FY 2008/2009		FY 2009/2010		FY 2010/2011		FY 2011/2012		FY 2012/2013	
	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records
Complaint Received → Closure in Complaint Unit	84	5278	84	5247	80	5755	91	5687	75	5886
Complaint Received → Closure at Field/Referred for Administrative or Criminal Action/Citation Issued	467	1585	464	1747	453	1861	419	2101	404	2143



All Case Types – FY 2012/2013

Data represents average days to complete process for records closed during timeframe.

MEDICAL BOARD OF CALIFORNIA
Enforcement Processing Timeframes
2012 Strategic Plan Objective 5.2

Enforcement Process	2008/2009		2009/2010		2010/2011		2011/2012		2012/2013	
	Cases[1]	AVG[2]	Cases	AVG	Cases	AVG	Cases	AVG	Cases	AVG
Complaint	6426	75	6563	76	7008	74	7217	83	7408	67
% of Complaints Below 50 days (Goal: 50-60%)	**43%**		**41%**		**35%**		**42%**		**48%**	
Investigation	1100	349	1290	328	1411	312	1545	264	1551	267
Discipline										
AG Processing to Preparation of an Accusation	240	103	304	106	294	107	333	103	298	90
Other Stages of the Legal Process (e.g., after charges filed)	228	381	232	368	216	417	280	396	293	434

[1] Some cases closed were opened in a prior fiscal year. **(Footnote applies to all years provided on report)**

[2] Average time (calendar days) in processing complaints during the fiscal year, for all cases, from date of original receipt of the complaint, for each stage of discipline, through completion of judicial review. **(Footnote applies to all years provided on report)**

ENFORCEMENT TIMEFRAMES

FISCAL YEARS	2006 - 2007		2007 - 2008		2008- 2009		2009 - 2010		2010 - 2011		2011 - 2012		2012 - 2013	
	AVERAGE	MEDIAN	AVERAGE	MEDIAN	AVERAGE	MEDIAN	AVERAGE	MEDIAN	AVERAGE	MEDIAN	AVERAGE	MEDIAN	AVERAGE	MEDIAN
COMPLAINT PROCESSING	54	49	61	49	75	63	76	63	74	77	83	64	68	54
INVESTIGATION	307	289	324	272	349	309	328	292	312	283	264	225	267	244
TOTAL MBC														
DAYS	361	338	385	321	424	372	404	355	386	360	347	289	335	298
YEARS	0.99	0.93	1.05	0.88	1.16	1.02	1.11	0.97	1.06	0.99	0.95	0.79	0.92	0.82
AG PREP FOR ACC	127	76	121	58	103	63	106	66	107	72	104	78	90	75
OTHER LEGAL	446	350	471	324	381	311	368	312	417	324	396	351	434	360
TOTAL AG														
DAYS	573	426	592	382	484	374	474	378	524	396	500	429	524	435
YEARS	1.57	1.17	1.62	1.05	1.33	1.02	1.30	1.04	1.44	1.08	1.37	1.18	1.44	1.19
TOTAL MBC & AG														
DAYS	934	764	977	703	908	746	878	733	910	756	847	718	859	733
YEARS	2.56	2.09	2.68	1.93	2.49	2.04	2.41	2.01	2.49	2.07	2.32	1.97	2.35	2.01

Years calculated using 365 days per year
Data source: MBC Annual Reports, except 2012-2013

Medical Board of California
Suspension Orders Issued
by Suspension Type

Suspension Order Type	FY 04/05	FY 05/06	FY 06/07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13
Automatic Suspension Order	5	1	5	0	3	7	4	6	4
PC 23 Order	8	4	8	6	15	7	12	12	22
Out of State Suspension Order	15	14	8	11	18	18	21	17	9
Agreement - No Practice/Restriction	2	6	5	2	3	3	2	0	3
Suspension/Cease Practice Issued by Chief	5	5	3	1	2	1	3	4	6
Interim Suspension Order	31	32	22	18	22	22	28	35	34
Temporary Suspension Order	1	0	0	1	0	0	1	0	0
Totals	**67**	**62**	**51**	**39**	**63**	**58**	**71**	**74**	**78**

Roles of Board Officers/Committee Chairs/Panel Officers

President

- Spokesperson for the Medical Board (including but not limited to) – may attend legislative hearings and testify on behalf of the Board, may attend meetings with stakeholders and Legislators on behalf of Board, may talk to the media on behalf of the Board, and signs letters on behalf of the Board
- Meets and communicates with the Executive Director on a regular basis
- Communicates with other Board Members for Board business
- Authors a president's message in every quarterly newsletter
- Approves Board Meeting agendas
- Chairs and facilitates Board Meetings
- Chairs the Executive Committee
- Signs specified full board enforcement approval orders
- Signs the minutes for each of the Board's quarterly Board Meetings
- Represents the Board at Federation of State Medical Boards' meetings and other such meetings

Vice President

- Is the Back-up for the duties above in the President's absence.
- Is a member of Executive Committee

Secretary

- Signs the minutes for each of the Board's quarterly Board Meetings
- Is a member of Executive Committee

Past President

- Is responsible for mentoring and imparting knowledge to the new Board President
- May attend meetings and legislative hearings to provide historical background information, as needed
- Is a member of Executive Committee

Committee Chair

- Approves the Committee Agendas
- Chairs and facilitates Committee Meetings

Panel Officers

- Chair – Chairs and facilitates Panel Meetings
- Chair – Signs orders for Panel decisions
- Vice Chair – Acts as Chair when Chair is absent