State of California
Business, Consumer Services and Housing Agency

MEDICAL BOARD OF CALIFORNIA

EXECUTIVE COMMITTEE MEETING AND ENFORCEMENT COMMITTEE MEETING

October 23

* *

FULL QUARTERLY BOARD MEETING

October 24-25, 2013

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MEDICAL BOARD OF CALIFORNIA
BOARD MEETING SCHEDULE

Historic Mission Inn
3649 Mission Inn Avenue
Riverside, CA 92501

October 23 – 25, 2013

Wednesday, October 23

- **2:00 p.m. – 4:00 p.m.** **Executive Committee**
  (Members: Levine (Chair), GnanaDev, Serrano Sewell, Diego, Yaroslavsky)

- **4:00 p.m. – 7:00 p.m.** **Enforcement Committee**
  (Members: GnanaDev(Chair), Levine, Schipske, Serrano Sewell, Yaroslavsky, Yip)

Thursday, October 24

- **8:30 a.m. – 12:30 p.m.** **Panel A**
  (*Members: Yaroslavsky (Chair), Bishop, Diego, Lewis, Serrano Sewell, Wright, Yip)*

- **8:30 a.m. – 12:30 p.m.** **Panel B**
  (Members: GnanaDev (Vice Chair), Krauss, Levine, Pines, Schipske, Tagami)

- **12:30 p.m. – 1:30 p.m.** **Lunch Presentation**
  (All Members)

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

- **5:00 p.m. – 6:00 p.m.** **Enforcement Committee (if needed)**
  (Members: GnanaDev (Chair), Levine, Schipske, Serrano Sewell, Tagami, Yaroslavsky, Yip)

Friday, October 25

- **9:00 a.m. – 3:30 p.m.** **Full Board Meeting**
  (All Members)

MEDICAL BOARD OF CALIFORNIA

QUARTERLY BOARD MEETING AGENDA

Mission Inn
3649 Mission Inn Avenue
Riverside, CA 92501
(951) 784-0300 (directions only)

Thursday October 24, 2013
12:30 p.m. – 1:30 p.m.
1:30 p.m. – 5:00 p.m.
(or until the conclusion of Business)

Friday, October 25, 2013
9:00 a.m. – 3:30 p.m.
(or until the conclusion of Business)

ORDER OF ITEMS IS SUBJECT TO CHANGE.

MEMBERS OF THE BOARD
Sharon Levine, M.D., President
David Serrano Sewell, J.D., Vice President
Silvia Diego, M.D., Secretary
Michael Bishop, M.D.
Dev GnanaDev, M.D.
Howard Krauss, M.D.
Ronald Lewis, M.D.
Denise Pines
Gerrie Schipske, R.N.P, J.D.
Phil Tagami
Jamie Wright, Esq.
Barbara Yaroslavsky
Felix Yip, M.D.

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.

Thursday, October 24, 2013

1. 12:30 p.m. Presentation on Information Technology and Healthcare – Ron Goldman, Kognito

2. 1:30 p.m. Call to Order/Roll Call

3. Approval of Minutes from the July 18-19, 2013 Meeting

4. Introduction and Swearing in of New Board Members

5. 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)]

6. Presentation on the Interim Suspension Order Process – Division Presiding Administrative Law Judge Alvord

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. Executive Summary
   B. Consideration of 2014 Board Meeting Dates

10. Request Approval to Obtain an Attorney General Legal Opinion Regarding Medical Assistant Scope of Practice – Ms. Webb / Ms. Kirchmeyer

11. Federation of State Medical Boards – Dr. Levine and Ms. Kirchmeyer
    A. Update on Federation of State Medical Board activities
    B. Approval of Recommendations for FSMB Committees

12. Update on the Enforcement Committee – Dr. GnanaDev

13. Enforcement Chief's Report – Ms. Threadgill
    A. Approval of Orders Following Completion of Probation and Orders for License Surrender During Probation
    B. Executive Summary

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

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

16. Licensing Chief's Report – Mr. Worden
    A. Executive Summary

17. Update from the Outpatient Surgery Settings Task Force; Consideration and Possible Action – Dr. GnanaDev/ Mr. Serrano Sewell

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

19. Update on Physician Assistant Board – Dr. Bishop / Mr. Sachs

20. Consideration of Regulatory Proposal to Revise Physician Assistant Scope of Practice (CCR, Title 16, Division 13.8, Section 1399.541) – Dr. Bishop / Mr. Sachs

RECESS

Friday, October 25, 2013

21. 9:00 a.m. Call to Order/Roll Call

22. 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)]

23. 9:00 a.m. REGULATIONS – PUBLIC HEARING – Ms. Webb / Ms. Cady
    Uniform Standards for Substance Abusing Licensees. Amendment of Section 1361 and Addition of 1361.5 to Title 16, California Code of Regulations. This proposal would implement the Uniform Standards for Substance Abusing Licensees.

24. Update from the Department of Consumer Affairs – Ms. Lally

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

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

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

28. Midwifery Advisory Council– Ms. Sparrevohn
   A. Consideration of Midwifery Advisory Council Member Nomination
   B. Update and Consideration of Council Recommendations

29. Consideration of Legislation/Regulations – Ms. Simoes
   A. 2013 Legislation
   B. 2014 Legislative Proposals
   C. Status of Regulatory Actions

30. Agenda Items for February 13-14, 2014 Meeting in San Francisco Area

31. CLOSED SESSION (1:00 p.m.)
   Pursuant to Section 11126(a)(1) of the Government Code, the Board will meet in Closed Session, to interview candidates for and discuss appointment of an Executive Director

32. Adjournment

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

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

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 health care consumers through the proper licensing and regulation of physicians and surgeons and certain allied health care 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.

Changing Health Behaviors
by Improving Conversations
www.kognito.com
212-675-9234

October 2013

Kognito Interactive

Company Overview for the Medical Board of California

1.0 About Kognito

Kognito Interactive is a leading developer of evidence-based, interactive training simulations that enable health providers and informal caregivers to master the communication and motivational interviewing skills to change the health behaviors of patients they interact with. Delivered online and via mobile devices, Kognito's simulations provide learners with challenging role-play experiences where they engage in conversations with emotionally-responsive virtual patients that possess their own memories and personalities and act and respond like real patients. Through these hands-on and highly-realistic practice scenarios, users gain the skill, confidence, and motivation to engage in similar conversations in real life.

Since 2009, Kognito has built an extensive library of practice conversations using its proprietary Human Interaction Game Engine™, which is based on research in neuroscience, social cognition, and adult learning theory. These programs have been adopted by over 450 hospitals, universities, non-profits, state agencies, and federal agencies to train over 2 million people. These organizations include the California Dept. of Education, Veterans Affairs, DoD, Departments of Health in over 12 states, and the California Community College system. Three of Kognito's simulations are listed in the National Registry of Evidence-Based Programs and Practices (NREPP). Overall, Kognito simulations provide organizations with cost-effective solutions to train large or geographically-dispersed audiences with effective learning tools that users can access at their convenience. View demos at www.kognito.com

2.0 Sample Simulation: At-Risk in Primary Care

Kognito's *At-Risk in Primary Care* is an online CME-approved course that teaches doctors and nurses to recognize when a patient's physical ailments are masking underlying substance abuse or mental health disorders and how to use motivational interviewing skills to integrate behavioral health into the treatment plan while building the patient's motivation to adhere to it. One of the role-play scenarios in this training involves dealing with a patient "demanding" a renewal of pain medication prescription. The program was recently adopted by NYC Dept. of Health to train 7,000 providers.
View demo at: www.kognito.com/pcp/demo

Snapshot of simulated conversation where users assume the role of a doctor and speak with a virtual patient

3.0 Contact Information

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MEDICAL BOARD OF CALIFORNIA

QUARTERLY BOARD MEETING

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

AGENDA ITEM 3

July 18-19, 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 July 18, 2013, 2013 at 1:40 pm. 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.
Gerrie Schipske, R.N.P., J.D, Vice President
Phil Tagami
Felix Yip, M.D.
Barbara Yaroslavsky

Members Absent:
None

Staff Present:
Eric Berumen, Central Complaint Unit Manager
Susan Cady, Staff Services Manager, Central Complaint Unit
Ramona Carrasco, Central Complaint Unit Manager
Dianne Dobbs, Department of Consumer Affairs, Legal Counsel
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
Armando Melendez, Business Services Analyst

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

Members of the Audience:
Teresa Anderson, California Association of Physician Assistants
G.V. Ayers, Consultant, Senate Business, Professions, and Economic Development Committee
Gloria Castro, Attorney General's Office, Los Angeles
Don Chang, Department of Consumer Affairs
Yvonne Choong, California Medical Association
Genevieve Clavreul
Zennie Coughlin, Kaiser Permanente
Frank Cuny, California Citizens for Health Freedom
Julie D'Angelo Fellmeth, Center for Public Interest Law
Hank Dempsey, Chief Consultant, Assembly Business, Professions, and Consumer Protection Committee
Karen Ehrlich, L.M., Midwifery Advisory Council
Karen Fischer, Dental Board
Corrine Fishman, Department of Consumer Affairs
Jack French, Consumer's Union Safe Patient Project
Julie Haskins, Anthem Blue Cross
Sarah Huchel, Consultant, Assembly Business, Professions, and Consumer Protection Committee
Christine Lally, Department of Consumer Affairs
Eduardo Martinez, California Medical Association
Tina Minasian, Consumer's Union Safe Patient Project
Michele Monserratt-Ramos, Consumer's Union Safe Patient Project
Alison E. Price, Licensed Midwife
Victoria Samper, Institute of Medical Quality
Taryn Smith, Senate Office of Research
Carrie Sparrevohn, Midwifery Advisory Council

Prior to agenda item two, Dr. Levine introduced and welcomed Ms. Christine Lally, the newly appointed Deputy Director for Board and Bureau Relations from the Department of Consumer Affairs, (DCA) and her Executive Assistant, Corrine Fishman; Taryn Smith from the Office of

Senate Research; G.V. Ayers, a consultant to the Senate Business and Professions Committee; and Karen Fisher, the Executive Officer of the Dental Board of California.

Dr. Levine then congratulated Ms. Gerrie Schipske for being chosen by the White House as a Champion of Change for Open Government. She is one of seven from across the country selected and will be honored at a ceremony next week at the White House.

Dr. Levine then announced that this meeting would be Dr. Reginald Low's last Board Meeting. He has served eight years, two terms, as a Board Member. She stated that his contributions and leadership role to the Board have been significant and that he will be missed by all. She stated that he was the Chair of the Enforcement Committee and is responsible for the tremendous work done over the last year and a half in really improving the Boards Expert Reviewer Program and implementing the excellent training program. Dr. Levine thanked him on behalf of all of the Members for his contributions.

Agenda Item 2 Public Comments on Items not on the Agenda

No public comment was heard on this item.

Agenda Item 3 Approval of Minutes from the June 4, 2013 Meeting

Dr. GnanaDev made a motion to approve minutes; s/Ms. Yaroslavsky. Motion carried.

Agenda Item 4 Presentation on Covered California – Dr. Jeffrey Rideout, M.D.

Dr. Levine introduced Dr. Jeffrey Rideout who is currently the Senior Medical Advisor for Covered California, the State of California's Health Insurance Exchange (the Exchange). He 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.

Dr. Levine asked Dr. Rideout to please cover in his remarks the implication for physicians and the role they can play in assisting their patients to understand the Affordable Care Act (ACA) and stated that the Board has the opportunity to use its communication channels to assist in that role.

Dr. Rideout stated that there has been a very large community awareness grant program, but the Exchange is also in the middle of a clinician and provider grant program, so physician organizations can decide on whether or not they want to apply for those grants so that part of the physician education exercise goes through known channels.

Ms. Yaroslavsky asked Dr. Rideout to provide any information regarding the stakeholders as well as the physicians and patient community as to where to find opportunities and information and what they should be looking for within their own practices that are now going to be covered.

Dr. GnanaDev asked Dr. Rideout to explain how the physicians are going to get paid through the Exchange program. He further asked if the Exchange is taking an approach to standardized billing and payments to and from different insurance companies.

Dr. Rideout stated that the Exchange is organizing health plans and their physicians and other provider delivery systems to supply insurance to those that are eligible, and subsidies for those who would like to buy coverage through the Exchange. The Exchange is not dictating or telling people how to create those networks or the rates that go into it. Currently, the network configurations are still with the regulators, but the actual configuration of the networks are something that is not politically available.

Dr. Rideout gave a presentation on how the Affordable Care Act (ACA) is working and how Covered California will be implementing the ACA and education of the different plan options that will be available to those who are eligible and take the opportunity to get insurance coverage through the Exchange.

Agenda Item 5 **Discussion and Consideration of Proposed Regulations to Implement SB 1441, Relating to Substance Abusing Licensees – Mr. Heppler / Ms. Dobbs**

Mr. Heppler gave the Board a brief background on the history of the Board's prior diversion program, noting that this program was not a required contracted program, but a "self-administered" program put together by the Board. There were three ways to get into the diversion program: self-referral, the voluntary option; ordered into it by a disciplinary order; or through a Statement of Understanding, in lieu of discipline.

Mr. Heppler advised the Board that if these regulations are adopted, the Board will not have a contracted diversion program nor will it have a self-administered diversion program. These standards will come into place when a licensee is disciplined. The adoption of these regulations will not bring back the former diversion program, nor will it implement a contracted diversion program. The Board will still continue to have substance-abusing licensees. There were 16 standards that were set forth by the Substance Abuse Coordination Committee (SACC), but not every one of those standards is set forth in the regulations. Standards 13, 14 and 15 deal with contracted based diversion programs, which are not applicable to the Board as the Board does not have a contracted diversion program nor a self-administered diversion program. Standard 16 instructs the Board, not a licensee to collect data. This standard is applicable to the Board; however, Mr. Heppler stated that his legal opinion is it does not have to be in regulation because it is governing the internal procedure of the Board. It does not affect a licensee. It does affect how the Board collects, reports on, and analyzes the data and will ultimately decide if the diversion program is successful or not, so he does not feel that it should be incorporated in the regulations.

Mr. Heppler announced that there is an error in one of the regulations and asked them to turn to page BRD 5-5, under subsection (5), biological fluid testing, subparagraph (i)(1), it reads: "The Board may revise the frequency, specified in section (i), upon a determination that the licensee is not currently employed in the healthcare field", and the erroneous language now reads, "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." It should read: "the licensee DOES NOT suffer from a substance use or abuse disorder."

He continued that the balance of these regulations and standards have been adopted in the proposed regulations. With the exclusion of standards 13, 14, 15 and 16, 1 through 12 have been incorporated in these regulations. If the Board sees fit, the proper motion would be to set this matter for public notice and hearing at the next available Board Meeting.

Ms. Yaroslavsky made a motion to approve the recommendation; s/Ms. Schipske.

Public Comment was heard on this item.

Julie D'Angelo-Fellmeth, Center for Public Interest Law, went over a list of specific language in the uniform standards that she believes are missing from Mr. Heppler's draft that was presented to the Board Members.

Michele Monserratt-Ramos, Consumer's Union Safe Patient Network urged the Board to adopt staff's recommendation that the Board place uniform standards into regulatory language, rather than including them in the disciplinary guidelines and stated that Standard number 16 should be placed into regulation.

Dr. Levine stated that the motion at this point was to approve the language. However, the Board could change that motion to add some language based upon the comments, and then notice that for regulatory hearing at the October Board Meeting. After discussion, it was determined to keep the original motion and to give the Board the opportunity, as required by law, to consider all oral and written comments received at the hearing in October.

Motion carried.

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

Ms. Kirchmeyer stated that at the last meeting, the Board reviewed four options for allowing individuals who were not physically in attendance at the Board Meeting to be able to make comments to the Board. The Board requested Ms. Kirchmeyer and Ms. Schipske discuss other options in more detail for members of the public to be able to offer public comment at the Board meetings without being in attendance. After discussion, it was determined that there are two viable options for the Board to consider.

The first option is to offer a telephone line that one could call to either make a comment to the Board or they can listen to the meeting and make comments. An individual would have the option of watching the video on webcast and calling in when they want to make a comment or listening to the whole meeting via the webcast and making comments at the appropriate time. This would be done with a moderator to monitor these callers.

The issue with this option is the time incurred to hear from all of the individuals at the meeting as well as those calling into the meeting. Legal Counsel has stated that the Board has the authority to limit the time afforded for public comment. Each speaker whether in person or on the phone would be given 2 minutes to provide his/her comment, and at the end of the comment time, the Board would then move to the next speaker. At the end of a set time (example 20 minutes), the public comment period would end. Limiting the time allocated for public comment on any agenda item is a change from the Board's current practice of just appointing time per speaker rather than for the complete public comment period.

The second option is to provide an email account where an individual watching the webcast could submit written comments or questions to a staff member who could monitor and read the comments or questions to the Board at the appropriate time. Again, the Board could impose limits to the time that it takes for these comments to be read. Per Legal Counsel, if the Board institutes time limit requirements equally for those present at the meeting and those joining remotely, regulations may not be necessary but are recommended. The Board would need to be very strict in enforcing time limits, The Board may choose to pilot one of these options at a future Committee Meeting before implementing at a full Board Meeting. The cost for either of these options is minimal, but would require staff to monitor either the phone or the computer.

Ms. Schipske thanked Ms. Kirchmeyer and staff for the time they put into finding these options. She added that she agrees that piloting one of these options at a Committee Meeting is a good way to start and see how much participation the Board gets and also how much staff time would be involved in handling the calls that are received. Ms. Schipske asked the Board to give this consideration and authorize a pilot.

Public comment was heard on this item.

Michele Monserratt-Ramos, Consumer's Union California Safe Patient Network, stated the Consumer's Union is pleased that there is a recommendation before the Board to take action to provide teleconferencing at Board meetings. They recommend that the Board apply a uniform time limit per person to people in the room and on the phone. They also recommend that the Board make the teleconferencing available for some time before making a final decision on whether the Board feels there is a need to propose an overall time limit on testimony for particular agenda items. They feel that the Board should establish an email opportunity to be used anytime the Board runs out of time for receiving oral testimony and that written comments can be emailed to the Board to be shared during the public comment period. This ensures that no one feels that there voice is being left unheard.

Jack French from San Diego stated he supports the teleconferencing that staff recommends. As a survivor of MERCA, there was a time when he could not travel to participate in meetings; with teleconferencing in place, other California's like himself can participate is the important business of the Board.

Tina Minasian, Consumers Union California Safe Patient Project, stated she also supports the teleconferencing option that staff recommends. As a survivor of medical harm, there are times

that she cannot attend Board meetings due to her injuries. With teleconferencing in place, other consumers like herself will be able to participate in important safety issues with the Board.

Ms. Schipske made a motion that the Board approve the concept to teleconferencing and allow a pilot effort to be launched with the direction of staff, to test the teleconferencing option out to see how best the Board can open up access to the meetings offsite; s/Ms. Yaroslavsky. Motion carried.

Agenda Item 7 **Board Member Communications with Interested Parties – Dr. Levine**

Dr. GnanaDev noted that he continuously talks with American Medical Association and CMA, but does not discuss Board issues.

Agenda Item 8 **President's Report – Dr. Levine**

Dr. Levine reported that since the Board Meeting in April, subsequent to the sunset review hearing, she met with previous chairs of both the Senate and Assembly Business and Professions Committee regarding the sunset review and the issues that were raised by the Committees. She spoke in great length with both Committee Chairs, both who have now been replaced. Dr. Levine will be setting up meetings to meet with both of the new Committee Chairs in the near future. She and Dr. Low presented at the Senate Business and Professions Committee hearing on SB 304. On July 2nd, Dr. Levine sent a letter to the Chairs of both Committee's providing an update on actions the Board has taken and the Board's desire to ensure that the Board is moving forward to meet every concern of the Committees and communicating clearly with the Legislature the actions being taken to ensure the Board's commitment to consumer protection.

Since the June 4th Board Meeting, Ms. Kirchmeyer has assumed the role of Interim Executive Director and she and Dr. Levine have had calls every two weeks with the Executive Team discussing issues and providing updates of Board activities, status reports, and the work of staff.

Dr. Levine announced that Senator Curran Price was elected to the Los Angeles City Council and Senator Ted Lieu has taken over as Chair of Senate Business and Professions Committee. She also announced that Assemblyman Gordon has moved from Assembly Business and Professions Committee to the Assembly Rules Committee and Assembly Member Bonilla has taken over as Chair of the Assembly Business and Professions Committee.

Public Comment was heard on this item.

Jack French, Consumer Union Safe Patient Project, urged the Board to change the policy that now states that the Executive Committee should have at least one public member within a group of five members. He feels that it is clearly the intention of the Legislature that public members be much more heavily represented in deliberations of the Board. California law requires that seven of fifteen of the Board Members be public members. He recommends that the Board set a

policy that requires all Committees have the same balance as required by the legislature for the full Board.

Dr. Levine announced some changes to the Board's Committees. Ms. Pines will be joining the Education and Wellness Committee as her background in media, marketing, communication and public education will be extremely valuable to the Board.

Dr. Yip and Mr. Tagami have both agreed to serve on the Enforcement Committee.

With Dr. Low's departure due to his term expiring, Mr. Serrano Sewell has agreed to serve as Chair of the Enforcement Committee.

Dr. Yip will also be serving on the Special Faculty Permit Review Committee with Dr. Low's departure.

Dr. Levine confirmed that Ms. Yaroslavsky and Dr. Bishop are the Members on the Prescribing Task Force and that they will be meeting sometime after Labor Day.

Dr. Levine announced that looking at the functions of the Board and after discussions with Executive Staff and the work of the Board distributed among the Committees, she would like to consolidate some of the work. Dr. Levine recommended to the Board that the Board incorporate the Budget Subcommittee, the Full Board Evaluation Subcommittee and what was the Strategic Plan Creation Subcommittee into an Organizational Effectiveness Committee which will essentially look at budget, full Board evaluation, and any necessary revisions and changes to the Strategic Plan in light of the sunset review and the work the Board has been doing subsequent to the sunset review. This will be a committee of two. Mr. Tagami has agreed to work with Dr. Levine on this Committee.

Dr. Levine then announced that Dr. Bishop was appointed by the Governor to the Physician's Assistant Board as well as being re-appointed to the Medical Board and congratulated him.

Agenda Item 9 Interim Executive Director's Report – Ms. Kirchmeyer

Ms. Kirchmeyer provided an update on several administrative items. She reported that she and the Executive Staff have a conference call twice a month with Dr. Levine to review the actions of the Board and to ensure that Board requests are being completed. Ms. Kirchmeyer has developed and maintains a spreadsheet which provides a status on all requests pending from the Board Members. She will be sending a monthly update to the Members on the status of items listed on this spreadsheet.

Ms. Kirchmeyer has bi-weekly meetings scheduled with the DCA Director, Denise Brown, to provide updates on the Board.

Ms. Kirchmeyer also has bi-weekly meetings scheduled with Ms. Castro of the Attorney General's (AG's) Office in order to remain up to date on items of interest to the Board and the AG's Office.

Ms. Simoes and Ms. Kirchmeyer met with legislative staff from the Senate and Assembly Business and Professions Committees to discuss the Board's sunset review and to provide an update on actions the Board has taken.

Ms. Threadgill and Ms. Kirchmeyer met with the DCA executive and personnel staff to discuss the Board's request to pursue pay differentials for the investigators. It was too late for this request to go into current negotiation discussions, but Ms. Kirchmeyer will be putting the information forward to DCA for future consideration.

Ms. Kirchmeyer stated that Ms. Threadgill has confirmed with the Office of Administrative Hearings (OAH) that an Administrative Law Judge will provide a presentation at the October Board Meeting regarding Interim Suspension Orders.

Ms. Simoes, Ms. Hockenson and Mr. Schunke met with staff from the Department of Health Care Services to discuss outreach to newly licensed physicians regarding fraud and how to prevent abuse of their license. Staff has agreed to partner with them in several ways, including putting their brochure on Protecting Medi-Cal against Fraud, Waste and Abuse into each new licensee's packet of information from the Board, coordinating outreach events, and possibly including a little blurb in Mr. Schunke's outreach to future applicants. The Department of Health Care Services will also be making a presentation to the Board at the October meeting.

Ms. Kirchmeyer announced that she, Ms. Simoes, Ms. Threadgill, Ms. Webb and Mr. Heppler met with the Receiver and his staff from the California Correctional Health Services regarding the recent investigation on female inmate tubal ligation. Ms. Kirchmeyer wanted to obtain information from them on the events surrounding the investigative report and to discuss what the Board needed in order to perform an investigation. The Board will be working with the Receiver's staff to obtain the necessary information to continue its investigation.

Regarding staffing, Ms. Kirchmeyer stated that she received notification Wednesday that the Board will be able to hire student assistants and retired annuitants. However, there is specific criteria that must be met and an approval process. The Board will be requesting retired annuitants to assist in background investigations, field training, personnel, and assistance with the BreEZe project until such time as all positions are filled. The Board is still at a 7% vacancy rate which equated to 20 vacant positions. Of those 20 positions, 11 individuals are either in background, pending a start date, or pending verification of eligibility. Therefore, the Board has only 9 positions that do not have an individual awaiting to fill the positions. This equates to a 4% vacancy rate, but there are two upcoming future retirements.

For discussion on the Board's budget, the Board's current fund condition shows that the Board's fund reserve at the end of this fiscal year is projected to be 4.3 months. The Board only has one BCP request that was approved for budget year 2013/2014 and that is for the BreEZe system.

The other approved cost is for CURES. Ms. Kirchmeyer stated that the Board would hear more on this issue from Ms. Simoes during her Legislative update and that the Budget bill included language that provided an appropriation for the new CURES system. All prescribing and dispensing licensing Boards were required to provide funding for the new system. The Board's portion was $848,000 in fiscal year (FY) 2013-2014 and $790,000 in FY 2014-2015. Ms. Simoes will discuss continued

funding for the CURES program when she discusses SB 809. The budget bill had specific language that stated the Feasibility Study Report has to be agreed upon by the DCA and the Department of Justice (DOJ). In addition, the DCA will work with the DOJ on the roles and responsibilities of each department as to the governance, development, implementation and utilization of the system. DCA has held three meetings with the affected Healing Arts Boards to discuss the current feasibility study report and the requirements for the system that DOJ is proposing. Each Board has been providing input into this process.

Ms. Kirchmeyer announced that the Board will be requesting four augmentations for FY 2014/2015. These requests include BreEZe costs; funding and position authority for an Operation Safe Medicine Unit in Northern California; funding and position authority for additional positions in the Enforcement Unit; and an increase in expert review rates, as approved by the Board. These positions and increases are necessary to continue to improve the enforcement process and reduce the complaint, investigative, and discipline timeframes.

Ms. Kirchmeyer stated that based upon these new projections, including the four future augmentations, it appears that the Board will be within its mandated two to four months reserve at the end of next fiscal year. Therefore, it is not prudent to consider any reduction at this time as previously recommended by the Bureau of State Audits.

Ms. Kirchmeyer referred Board Members to a page in their packet that shows the Board's actual expenditures as of May 31st. Although the budget is in line, she wanted to point out a couple items that may seem odd, referring to the line item for Other Items of Expense. This line item, due to its extremely low budget, shows that it is extremely over budget. Staff has reviewed the items of expense, which included law enforcement materials needed for POST, and determined that the increase this year was due to the fact the Board had a significant amount of staff attending POST. Staff will adjust the budget for this fiscal year to accurately reflect the spending in this line item so it does not continue to go over budget. Another item that is over is the vehicle operations which is indicative to the old cars and the need for repairs on them. Staff's training has increased due to the POST academy and training for BreEZe.

Ms. Kirchmeyer then discussed the budget report specifically for licensing, enforcement and the AG expenditures. She noted that the AG's Office spending is down this year. She believes it is due to the fact there are several vacant positions. Ms. Kirchmeyer stated that Ms. Castro will be providing information regarding hires during her presentation.

Ms. Kirchmeyer referred Members to a document in their packet that is in response to the strategic plan objection 5.3. This chart shows a cost comparison for the past five fiscal years for external agencies' spending. She asked that the members please note that the last column in this document for FY 12-13 is what is budgeted and also includes what was actually spent.

Ms. Kirchmeyer then gave a brief update on the BreEZe project reminding Members that this is the computer system that will replace the legacy licensing and enforcement systems. She stated that staff was notified recently that the project team is currently projecting a Go-Live date for September 17, 2013. However, in order to reach this release date the staff must complete a significant amount of testing on the new system and on the data conversion process. The Board has a significant number of

staff working on this project and this work will continue not only prior to the release date, but after the Go Live date due to the need to continue to test certain items. Ms. Kirchmeyer also reminded everyone that there will definitely be a learning curve after the system has been implemented and that staff will make every effort to mitigate this possible slowdown in productivity while the staff learns the new system and that when the system does Go Live, there will be a few days of down time. Staff will notify licensees of this, but wanted to let the Board know that physicians will not be able to renew online during this time. Staff will post this information on the Web site and do everything they can to let those who have to renew that month know that the Board is changing computer systems and it may impact their renewal so they need to renew as early as possible.

Lastly, in regards to the sunset review update, Ms. Kirchmeyer stated that Ms. Simoes will discuss the Board's Sunset Bill, SB 304 during her presentation and again reminded the Board the Senate Business and Professions Committee had 39 issues for the Board to address. Most of these issues are in SB 304. There were a few issues that were resolved and answered via the Board's response to the sunset review report submitted in April, and the Board still has a few issues that require research, studies and/or workshops to be held. Staff has prepared a spreadsheet to track these items and will continue to work toward resolution of the items that require follow-up. The Board staff will be working on these items in the next few months and will provide an update at the October Board Meeting.

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

Ms. Kirchmeyer stated that at a prior meeting, the Board requested information on the history of the gag clause legislation. This request was made after the Board heard from a physician who was disciplined for violating this law. Ms. Kirchmeyer gave a brief summary of what the gag clause is stating section 2220.7 of the Business and Professions (B&P) Code states a physician and surgeon cannot include in a settlement any language that says the patient cannot file a complaint or cooperate with the Board, or include any language that requires the patient to withdraw a complaint. If a physician does this they are subject to disciplinary action.

In the 2003/2004 legislative cycle, Assembly Member Correa introduced a bill that would have done exactly what the Board's current law requires in prohibiting a gag clause; however, it included the prohibition for all licensees licensed by boards under the DCA, including the Medical Board. This bill passed out of the Legislature, but was vetoed by the Governor.

The following year, in 2005, Assembly Member Negrete-McLeod introduced a very similar bill for all of the DCA, however, again the bill passed out of the Legislature, but was vetoed by the Governor.

In 2006, the Board sponsored a bill which was authored by Assembly Member Negrete-McLeod to prohibit physicians from including any gag clause language in a settlement. The Board had heard from public members during public comment on the impact a gag clause can have on the Board's ability to take disciplinary action against a licensee. With the Board's mission of consumer protection, it was decided that they should request a legislative change which prohibited gag clauses. This bill was signed into law in 2006 and became effective January 1, 2007.

Ms. Threadgill stated that the Board has alleged this violation against licensees in several actions. In one case, staff found the violation as a result of a settlement report. During the investigation the existence of the confidentiality agreement was discovered when the patients attorney declined to cooperate with the release of records citing the confidentiality agreement signed by the patient when the civil case was settled. This case resulted in the issuance of a public letter of reprimand to the physician for violation of B&P Code Section 2220.7. Ms. Threadgill stated that in another case that involved sexual misconduct, the patient and the physician entered into a civil settlement agreement and again, the physician's attorney cited the confidentiality agreement provision as a barrier to unlimited production, so an accusation was filed alleging multiple violations including B&P Code Section 2220.7. Ms. Threadgill stated that this kind of agreement is against public policy. Because physicians are entering into these agreements, investigators have to work harder to get the courts to break the agreement and order the records be released.

Ms. D'Angelo Fellmeth stated that lawyers have been forbidden to use regulatory gag clauses in civil malpractice agreements for about 30 years. A 2012 bill AB 2570 introduced by Jerry Hill expanded the gag clause ban to all licensees of the DCA, so everyone is subject to this clause. She also stated that there is a difference between a confidentiality clause and a regulatory gag clause and the only thing that is banned currently is the regulatory gag clauses. The meaning of that is the clause prohibits the patient from complaining to the regulators. The confidentiality clause tends to require the plaintiff to agree not to reveal how much paid, etc. This clause is still legal.

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

Ms. Yaroslavsky announced that the Health Professions Education Foundation (Foundation) has had a problem with the number of people it has as Members and the ability to generate a quorum. The Foundation has a new appointee to their Board, Dr. Delvekio Finley, Chief Executive Officer of the Los Angeles County Harbor UCLA Medical Center since 2011. Previously he was Vice President of operations for California Pacific Medical Center and the Associate Hospital Administrator for the San Francisco general hospital from 2006 – 2009. The Foundation entered into and signed an interagency agreement with the Assembly Rules Committee for $2 million dollars to deploy a minimum of 134 primary care practitioners throughout the State of California. They signed the first grant agreement with the California Endowment for $155,000 for administrative support. The Foundation is currently in the process of submitting a second grant proposal for $13 million dollars, which is due next month. The Foundation released their electronic application forms for the California Healthcare, Cal Reach program and have found that one new application is initiated every 11.8 minutes. The Foundation has 381 scholarships, and 709 loan repayments in progress at this time.

Agenda Item 12 **Update of Federation of State Medical Boards – Dr. Levine / Ms. Kirchmeyer**

Dr. Levine gave an update on the Federation of State Medical Board (Federation) meeting that took place in April, 2013. She reported that the theme of the meeting was the *Medical Workforce; What Regulators Need to Know Now*. A presentation was made by Dr. Sparrow, a professor from the John F. Kennedy School of Government on the Art of Harm Reduction on lessons from the world of regulatory practice. The presentation was about regulation from two difference perspectives. One which was harm

reduction and the other was, looking at regulations as a tool and an approach to improving the industry and/or enterprise that it is regulating. These are two very different approaches and there are strengths and weaknesses in each. Dr. Sparrow's conclusion being that this is not an either/or world, but that it needs to be looked at from both a consumer protection harm reduction perspective and also as regulation being an opportunity to improve the performance and public accountability of whatever enterprise is being regulated. Dr. Sparrow has written a book on the topic.

Dr. Levine stated there were three particular topic discussions that she feels is important to the Board. The first was the issue of multi-state licenses. With the growth of the telehealth industry, and the technology of telemedicine there is an interest in using this mechanism to provide health care remotely, with remotely meaning anywhere in the world. There have been two bills introduced in Congress supporting the telecommunications industry to get Congress to enact the pathway to a national license. It has been a topic of concern with all State Medical Boards as it would separate the licensing function from the enforcement function. All State Medical Boards that were in attendance of the Federation meeting opposed any support for the notion of national licensure. However, several other options were explored that states might look at to enable states to get specialty consultation from adjacent states. The notion that was approved for exploration was interstate compacts; the development of a model for example, Wyoming and Washington State to enter into an agreement for certain services and consultants whom could operate across state lines without requiring state licensure in each state. The states would work out agreements amongst themselves in regards to the enforcement function, continuing medical education, etc. Dr. Levine feels that consumer protection will be very awkward and very difficult should national licensure happen.

The second item is the pilot project that is just beginning on maintenance of licensure. The Federation is working with several interested states to pilot an effort to parallel the work being done by the American Board of Medical Specialties (ABMS) to create a process for maintenance of competency. Currently, most states have continued medical education (CME) requirements which vary from state to state. The ABMS has universally moved from lifetime board certification to time limited board certification. For some of the boards, they have moved from an exam based board certification to what is called maintenance of certification. This requires the physician on an annual basis to engage in activities in four domains which demonstrate competency, quality improvement, etc. There are a number of dimensions that have to be documented on an annual basis. Many of the boards are moving away from the once every ten years exam. There are approximately 878,000 physicians who are in active practice in the United States and 200,000 are board certified. Approximately three to four hundred thousand licensees have either let their board certification lapse or have lifetime board certification. The maintenance of licensure issue is focusing on those physicians who do not have the opportunity to demonstrate competency on an on-going basis through re-certification either through maintenance of certification or an exam. The Colorado Medical Board was interested in being a pilot because in Colorado, state law prohibits the requirement for CME, except in discipline, so the only time Colorado can require CME is if the physician has been shown to be deficient and is being disciplined by the Medical Board.

The third issue is that there has been a lot written in the policy world and medical journals about the increasingly burdensome debt that physicians are leaving training with and questioning whether the current number of years required for medical school and residency program are necessary to produce competent physicians. A number of medical schools in the country are participating in innovative

approaches to possibly combining the four years of medical school, particularly in primary care. They are looking at accelerating what is now a seven or eight year medical school training into three years of medical school and three years of graduate medical education. While the Board has no action to take at this point, the issue was raised in the sunset review that the requirements for licensure in California may need to be looked at if some of the California medical schools or US medical schools are producing graduates whose technical graduation requirements do not meet what is in current law.

Ms. Kirchmeyer stated that the Federation, the house of delegates approved the creation of the interstate compact. At this point the Federation is just exploring what it would look like and how it would come to fruition. The information has been forwarded to Ms. Kirchmeyer.

Ms. Kirchmeyer announced that she is serving on the IAMRA's physician information exchange working group. Ms. Kirchmeyer is also working with the Federation on a minimal data set.

Agenda Item 13 Update on Physician Assistant Board – Mr. Schunke

Mr. Schunke announced that Governor Brown has appointed Dr. Bishop to the Physician's Assistant (PA) Board in June and he will fill the position for the physician member. The PA Board has taken a support position on SB 352, the bill which would authorize a physician to allow a PA, Nurse Practioner, or Certified Nurse Midwife to supervise medical assistants when the supervising physician is not on site. The PA Board has finished the regulatory process for the free health care events. It has gone through the DCA and the State of Consumer Services Agency; the package has been submitted to the Office of Administrative Law and is awaiting its approval. The next PA Board meeting is scheduled for August 26, 2013.

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

Mr. Schunke stated that in the 15 years he has been with the Board, he feels that this year has been the best due to the hard work of staff in getting the applicants licensed. There were just a few delays with fingerprints not coming through on time, but the last outstanding fingerprint result came through just recently and those applicants are now licensed. At last count, there are only four applicants who needed a license by July 1, 2013 to start their training program that have not been licensed yet. Mr. Schunke congratulated Mr. Worden and two of his managers, Ms. Oseto and Mr. Salgado, for doing what they needed to do to get people licensed as quickly as possible.

Mr. Schunke announced that he had finished orientation at all of the teaching hospitals. He will travel around the State to give a brief introduction to all the new residents in California. He will be starting in August going to licensing fairs through Northern and Southern California.

Ms. Yaroslavsky reminded the Board Members that what Mr. Schunke does is very important by being out there in the communities and making sure that the applicants get their paperwork completed in a timely fashion and that the staff at the medical schools and hospitals know what is going on and have a direct conduit to the Board. Ms. Yaroslavsky thanked Mr. Worden and his staff as well. She recommended the Board Members attend the licensing fairs with Mr. Schunke to see what he does.

Dr. GnanaDev would like to see staff do a similar outreach on the enforcement program. It would make a tremendous difference by reaching out to the doctors to assist in preventing them from getting into trouble.

Ms. Threadgill stated that enforcement has been doing these types of presentations for a number of years and frequently get requests to do presentations all over the State. Requests have also been coming to Board Members from the various parties asking whether they would like to participate in those presentations. The Enforcement Program staff can assist in putting a presentation together and co-presenting with a Board Member.

Dr. Salomonson complimented Ms. Sweet for the beautiful job she did while presenting at the plastic surgeons annual meeting. She feels it was very well received.

Dr. Levine requested that something on ways to protect your license be put into the new licensee packet. She feels that many of the new graduates see licensure as an entitlement until they have a problem.

Ms. Yaroslavsky complimented the communications staff for using the Newsletter as a tool to help educate physicians on enforcement dangers.

Dr. GnanaDev stated that this is a good opportunity to push that the number one thing of importance is patient safety and how protecting their license falls in line with patience safety.

Dr. Yip suggested that with the approval of the Board, any Board Member, in any part of the State, go to the medical schools, during first or second year, and do a talk and case study to educate students on Board experiences. He has been asked to do a talk at a local school.

Ms. Yaroslavsky stated that when one first comes out of medical school, they are so inundated with information that they need reminder courses after several years.

Agenda Item 29 **Election of Officers**

Mr. Tagami made a motion to nominate Dr. Diego as secretary; s/Ms. Yaroslavsky. Motion carried.

Mr. Tagami made a motion to nominate Mr. Serrano Sewell for Vice President; s/Dr. GnanaDev. Motion carried. Mr. Serrano Sewell agreed to serve as Vice President, but stated that he would resign as Chair of the Enforcement Committee.

Ms. Yaroslavsky made a motion to nominate Dr. Levine to continue as President; s/Ms. Schipske Motion carried.

Dr. Levine took the opportunity to recognize a very valued Board Member who served on the Board from 2004 to 2012, Dr. Shelton Duruisseau. Dr. Duruisseau played a very important leadership role in many aspects during his tenure on the Board. Dr. Levine wanted to call out specifically his contribution in convening and putting focus on what became the Physician Wellness Committee at the time the Diversion program was sunsetted. Dr. Duruisseau was an important voice is saying that the

Board needs to focus on what it can do to prevent physicians from getting into a situation where impairment puts their license and career at risk. He was instrumental in bringing experts in the field to share their expertise with the Board. He was elected Vice President at the July 2012 meeting and served in that role until his tenure ended.

Dr. Levine thanked Dr. Duruisseau for his service to the Board and presented him with a recognition plaque. Dr. Duruisseau thanked Dr. Levine and congratulated her on being re-elected as President. He thanked the Board for the work that it does and that it is a work of labor and love and stated that the Board needs to be congratulated for their commitment and dedication. He also recognized the staff as well for the work that they do in supporting the Board. He feels it is very important for the Board and the staff to work together as a team to make the Board what it is. He stated serving on the Board was probably one of the greatest things he thought he could do and he hopes that the small contributions that he made served the people of California.

Dr. Levine adjourned the meeting at 5:06 pm.

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Agenda Item 15 **Call to Order / Roll Call**

Dr. Levine called the meeting of the Medical Board of California (Board) to order on July 19, 2013 at 10:10 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
Janet Salomonson, M.D.
Gerrie Schipske, R.N.P., J.D, Vice President
Felix Yip, M.D.
Barbara Yaroslavsky

Members Absent:
David Serrano Sewell, J.D.
Phil Tagami

Staff Present:
Aaron Barnett, Investigator
Eric Berumen, Central Complaint Unit mANAGER
Susan Cady, Staff Services Manager, Central Complaint Unit
Ramona Carrasco, Central Complaint Unit Manager
Dianne Dobbs, Department of Consumer Affairs, Legal Counsel
Andrew Heglein, Office of Standards and Training
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
Natalie Lowe, Licensing Manager
Jim Nuovo, UC Davis, Medical Consultant
Dino Perino, Business Services Officer
Monica Peretto, Investigator
Regina Rao, Business Services Analyst
Paulette Romero, Central Complaint Unit Manager
Dave Ruswinkle, Associate Governmental Program Analyst, Enforcement
Kevin Schunke, Licensing Outreach Manager
Jennifer Simoes, Chief of Legislation
Laura Sweet, Deputy Chief, Enforcement
Kathryn Taylor, Licensing Program Manager
Renee Threadgill, Chief of Enforcement
Lisa Toof, Administrative Assistant II
Anna Vanderveen, Investigator
See Vang, Business Services Analyst
Michel Veverka, Investigator
Kerrie Webb, Legal Counsel
Curt Worden, Chief of Licensing

Members of the Audience:
Teresa Anderson, California Association of Physician Assistants
G.V. Ayers, Consultant, Senate Business, Professions, and Economic Development Committee
Gloria Castro, Attorney General's Office, Los Angeles
Yvonne Choong, California Medical Association
Genevieve Clavreul
Zennie Coughlin, Kaiser Permanente
Frank Cuny, California Citizens for Health Freedom
Julie D'Angelo Fellmeth, Center for Public Interest Law
Hank Dempsey, Chief Consultant, Assembly Business, Professions, and Consumer Protection Committee
Stan DiOrio, Senator Wright's Office
Bryce Docherty, California Ambulatory Surgery Association
Karen Ehrlich, L.M., Midwifery Advisory Council
Corrine Fishman, Department of Consumer Affairs
Jack French, Consumer's Union Safe Patient Project
Julie Haskins, Anthem Blue Cross
Virginia Herold, Board of Pharmacy
Sarah Huchel, Consultant, Assembly Business, Professions, and Consumer Protection Committee
Christine Lally, Department of Consumer Affairs
Eduardo Martinez, California Medical Association
Tina Minasian, Consumer's Union Safe Patient Project
Michele Monserratt-Ramos, Consumer's Union Safe Patient Project

William Pinsky, M.D., Ochsner Health System
Alison E. Price, Licensed Midwife
Sonja Palladino, Assemblymember Bonilla's Office
Victoria Samper, Institute of Medical Quality
Taryn Smith, Senate Office of Research
Anne Sodergren, Board of Pharmacy
Carrie Sparrevohn, Midwifery Advisory Council

Agenda Item 16 Public Comments on Items not on the Agenda

Genevieve Clavreul spoke on a Workers Compensation issue she is dealing with and asked the Board who she could speak to about how to work with the physician to get the reports done in a more timely manner.

Karen Ehrlich, a licensed midwife, requested the Board have the webcasting chaptered when posted to the Web site.

Frank Cuny, California Citizens for Health Freedom thanked the Board for their action taken on SB 117, the bill that will make alternative cancer treatment legal in California. He offered to send anyone on the Board additional information on alternative treatments, if interested. He would send them the same information he is sending the Legislature.

Tina Minasian, thanked the Board for the time and efforts it has put in over the years to make such a difference in patient safety.

Agenda Item 17 Update on Education and Wellness Committee; Consideration of Committee Recommendations – Ms. Yaroslavsky

Ms. Yaroslavsky announced that the committee held the working group meeting required in SB 380. The meeting was broken down into three portions and the working group members included seven physicians that were recommended by the bills author's office and the sponsor. Julie Hopkins from the institute for Medical Quality also made a presentation. The first portion of the working group focused on the background and how changes in nutrition and lifestyle behavior help in the prevention of chronic diseases. Dr. John McDougall gave an informative presentation on the effects of diet therapy on the prevention of chronic diseases and six other physicians provided information on this matter. The next portion focused on CME and integrating prevention of chronic diseases by nutrition and lifestyle behavior changes into CME. There were some working group members who advocated for mandatory CME.

The last portion focused on the mandate in the bill that requires the Board to periodically disseminate information and educational materials, regarding the prevention and treatment of chronic disease by application of changes in nutrition and lifestyle behavior, to each licensed physician and surgeon and to each acute care hospital in California. It was discussed that there is already some good information available for physicians to use as resources and for the Board to possibly disseminate via the Newsletter or email blast. The California Department of Public Health (CDPH) has a "Let's Get Healthy, California" report and is working on a wellness plan for California. It was suggested that the Board

survey physicians to obtain information that they feel would be most useful in their practice. It was also suggested that the Board reach out to medical schools to get information on what is being taught to medical students regarding nutrition and lifestyle behavioral changes to prevent chronic disease. There was much discussion on the coordination of a campaign that the Board could be part of and collaborate with other agencies, such as CDPH and CMA. The Committee approved a task force of members to work with staff on its outcomes of this meeting. The Committee directed staff to develop an action plan and this plan will be presented at the next Education and Wellness Committee.

The Committee then revisited the issue of creating a mission statement for the Education and Wellness Committee. The following mission statement was developed: *"The mission of the Education and Wellness Committee is to actively pursue opportunities to educate the public on functions and responsibilities of the Board, to protect the public by continuing to provide updated and current information regarding the Board's laws, regulations and relevant healthcare information to physicians and the public and to encourage physicians to maintain a sound balance in their personal and professional lives so that they can offer quality care to their patients."*

Proposed goals were also discussed and the Public Affairs Manager, Cassandra Hockenson, will provide an update on these at the next Committee Meeting. An update on the public affairs Strategic Plan was provided by Ms. Hockenson as well. Social media was discussed and Committee Members were provided a copy of the IT policy from the State CIO which encourages state agencies to use social media technologies to engage their customers and employees.

Ms. Hockenson discussed the new look of the Board's press releases on the Web site, which will now be in PDF format and prominently displayed upon release on the main page. In addition, the Board has partnered with the DCA to utilize the Media Hub which provides up-to-date information to media contacts and other databases for purposes of distribution of information and press releases.

Ms. Hockenson reported that the Board participated in a successful consumer outreach event, a health fair, with the Franchise Tax Board (FTB). Thousands attended and asked questions and picked up consumer brochures about the Board. Ms. Hockenson indicated the Board has been invited to participate in several other outreach events.

The Committee received a preview of the new Web site by Charlotte Clark and Sean Heaney from the Boards Information Systems Branch. The goal of the new Web site is to be more user friendly, intuitive and informative. Input on the Web site was obtained by Committee Members and the Board staff plans on getting input from consumer groups. Ms. Schipske's recommended having her health care administration students review the site.

The next Committee meeting will be to review the goals and Ms. Hockenson will make a full presentation on social media. An action plan on SB 380 will be presented at the next meeting as well as an update on the affordable care act.

Stan DiOrio, Legislative Director for Senator Wright, author of SB 380, thanked the Board Members, particularly Ms. Yaroslavsky, for her time and assistance on implementing SB 380. He stated Ms. Simoes has been tremendous in working with the Senator's office on this bill. He stated that SB 380 was designed to try and begin a dialogue that will change the paradigm of medical care from treatment

to curing, at least in the area of chronic diseases. He made two suggestions to the Board, one being to consider keeping the working group together as an advisory body, the other being that each Member of the Board take the time to look at the Webcast of the meeting and the presentation that was made by Dr. McDougall.

Tina Minasian, Consumers Union Safe Patient Project, stated that she was unable to attend the Education and Wellness Committee Meeting but learned from the staff report that the Committee's strategic plan is to promote better outreach and communication to consumers and others. Consumers Union activists have found some Members communications and communication policies to be problematic. For a couple of years, Consumer's Union has been contacting the Board and DCA in regards to a problem with the statute of limitations. When the statute of limitations runs out on a case, it can allow a physician to continue to practice without any form of discipline. The sunset review report shows seven cases where an investigation had been completed, referred to the AG's office with a request to file an accusation against the physician, and the case was dropped because the statute of limitations had run out. It was recommended that the Board put in place communications and processes to keep this from happening to be sure that consumers are informed about the statute of limitations. She recommended that the Board staff work with the Consumer's Union Safe Patient Project to improve the Board's communication regarding its statute of limitations. She also urged the Medical Board to make clear on its web site the opportunities and rules for public participation at Medical Board meetings including how to submit written testimony to Board Members.

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

Mr. Worden referred the Board Members to the preliminary review of the request by the University of Queensland/Ochsner Clinical School Program for recognition under California Code of Regulations, Title 16, Division 13, Section 1314.1(a)(2). Mr. Worden stated that the University of Queensland is already recognized by the Board pursuant to California Code of Regulations 1314.1(a)(1) as the school is owned and operated by the Government of Australia; however, the partnership between Queensland and Ochsner is not part of that recognition as the primary purpose of that program is to educate the citizens of the United States or other citizens to practice in other countries. Staff has determined that the University of Queensland/Ochsner does meet the criteria to be reviewed by the code sections and standards of 1314.1(a)(2) and the requirements of the B&P Code Sections 2089 and 2089.5. Mr. Worden noted that the staff report, as well as Dr. Nuovo's report, are both in the Members packet for review.

Mr. Worden introduced Dr. Nuovo who would present his evaluation to the Board and answer any questions the Board might have. Mr. Worden announced that Dr. William Pinsky, the Executive Vice President of Academics and Ochsner's International Chief Medical Office, was in attendance to represent the University of Queenland/Ochsner and to answer any questions.

Dr. Nuovo introduced himself as a professor and associate dean in medical education at UC Davis. Dr. Nuovo gave a brief description of what the process is for a school to request recognition. The school submits a self-study which resulted in a series of questions that were submitted back to the school. Those were responded to and then a meeting took place with Dr. Pinski in May 2013. This proposal

represents a substantial effort to train U.S. citizens and to prepare them to enter graduate and medical education programs in this country. The two years of basic science training, the preclinical years are done in Queensland and two years are done within the Ochsner health system. Ultimately, there will be a total of 480 students enrolled in this program. One of the key themes in the review was determining if there is an infrastructure for resources for oversight to ensure that those 480 students are competent and capable of moving to the next level of training. Dr. Nuovo suggested that a site visit needs to be conducted to address the primary concerns that are highlighted in the summary report.

One concern is whether the home site in Queensland has the facility and the resources necessary to train a group this size and to provide adequate oversight; the same thing applies to Ochsner. Queensland and Ochsner both have a long track record of training in undergraduate and graduate medical education.

Another concern that is stated in the report is regarding the admissions process. The concerns is that there are no interviews of applicants for the program. This is a substantial departure from U.S. and Canadian schools who use interviews in their determination as to whether an applicant is eligible for admission into the program. These concerns led Dr. Nuovo to the conclusions that he is not confident that the self-study documents demonstrated compliance with Section 1314.1. In the final analysis, Dr. Nuovo believes that these conclusions do require a site visit to Queensland at this time. Dr. Nuovo recommends that a site visit be done in New Orleans Ochsner before determining if a site visit to the Queensland campus is necessary. The site visit to New Orleans would include a review of resources, oversight and how the school deals with corrective action for students who are not performing according to standards.

Dr. Pinsky stated that the University of Queensland is a state school of the state of Queensland and Ochsner Health System is a tax exempt 501(c)(3), non-profit organization. The Queensland program is accredited by the Australian Medical Council. The curriculum admission policies regarding students are uniform throughout the program because they are part of the accredited program.

Dr. GnanaDev made a motion to approve Dr. Nuovo's recommendation for a site visit to Ochsner; s/Yaroslavsky. Motion carried.

Ms. Yaroslavsky asked how the foreign schools are chosen to be evaluated? Dr. Levine stated that school submitted a self-assessment. This is the first type of application that has come in that has a physical separation between the clinical and the pre-clinical training, but probably not the last that will be received.

Mr. Worden added that this school chose to apply for recognition through the Board as they want their students to be eligible to participate in post graduate training and licensure in California. Currently their program would be considered unrecognized by the Board. Without the recognition, their students would have to attend post graduate training and be licensed for 10 years in another state and become ABMS certified before they could be eligible to apply for licensure in California.

Ms. Kirchmeyer reminded the Board the staff would have to go through the process of submitting an out-of-state travel exemption request to DCA and also put a site team together.

Agenda Item 19 **Update of Activities of the Board of Pharmacy – Ms. Herold / Ms. Sodergren**

Ms. Herold and Ms. Sodergren, Board of Pharmacy, (BOP) introduced themselves and thanked the Board for allowing them to share information from BOP with the Board. Mr. Herold reported that there is an issue about how the CURES program is going to be funded. During the forum, a lot of time was spent discussing the need for CURES, the benefits of CURES, and how it can provide information to both prescribers and dispensers. As part of the budget year 13/14, all of the regulatory boards will contribute a sum of money to fund CURES for the next two years in order to create a new computer system. This was done as part of a trailer bill to make sure that this program is no longer funded by the General Fund. One component of CURES is the prescription drug monitoring program where prescribers and dispensers can call up and find out where a particular patient is with respect to prescribing and getting the drugs dispensed. Sign up of practitioners and pharmacists has been encouraged, however, it has been a slow process. Ms. Herold stated it is the hope that this new CURES computer system will assist in raising the enrollment rate and the ability to get enrolled.

Ms. Herold then stated that one of the main priorities for the BOP is implementation of a new law called e-pedigree. This program tracks prescription drugs from the manufacturer though repeated sales down to the pharmacy or the prescriber. It creates a secure chain of custody for that product, so every time someone buys it and sells it, there is a certification that follows who bought and/or sold the drug to whom. If a particular drugs enters into the chain without a history, it can be researched to determine who manufactured it, etc. The implementation of the program is still in progress and is scheduled to take effect in January of 2015, with 50% of the drugs sold in California having to be serialized and the remaining 50% a year later. Wholesalers have until July of 2016 to be ready to read and transmit pedigrees and the last stage are the prescribers and pharmacies who have until July of 2017. The BOP has regulation packages that are in the final stages of review and another three that are going to the BOP at the next Board Meeting. A fourth package is still being worked on right now that would probably be of interest to physicians because it concerns drop shipments, where the manufacturer ships the drug directly to a practitioner for a patient.

Ms. Herold announced that at the next BOP meeting, there will be a person from Turkey who is responsible for the design and the implementation of California's system in the country of Turkey. They did it in a three year period based on California's 2008 law and had it up and running by 2010.

Another project the BOP is working on pertains to their regulations known as patient centered labels on prescription container labels. It was established that a standardized order of particular elements that are most important to patients be listed. There is 50% of dedicated space on the label used for these particular elements and they have to be standardized. Associated with this issue is the requirement for a translated label for people who speak other languages. There is a bill that has been introduced that will require all labels for all patients who are non-English speaking to be translated into the language of the patient. There is an interpreter requirement where if a non-English speaking patient goes into a pharmacy to get a prescription filled, there has to be an interpreter service available to the patient either via telephone access or someone in the pharmacy itself.

Ms. Herold then briefly discussed that the BOP is looking at the problem with drug diversion, particularly of controlled substances throughout the U.S. The BOP has noticed that there is quite an

effort on the part of the drug enforcement administration (DEA), in particular, to clamp down on wholesalers, and when the wholesalers get a reduced supply of drugs, they clamp down on the pharmacies including providing continuing education with the DEA talking where they are talking about drug diversion and drug abuse. The BOP then talks about corresponding responsibility, how to avoid being the victim of a theft, and other pitfalls of practice.

Public Comment was heard on this agenda item:

Genevieve Clavreul recommended the Board take a look at the prescription monitoring program that Oklahoma uses and compare it to CURES. The Oklahoma program can identify within one hour a patient that has already been prescribed a drug.

Julie Haskins, an investigator for Anthem Blue Cross, stated that Anthem Blue Cross provides prescription drug information via a quarterly report, to many regulatory and law enforcement bodies on the top prescribers of California. She is happy to supply that report to anyone in a regulatory agency who is interested in seeing it. A subpoena is not required, only a written request.

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

Ms. Herold stated that, like the Board, the BOP created a task force to work on the next forum. The BOP task force is interested in working with the Board's task force. There were a number of action items that were generated at the close of the February Joint Forum and have been preserved for the next forum that will hopefully take place the first part of 2014. The BOP has two Board Members whom are extremely interested in participating in the upcoming forum. Ms. Kirchmeyer stated that the upcoming forum will take place in Southern California. She stated there were some items that came out of the Boards' recent Education and Wellness Committee as far as identifying issues in a possible brochure that will be discussed between both Board's task forces prior to the next Joint Forum.

Agenda Item 21 **Update of Prescribing Task Force – Ms Yaroslavsky / Dr. Bishop**

Dr. Bishop reported that on July 2, 2013, the prescribing task force met with staff to establish the mission, vision and objectives of the task force. The following mission statement has been identified: "*The task force will identify ways to proactively approach and find solutions to the epidemic of prescription drug overdoses through education, prevention, best practices, communications and outreach by engaging all stakeholders in this endeavor.*" The task force will hold its first meeting on Monday, September 23, 2013. Currently the meeting is scheduled to take place in Sacramento. The first issue the task force will be looking into is identifying the appropriate patient information that can, and should, be shared and discussed between the prescriber and the pharmacist. This is an issue that was raised at a prior Board meeting by CMA. Based on information received, this is a significant issue that needs to be resolved. The task force believes that having all of the appropriate interested parties at the table to discuss this issue will provide a solution. The task force hopes to create a document that identifies appropriate information that can be shared between the prescriber and the dispenser based on input from all stakeholders. This document could be shared and posted on all licensing board Web sites who prescribe and dispense.

The task force also wants to begin identifying best practices in prescribing. This will be a large task and will take several meetings to reach a consensus and product that can be provided to all stakeholders. Once best practices have been identified, the task force can then move to revisiting the pain management guidelines; educating prescribers, dispensers, and the public on prescribing issues; and developing an outreach plan to provide information to all interested parties. The task force will be conducting working meetings with representatives from numerous interested parties, including all prescribers (physicians, nurse practioners, dentists etc.), pharmacists; prescribing and dispensing associations; law enforcement agencies such as the DEA, DA's office, Sheriff's office; consumer advocate groups; the healing arts boards; insurance companies; and Senate and Assembly Committees. The meetings will be closely facilitated. The task force hopes that by having significant input, they will get several viewpoints and be able to put together a cohesive, comprehensive document that will be useful for all prescribers and dispensers. At the October Board Meeting, the task force will provide an update from the September meeting and will hopefully have a draft of a document regarding the appropriate information to share between the prescribers and the dispensers.

Public Comment was heard on this agenda item:

Yvonne Choong, CMA, stated that they wanted to express their appreciation for the Board's efforts in establishing the Prescribing Task Force. She also stated that from reading the staff report, given the scope, mission and objectives of the Task Force, the Board may want to reconsider the scope of work that the Task Force is considering; for example the Strike Force may also benefit from some review by the Task Force in order to help the Board take a comprehensive approach to this issue. CMA also feels that with the broad nature of what the Task Force intends to accomplish, it will require collaboration among many entities and requires a strong public health approach in terms of data collection. In looking at the list of representatives, they would like to see some additional public health representatives including the Department of Public Health who are involved in regulating substance abuse treatment programs, as they have a role here as well.

Genevieve Clavreul reminded the Board that she, as a member of the public, would like to be included on this task force. Ms. Kirchmeyer stated to Ms. Clavreul that her name is on the invitation distribution list.

Agenda Item 22 **Update and Discussion of the Strike Force for Prescribing Violations – Ms. Threadgill / Ms. Sweet**

Ms. Sweet gave an update on the short and long term goals for addressing the inappropriate prescribing situation. Pursuant to the Board's direction from the last meeting, staff was redirected to create a temporary strike force team called Operation RX (ORX). This team consists of a supervising investigator, four investigators and an analyst who have been redirected from their traditional assignments. As of June 10, 2013, there were 161 prescribing cases in the field office caseload. Each of those cases were reviewed and 35 of those cases were identified as requiring immediate attention and were appropriate for reassignment to the ORX. The team has been welcomed by local police jurisdictions and the DEA, who have been very cooperative in the team's efforts. The downside of creating this strike force team is the workload for the remaining staff and due to limited resources, the team is having to travel quite a bit. The team has already executed one search warrant, and another will

be executed within the next two weeks. She is confident that there will be arrests to be announced at the next Board Meeting.

Ms. Sweet continued her update with the long term plan goals stating that the Board needs more staff to combat this problem. Drug induced deaths have become the leading cause of injury related deaths, even more than motor vehicle accidents. Of 38,329 drug overdose deaths in 2010, approximately 22,000 of them involved prescription drugs.

Ms. Sweet stated that these types of cases are very time consuming and the only way to address the problem permanently is to attach more resources that are commensurate with the issue. Ms. Sweet was asked by a Board Member previously, what would it take to combat this issue. The Board staff proposes two offices, one in Northern California and one in Southern California, each composed of a supervising investigator, six investigators, an office technician, a staff services analyst, and a medical consultant. Staff believes there are clearly enough prescribing cases at this time to support those positions, but the staff will continue to analyze the data over the next year to gather specific statistics to support augmentation of staff.

Public Comment was heard on this agenda item.

Yvonne Choong, CMA, stated they would like to express their support for any reorganization of the Board's resources that allows investigation by case type if it leads to more efficient investigations. Understanding this is the first draft of the proposal for this task force, they have some issues that should be addressed for clarification. The scope of the strike force was unclear. They would also like to know what the sources of complaints will be. With concerns to fiscal estimates, how does this new program impact the fiscal analysis of SB 62, and if SB 62 does pass, would that provide an additional source of complaints. Lastly, in terms of funding, they would be interested in knowing how the Board would intend to fund the Strike Force, and if it would create a fee increase to physicians.

Agenda Item 23 Legislation / Regulations – Ms. Simoes

Ms. Simoes introduced some of the audience members: G.V. Ayers from the Senate Business and Professions Committee, Taryn Smith from the Senate Office of Research, and Sonja Palladino from Senator Bonilla's office.

Ms. Simoes referred the Members to the tracker list in their Legislative Packets, stating that the bills in orange will be discussed today, the bills in green are those where the Board has taken positions and they have either not been amended or the amendments do not affect the Board's position and do not need Board discussion, and the bills in blue are two year bills

AB 1000 (Wieckowski) is sponsored by the California Physical Therapy Association. The Board was previously opposed to this bill; however, this bill was significantly amended. This bill, as originally introduced, would have allowed a physical therapist (PT) to make a physical therapy diagnosis. This bill would have allowed 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. There were no limits placed on how long a patient could directly access PT services.

This bill was significantly amended to address concerns raised by the opposition. This bill no longer allows a PT to make a "physical therapy diagnosis". 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.

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

AB 1308 (Bonilla) is sponsored by the American Congress of Obstetricians and Gynecologists. 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.

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.

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.

Public Comment was heard on this agenda item.

Carrie Sparrevohn, current chair of the Midwife Advisory Council (MAC), encouraged the Board to support this bill, if amended.

Ms. Palladino, Senator Bonilla's office, thanked the Board for their support on this bill as well as thanked staff who has been very helpful with providing technical expertise on the history of the issue of supervision and the other issues with midwifery.

Genevieve Clavreul stated that it is important to delineate the consequences of what happens when you have a delivery and a physician is not notified and an outcome arrives where the infant dies for the lack of calling a physician in to assist.

Karen Ehrlich, licenses midwife, wanted to remind the Board that the only drugs, devices and diagnostics that the midwives are asking to have the authority to use are those for which they are trained, and ones that they are expected to use in an out of hospital setting. They are also hoping that with this bill, physicians are not liable for any care midwives provide and are not liable until such time the physician has completely assumed care.

Frank Cuny, California Citizens for Health Freedom, urged the Board's support for this bill.

Ms. Yaroslavsky made a motion to support if amended; amendment being working with sponsors, author's office and interested parties to try and help resolve the issue of physician supervision; s/Ms. Schipske. Motion carried. Five approved / four abstentions, (Bishop, GnanaDev, Diego and Salomonson)

Dr. Levine called for a lunch break at 12:45 pm. Meeting to resume at 1:15 pm.

Meeting reconvened at 1:23 pm.

Ms. Simoes continued with her legislative update.

SB 62 (Price) was previously amended to require a coroner to report deaths to the Board when the contributing factor in the cause of death is related to toxicity from a Schedule II, III, or IV drug. The initial report must include the name of the decedent; date and place of death; attending physicians, podiatrists, or physician assistants; and all other relevant information available.

The bill was recently 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 existing law.

Ms. Simoes stated the Board will handle coroner reports 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.

Public Comment was heard on this agenda item.

Eduardo Martinez, CMA, spoke about some concerns that CMA has about this bill. The CMA feels this bill is broad and will capture many cases that will have nothing to do with patient/physician relationships. Tolerance of a drug varies from person to person and tolerance in an individual builds over time which can lead to levels of a drug in a body that might be considered toxic in a forensic examination, but may have been medically appropriate. The difficulty is that most physicians' use urine drug screenings to monitor compliance with prescriptions; however, coroners use blood screenings to quantify levels of medications in a body. They believe this law would have a chilling affect on physicians' willingness to assume treating patients for whom a controlled substance is the appropriate course of treatment.

Julie D'Angelo Fellmeth, Center for Public Interest Law, stated that they have always supported this bill and continues to, but wanted to give a brief response to the CMA. This report is just that, a report. It is a piece of information, that is why there are investigations and she does not feel that CMA's concerns are justified.

Genevieve Clavreul stated that to take that measurement in a final diagnosis of a death is arbitrary. She does not know of any study of people's absorption of different drugs, as every individual metabolizes drugs differently.

Dr. Yip made a motion to continue to support the bill; s/Dr. Bishop. Motion carried.

SB 304 (Price) is the Board's sunset bill. The Board discussed almost all of the provisions in this bill at its last meeting and took a support if amended position on the bill, with the amendments being to include language that would extend the Board's sunset date, and to include some of the other new issues from the Board's sunset review report that would enhance consumer protection. However, the bill was amended during the last Board meeting to transfer all investigators employed by the Board and their staff to the Department of Justice (DOJ), effective January 1, 2014.

Moving the investigators over to DOJ could streamline the enforcement process by placing investigations and prosecutions under the jurisdiction of one agency. Allowing investigators and Deputy Attorneys General to be more easily co-located will also help to enhance communication.

Ms. Simoes provided information on the investigator's tenure and retention. Regarding information on retention, the data was broken down into three time periods that equal the last 10 years. In the last 5 years from 2008 - 2013, 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 from 2005 - 2008, 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 from 2003 to 2005, 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.

Ms. Simoes pointed out some issues and 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.

Ms. Simoes discussed the 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.

Ms. Simoes stated 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.

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 stop 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.

Public Comment was heard on this agenda item.

Julie D'Angelo Fellmeth, Center for Public Interest Law, stated that for the last several years, the AG's office has been responsible for both the investigation and the prosecution of Board disciplinary matters and is required to use vertical enforcement. With investigators working side by side with the attorneys, it would make it easier to implement vertical enforcement. They would be required to use the same procedure manual, use the same computer system, and be co-located which they are not doing now. Ms. Fellmeth stated she did not believe that the Board would lose control as the Board still has the Central Complaint Unit which would review the cases and decide which ones to refer for investigations. The Executive Director would still be responsible for signing off on an accusation and the Board would still review all proposed ALJ decisions and stipulations.

Genevieve Clavreul stated that she is opposed to this bill as the DOJ has a more punitive and criminal aspect that she does not like to see in the practice of medicine.

Tina Minasian, California Patient Advocate, stated that this bill is a very sensitive issue for her as she was injured by a doctor whose license was revoked, but it took two and a half years for her complaint to turn into an investigation against this doctor while vertical enforcement was in place. She stated that she is not for or against this bill particularly, but feels the Board should look into their own staff processes to determine why it takes so long for complaints to turn into investigations.

Ms. Yaroslavsky made a motion to continue to support this bill with the amendment to include sunset extension language and delete the language that would require investigators to be transferred to DOJ; s/Dr. GnanaDev. Motion carried.

SB 352 (Pavley) is sponsored by the California Academy of Physician Assistants, and would allow physician assistants (PAs), nurse practitioners (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.

The Board had a support if amended position on this bill and requested amendments. Recent amendments addressed the Board's concern, and the Board now has a support position on this bill.

Public Comment was heard on this agenda item.

Theresa Anderson, on behalf of the California Academy of Physicians Assistants, thanked the Board for working with them on amendments and coming to a support position.

SB 492 (Hernandez) would have deleted the definition of the practice of optometry in existing law and would have expanded 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.

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.

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.

Ms. Yaroslavsky made a motion to support if amended as specified; s/Dr. GnanaDev. Motion carried.

SB 493 (Hernandez) would allow pharmacists to furnish medication, order and interpret tests, furnish self-administered hormonal contraceptives, initiate and administer vaccines, and furnish prescription smoking cessation drugs and devices.

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.

At the last Board meeting, the Board voted to support this bill if it was 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.

SB 670 (Steinberg) would authorize the Board to inspect the medical records of a deceased patient without the consent of the patient's next of kin or a court order.

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.

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. The Board is working with the author's office and interested parties on amendments to address the Board's concerns.

Ms. Yaroslavsky made a motion to continue to support if amended; motion seconded. Motion carried.

SB 809 (DeSaulnier and Steinberg) is sponsored by the California Attorney General Kamala Harris, and as originally introduced, would establish the CURES Fund that would be administered by the DOJ, and would be funded by an annual 1.16% (as of July 1, 2013) licensing, certification and renewal fee increase for licensees of boards that are authorized to prescribe or dispense Schedule II, III, or IV controlled substances. (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.) This bill would have required manufacturers, and health insurers to contribute as well and would have eventually required all prescribers and dispensers 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.

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.

The Board believes CURES is a very important enforcement tool and an effective aid for physicians to use to prevent "doctor shopping". Due to the importance of this program, Board staff is suggesting that the Board support any effort to get CURES more fully funded in order for the PDMP to be at optimum operating capacity. Board staff is suggesting that the Board support this bill if it is amended to fix the fee and implementation.

Public Comment was heard on this item.

Eduardo Martinez, CMA, stated that CMA is in support of SB 809 as its members want to see an upgraded and well-funded CURES system to identify red flags and they want to be part of the solution in addressing the prescription drug abuse issue.

Genevieve Clavreul agreed that everyone should participate in funding this system as everyone will benefit from it at some point.

Ms. Yaroslavsky made a motion to support if amended to fix the fee and implementation; s/Dr. GnanaDev. Motion carried.

Agenda Item 24 Licensing Chief's Report – Mr. Worden

Mr. Worden began by thanking his staff for doing an excellent job this quarter especially with the other projects such as Breeze taking staff away from their regular duties. Mr. Worden gave a brief update on the vacancies in the licensing unit.

Mr. Worden referred the Members to their packets. He stated the consumer information unit answered 23,400 calls the past quarter and 92,611 calls for the fiscal year. The Board received 1,552 physician/surgeon applications in the fourth quarter and 6,697 applications for the fiscal year. The Board completed 1,720 initial application reviews in the fourth quarter and 6,671 application reviews for the fiscal year. There were 1,438 physician licenses issued in the fourth quarter and 5,540 were issued in the fiscal year. There are approximately 28 pending applications at the senior review level for the fourth quarter.

There is a five year licensing history shown in the Board Packet of the physician and surgeon licenses and the Board issued 89 more licenses in this fiscal year than the fiscal year 11/12, and in comparison, that is 752 more licenses issued than in fiscal year 08/09. Also in the packet is a five year history of applications received and this year there were 68 more applications received than fiscal year 11/12 and 590 more than in fiscal year 08/09.

Mr. Worden stated the strategic plan goal of reviewing an application within 45 days of receipt was maintained for the fourth quarter. Currently, the number of days to review a U.S. file was 30 days, for the IMG file it was 37 days, and pending mail dates were eight days for each of those application types.

Mr. Worden stated there are approximately 91 schools pending approval at the end of the quarter; of those there are eight who are self-assessment reports. If a school qualifies for the 1314.1(a)(1), those are recognized in-house based on it being a school with the primary purpose of teaching citizens within their country and it is a Government or State owned bonafied non-profit school. There are three schools that are in consultant review at this time.

Mr. Worden reported that there were not any events during the fourth quarter, however they received notification recently in regards to a couple of upcoming events. The California Dental Association Foundation is going to hold one in December and noted that they intend to have some physicians there although no physician applications have been received for that event. The RAM organization is planning an event for next April assuming that AB 512 gets passed and extends the program to 2018.

Agenda Item 25 Update on Outpatient Surgery Settings Program

A. Update from Task Force; Consideration and Possible Action – Dr. GnanaDev / Dr. Salomonson

Dr. GnanaDev reported that he and Dr. Salomonson met on June 25th with the staff in Sacramento to discuss the Outpatient Surgery Setting Program (OSS). There were three main objectives for this meeting. The first was to view the Board's Web site and the OSS database to determine if further edits needed to be made. Board staff walked Members through several edits that had been completed and some that were still in process. Some significant edits included having the inspections report and any subsequent corrective action plans available to the public and having an indicator that the facility is CMS approved. It was identified that the OSS Web site pages need to be rewritten into a format that is more understandable and easier for the public to navigate. The staff is going to be rewriting this page to make it more user friendly. Another recommendation was to be able to do a geographical search of the OSS locations by entering a city name. Staff will be working on these enhancements, but due to other priorities, this will not be done in the immediate future.

Dr. Salomonson reported that after reviewing the Web site, the Task Force members looked at the requirements in Health and Safety Code Section 1248.15. They went through the laws, line by line. In reviewing the accreditation agency documents, the Members needed more information on what they looked at to ensure the physicians are appropriately trained.

Dr. Levine stated that she went through the criteria of the accreditation agencies line by line and had found differences, however, there are a number of areas where all four agencies have the same standards.

Dr. GnanaDev stated that there was a difference of opinion on whether or not you should have hospital admitting privileges, he did not agree with that, so that is why staff was asked to look into this and ask each agency what they would do in certain situations.

Dr. Salomonson discussed the reporting issue that was identified. Current law requires each OSS to report adverse outcomes to the CDPH, however the Board does not get the reports from the CDPH. Additionally, the Board has no authority to issue citations to an OSS for failing to report. The CDPH

does have authority to issue a citation and fine but does not have authority over the accrediting agencies, so there is a loop hole that needs to be fixed by a statute change.

Dr. GnanaDev stated that at this time, those reports are going to CDPH and the information cannot be shared with the Board. Since the Board has the responsibility for the OSSs, those adverse actions should be reported to the Board, and the Board should have the right to cite and fine. The law needs to be changed as right now, the Board is responsible for supervising the OSSs, but have no other input. Mr. Worden stated that the most critical part is to get the law changed to where the Board receives these reports.

Public Comment was heard on this agenda item.

Tina Minasian, Consumer's Union, stated that Consumer's Union has submitted to the Board a number of written testimonies regarding OSSs. They applaud the Outpatient Surgery Center Task Force recommendation for legislation to require outpatient surgery centers to submit adverse event reports to the Board for the purpose of investigation and to authorize the Board to cite surgery settings that do not submit the required report. These are keys steps that must be taken to fully implement the States' strong patient safety laws. However, Consumer's Union feels the task force is missing some important opportunities to strengthen standards for accreditation of physician owned surgery centers. They believe that the Board should require that physicians performing surgery under general anesthesia in physician owned outpatient centers be board certified or board eligible and also have hospital privileges for the specialty procedures they are performing in outpatient centers. In addition, the Board should require that the surgery centers seeking accreditation post a notice on the premises 6 months prior to finalizing the accreditation to inform the employees, patients and the public how to confidentially contact the accreditation agency about concerns they may have regarding patient safety at the surgery center. Lastly, the Board should require that future inspections by agencies be unannounced. Consumer's Union urged the Board to apply rigorous oversight to these surgery centers and their accrediting agencies.

Genevieve Clavreul thanked the Board for doing what they are doing as it is a huge issue. She feels that it is imperative that they be appropriately credentialed and that the accrediting agencies' visits should be unannounced.

Julie D'Angelo Fellmeth, Center for Public Interest Law, stated that consumers at this point have no idea who regulates the outpatient surgery centers. They are not aware that there is a distinction between physician owned clinics that are accredited by one of the Board's accrediting agencies and one that is licensed by CDPH. Since there is legislation being sought on the reporting issue, she suggests that the Board consider including a signage requirement similar to the notice to consumers that requires physicians to post a sign in their waiting room stating that doctors are regulated by the Medical Board of California. This would direct patients to the information about these surgery centers that is posted to the Board's Web site and also would direct them on where to file a complaint if needed.

Victoria Samper, Institute for Medical Quality, stated the Health and Safety Code 1248 does require that outpatient settings post the name and telephone number of the accrediting agency with instructions on how to submit a complaint in a location readily visible to patients.

Dr. Levine asked if the OSSs under the purview of the Board are currently required to post information about the agency that accredits them and the contact information for that agency, which is where the complaint would go.

Ms. Webb stated they are required to post a sign regarding the accreditation agency, however if the issue is that the Board wants people to know that the Board oversees the accrediting agency that is not what is demanded by the statute.

Ms. Yaroslavsky made a motion to support the proposed legislation;/s Dr. GnanaDev. Motion carried.

B. Web site and Program Update – Mr. Worden

Mr. Worden asked Ms. Lowe to join him in this update. Ms. Lowe reported that staff has been working diligently to obtain and upload the required information from the four accreditation agencies into the Board's OSSs database. Ms. Lowe stated after making several enhancements to the public Web site have been made including: adding the inspection reports, the corrective action plans and outcome reports; defining the requirements for what data is actually required to be reported and displayed on the Board's Web site based on whether a setting is CMS approved or not; and identifying the timeframe of the actual values that is being reported. Staff is confident that they are near completion on entering the missing data. Although when searching for information previously on the public site, it did appear that there was significant data missing from the Web site, and the data that was missing was due in part to the OSSs that were CMS approved, as well as missing reports because the timeframes were prior to the reporting period that the accreditation agencies had to provide that information. Disclaimers have been added to the Web site for those values that are not reportable as well as information on settings that are CMS approved. As settings that are not CMS approved are not required to be reported to the Board, staff has partial information on some of these settings. Staff has asked the accreditation agencies to continue to provide this information as a courtesy so that the Board can provide the most information to the public.

As of July 17, 2013, after entering all of the available data that was provided from the accrediting agencies, an internal exception report was run to determine what information was still missing and what was still needed. Of the 1,279 total settings in the database, 367 of them were identified as CMS approved. Ms. Lowe stated that after running the internal exception report, filtering out information that is not actually required to be reported, and taking into consideration time frames of the law being implemented, the database is really only missing 27 values out of 872 settings. Ms. Lowe believes staff is at a point where these internal exception reports can be run on a regular basis, not only to say which values are missing, but also what information needs to be updated. It is the responsibility of the accrediting agencies to provide the updates. Staff will work with the agencies directly to assistant in receiving updates and/or missing information that needs to be provided.

Ms. Lowe reported that the Web site is still a work in progress and it will continuously be updated regularly adding a search option by city or county in order to locate an OSS in a particular area. In addition, a search will be added for those OSSs that are doing business under a different name, as currently a search is not available, for a DBA name.

Ms. Lowe also gave an update on the accrediting agency renewals stating that all four accreditation agencies have submitted their renewal packages, which included extensive documentation on their standards, development plans, review processes, etc. An internal review has been done on all four of the renewal packages and based on that review, all four agencies continue to meet the requirements as outlined in the Health and Safety Code. All four have been approved and renewed.

Dr. GnanaDev stated his strong appreciation to staff who have worked so diligently on these enhancements.

Mr. Worden also thanked the Board's ISB staff who continued to improve the Web site on such short notice while trying to do the BreEZe project as well. Also, the accreditation agencies provided staff with the additional requirements that have been provided in the Board packet. Mr. Worden directed the Members to a side by side chart that shows how the accreditation agencies meet the required elements, as well as the additional requirements that each agency has.

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

Mr. Worden announced to the Board that Michael Zarski, CEO of the HFAP, had planned on attending the Board Meeting, but was unable to due to a board meeting of HFAP in Chicago. This item is a request for another accreditation agency to be approved by the Board. The Healthcare Facilities Accreditation Program is part of the American Osteopathic Association. They have submitted an application for approval. They have been providing medical facilities with an objective base review of services since 1945 and in 2003 they were granted deeming authority by the Center for Medicare/Medicaid Services (CMS) to conduct accreditation surveys of ambulatory surgical centers for CMS. In addition HFAP is a CMS deeming authority to survey acute care hospitals, critical care hospitals and hospital facility laboratories. Board staff reviewed their application and requested additional documentation. Additional clarifying information and after reviewing the clarifying information, it was determined HFAP met all requirements to become an approved accrediting agency.

Dr. GnanaDev made a motion to approve this facility; s/Dr. Bishop. Motion carried.

Agenda Item 27 Enforcement Chief's Report – Ms. Threadgill

Ms. Threadgill began with requesting a motion to approve nine orders restoring license to clear status following completion of probation during the period from 1/30/2013 through 4/16/2013.

Ms. Yaroslavsky made a motion to approve the nine orders requested; s/Dr. GnanaDev. Motion carried.

Ms. Threadgill then asked for another motion to approve 11 orders restoring license to clear status following completion of probation during the period from 4/23/2013 through 7/3/2013.

Ms. Yaroslavsky made a motion to approve the 11 orders requested; s/Dr. GnanaDev. Motion carried.

Ms. Threadgill referred the Board Members to their agenda packet. She stated that during a previous Board meeting staff presented a proposal to increase the hourly rate for expert reviewers. The question was raised regarding the hourly rate for expert reviewers in other states. The chart in the Board packet provides the information staff was able to obtain from other states.

Ms. Threadgill stated the Board has a total of 936 active experts. The Board utilized 258 to review 372 cases in the second quarter of the calendar year. She reported that the next expert reviewer training is scheduled to be held on November 2, 2013 at UCSD, La Jolla Medical School Campus. She encouraged Members who are available on that date to attend this excellent training. She will continue to provide the Board Members with information as the date approaches.

She reported that the investigator vacancy rate is currently 11%; however, when the vacancies that have candidates in background are deleted the rate is 1%. The vacancy rate for Supervisors remains at 10%.

During this fiscal year the enforcement program hired 17 new investigators. In addition, staff held a four week mini academy that was specific training on Board cases. The Board plans to send five investigators to the required POST academy in August although this is contingent upon the Board getting clearance to hire those candidates in background prior to the start of the Academy. POST conducted an audit of the Board's background investigations and indicated that the files look great and the narratives are really good.

DCA Audits Unit is currently conducting an audit of the Board's evidence accounts. Those results with be provided to the Board at the next Board meeting.

On June 3, 2013 staff provided DCA with a request to establish and fill the CPEI (6 non-sworn special investigators and 1 Supervising Special Investigator non-sworn) positions. These positions are still pending at DCA. However, the Board received notice that CalHR is reviewing the use of this class at DCA.

Staff is conducting an intensive statewide training for the Board's staff, January 13-17, 2014, which will focus on excessive prescribing cases. This is a joint effort between Board staff and the LA County DA's office. Ms. Threadgill will inform Board Members of schedule details, as interested Members may wish to attend.

The Board continues to support providing medical related training to Administrative Law Judges. They will receive a one and a half hour anatomy presentation on August 16 and another one and a half hour physiology presentation on September 20. In June, the ALJs had internal Interim Suspension Order Training and internal Disciplinary Guideline training in July.

Ms. Threadgill referred Members to a series of graphs in the Board packet. These graphs show that the time to complete a complaint in the complaint unit is decreasing. At the time of preparation of this package, data for the month of June was not available; however, she stated that the time for the month of June is 67 days. This is in large part due to suggestions from Dr. Low regarding reducing the time that medical consultants are allowed to review a case. Members can see the correlation by reviewing

the medical consultant average days also in the packet. She stated that Dr. Low's idea worked and thanked him.

Ms. Threadgill stated that she is extremely excited about the productivity of staff during this fiscal year. She disclosed that the numbers that she references are rough approximates that have not been through the validation process for the annual report, so they are not the official numbers. She identified the following statistics:

- Staff referred 143 criminal cases to the DA this fiscal year. This is remarkable considering two years ago only 56 case were referred and last year 112. OSM is responsible for 77 of the criminal referrals.
- Staff had a total of 1689 investigation dispositions this fiscal year, whereas, only 1605 last year.

San Jose staff recently arrested a subject on a $25,000 warrant for transporting controlled substances and dispensing or furnishing prescription drugs without a license and practicing medicine without a license.

Ms. Threadgill invited any Member who would be interested in taking a look at closed case reviews, cases that are not going forward for adjudication or prosecution to visit a district office to see how it operates and to get a clearer picture of what work actually goes on in those offices.

Dr. Levine recommended that Ms. Threadgill send an email to all of the Members with the addresses of the district offices and ask for a response as to when the Member could visit an office.

Dr. Yip asked if there was any detailed information on why the previous enforcement staff had left the board.

Ms. Threadgill stated that she does do exit interviews and could provide that information to the Members.

Agenda Item 28 Vertical Enforcement Program Report – Ms. Castro

Ms. Castro thanked Ms. Webb and Ms. Dobbs for the Disciplinary Guidelines presentation. She stated that she was very impressed with it and agreed with what was provided. Ms. Castro reminded the Board that the AG's office works hand in hand with the Boards Enforcement staff as the Board has appointed as necessary and regionally to obtain settlement recommendations from the Board as soon as an accusation is filed and received.

Ms. Castro reported that the AG's office is active in the early settlement conference process, as well as the mandatory settlement conference process, to obtain information for the Board to act as needed and as informed as possible on the recommendations on stipulations. The Board will see more uniformity in the DAG memos and the Board will be able to find out everything that needs to be known about the case, so an informed decision can be made. She looks forward to the Board continuing to remind OAH that it is the Board's position that admissions are favored in stipulations whenever possible,

rather than a nolo plea. These are client attorney privileged communications that are very important and they will continue to give as much information as possible, consistent with the rules of professional conduct.

Ms. Castro then gave a brief update on the Vertical Enforcement Program. She stated she meets every other week with Ms. Kirchmeyer and feels the meetings have been very productive. The AG's Office and the Board continue to meet quarterly to discuss enforcement issues as they relate to district offices, lead prosecutors. and the Vertical Enforcement Program. The next meeting is scheduled for August 2, 2013. They continue to produce reports to Ms. Kirchmeyer and try to improve on that process. Ms. Castro also receives reports regularly from the Board staff to be more consistent with each other. In March, the Enforcement Sub Committee agreed that conviction only cases, that do not involve quality of care issues, will not be assigned to a primary DAG. This allows the primary DAG to focus on Interim Suspension Orders and subpoena enforcements. Finalized protocol will be discussed with the Board staff in August as to how that will work. Ms. Castro stated that she continues to be interested in the forming of any sub committee and is available to be invited to participate on an as needed basis.

She and her staff are excited that the Board will be issuing cease practice orders on PACE failure cases and failures to enroll in PACE, as well as the biological fuel testing positive results. Staff is working to be sure that petitions to revoke probation can be filed as soon as possible.

The Board had requested that subpoena enforcement matters take priority and staff has responded. Eight subpoena enforcement actions have been filed in superior court. The AG's office is starting to educate superior courts statewide as to the Board's power to demand medical records without patient release where good cause is shown and public safety outweighs patient concerns. These enforcement subpoena cases will be followed to ensure decisions align with the Board's goal of public protection, as well as balancing patient privacy concerns.

Ms. Castro stated that she has had two staff that had been with HQE for many years that retired. She had one member of the HQE staff appointed to the Assembly, two appointed to the bench at OAH, and one additional staff retire. They have recently hired six new people and should be fully staffed within the next month. They are replacing seven DAG positions as well as two supervising DAG positions.

Dr. Levine thanked Ms. Castro for her spirit of collaboration.

Dr. Levine requested to return to her President's report and stated that during elections the day prior, David Serrano Sewell had asked to step down from his recently appointed position as Chair of the Enforcement Committee due to his election of Vice President. Dr. GnanaDev has agreed to serve as Chair of the Enforcement Committee.

Dr. Levine stated that Dr. GnanaDev and Mr. Tagami have been working as a two person task force to look at revising the posting for the permanent Executive Director position, which has gone through the DCA office of personnel and is currently posted on the Web until the second week in August. She thanked them both for looking at that and making sure the roll description fit the needs of the Board.

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

Dr. Levine announced the following agenda item requests for the October Board Meeting:

- A presentation on fraud and fraud prevention from the Department of Health Care Services,
- recommendations for the dates for last two board meetings in 2014,
- A presentation by an Administrative Law Judge on Interim Suspension Order's,
- A presentation from Games for Health Care,
- A presentation on Vial of Life Program,
- Two presentations, which may go to committees: one on pharmaceutical industry patient assistance programs and one on fictitious name permits and med spas.
- A presentation on the funding of graduate medical education

Agenda Item 31 **Adjournment**

Dr. Levine adjourned the meeting at 4:21 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

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

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

Education & Wellness Committee ********** **Subcommittee Members**	**Barbara Yaroslavsky, Chair** Silvia Diego, M.D. Sharon Levine, M.D. Denise Pines 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.
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** Michael Bishop, M.D. Silvia Diego, M.D. Ronald Lewis, M.D. David Serrano Sewell, J.D. Jamie Wright, Esq. Felix Yip, M.D.
Panel B	**Vacant, Chair** Dev GnanaDev, M.D., Vice Chair Howard Krauss, M.D. Sharon Levine, M.D. Denise Pines Gerrie Schipske, R.N.P., J.D. Phil Tagami
Organizational Effectiveness Committee	Sharon Levine, M.D. Phil Tagami
Legislation Subcommittee	Sharon Levine, M.D.
Prescribing Task Force	Michael Bishop, M.D. Barbara Yaroslavsky
Outpatient Surgery Settings Task Force	Dev GnanaDev, M.D. David Serrano Sewell, J.D.

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 <u>one</u> public member within group of five members.

Revised: October 2013

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: October 10, 2013
ATTENTION: Members, Medical Board of California
SUBJECT: Interim Executive Director Report – Executive Summary
STAFF CONTACT: Kimberly Kirchmeyer, Interim Executive Director

REQUESTED ACTION:
This report is intended to provide the Members with an update on the staffing, budget, and other administrative functions/projects occurring at the Medical Board of California (Board). No action is needed at this time.

Administrative Updates:
Board staff have had several meetings with interested parties regarding the Board.

- Dr. Levine and the Executive Staff continue to have conference calls twice a month to review the actions of the Board and ensure the requests of the Board are being completed. Board Members are receiving monthly updates on activities at the Board as well as a pending projects list.
- Regular meetings continue to be held with Denise Brown, Director of the Department of Consumer Affairs (DCA).
- Regular meetings continue to be held with Gloria Castro, Senior Assistant Attorney General.
- Staff has met and will continue to meet with consultants from the Senate and Assembly Business and Professions Committees.
- The Department of Finance (DOF) met with staff to review the Board's enforcement process. In addition, DOF provided a questionnaire on staffing and enforcement statistical data, which staff completed and submitted to DOF.
- Due to an article in the media, and a subsequent letter to the Board from Senator Lieu, Board staff met with representatives from Purdue Pharma L.P. (Purdue) regarding a list of physicians in what they referred to as "Region 0". The Board requested and subsequently received the list of physician names from Purdue. Board staff are reviewing the list to determine whether further action is warranted.
- Board staff have met with the California Ambulatory Surgery Association regarding the laws and regulations pertaining to outpatient surgery settings. With the passage of SB 304 and the change in adverse event reporting, we will continue to meet with them (and other interested parties) to ensure individuals are educated on the reporting requirements.
- Board staff met with a Chinese Delegation from the Health Department of Hubei Province to educate them on the mission, processes, laws, and regulations of the Board.
- Board staff and two Board Members met with the Los Angeles County Medical Association (LACMA) regarding educating physicians and ways to partner to better inform physicians. The Board staff will be providing information/articles regarding the Board's enforcement processes, laws, regulations, and need for expert reviewers that can be placed in LACMA's publications. Board staff will work to build these relationships with other similar organizations in order to educate physicians, thereby furthering the Board's mission of consumer protection.

Teleconferencing Project Update:
The Board has been looking into the logistics of teleconferencing at a meeting, pursuant to the Board's approval at the last meeting. After researching the logistics for teleconferencing a meeting, Board staff believe this should be ready for an upcoming committee meeting. The Board plans to use this option at the Committee on Physician Supervisory Responsibilities and the Education and Wellness Committee. These Committee Meetings will be held prior to the next Board Meeting. This will allow an update to be presented to the Board at the February meeting on the outcome of using this new process of taking public comment.

Staffing Update:
Upon receiving notification that the Board was able to hire retire annuitants, the Board submitted a request to re-employ eight retired annuitants to perform investigative functions, to perform background investigations and field training, to perform supervising investigator duties until the vacant position is filled, to assist with personnel, and to assist with BreEZe training. Five of the eight requests were approved, two were placed on hold due to a pending classification audit and one was denied. The hiring of these individuals assists with the enforcement process timelines and also with the transition to the new BreEZe system.

The Board continues to be at a 7% vacancy rate which equates to 19 vacant positions. However, of those 19 vacant positions, the Board has 8 individuals either in background, pending a start date, or pending verification of eligibility. Therefore, the Board only has 11 positions that do not have an individual identified for the position. This equates to a **4% vacancy rate** for the Board. The Board does have one future vacancy due to an employee leaving the Board. The Board will continue to move quickly to fill vacant positions.

Budget Update:
The Board's budget documents are attached, beginning on page BRD 9A-4 and continuing to page BRD 9A-14. The Board's fund condition on page BRD 9A-4 projects the Board's fund reserve, at the end of fiscal year (FY) 2013/2014, to be at 4.1 months. The Board's fund reserve at the end of last FY (2012/2013) was at 5.4 months. It is important to note that in FY 2012/2013 the Board was still under the personal leave program for all employees, resulting in a 4.65% pay decrease for all employees. The projected spending due to the BreEZe project did not occur because the system was not released in July 2012 as originally planned. In addition, the line item for the Attorney General (AG) was underspent by $1.57 million. All of these factors led to the Board reverting a significant amount of money and the fund reserve going to 5.4 months at the end of FY 2012/2013. A final budget expenditure report for FY 2012/2013 is provided on page BRD 9A-13.

The fund condition report indicates that the Board's fund reserve will be negative in FY 2016/2017. However, the Board continues to have two outstanding loans to the General Fund. These loans will be repaid when the Board reaches its minimum mandated level of two months' reserve. Therefore, page BRD 9A-5 shows repayment of the outstanding loans in FYs 2015/2016 and 2016/2017. With the repayment of these loans, the Board would remain at its statutory mandate. The Board will continue to monitor the fund condition of the Board.

The Board only had one BCP request that was approved for budget year 2013/2014 and that was for the BreEZe costs. This BCP is identified under the 2013/2014 approved costs. As stated at the last meeting, $1.638 million was approved via budget bill language for and upgrade to the CURES system. All prescribing and dispensing licensing boards were required to provide funding for the new system in the budget bill language. The budget bill had specific language that stated the Feasibility Study Report has to be agreed upon by the DCA and the Department of Justice. The DCA and the licensing boards have provided input to the DOJ regarding the requirements/needs for the new CURES system.

Based upon all of the factors identified above, it is not prudent at this time to consider any reduction in licensing fees as previously recommended by the Bureau of State Audits. The other element to take into consideration when reviewing the fund condition is that the Board does not know the impact of the

transfer of the investigators to the DCA and therefore, should wait until the transition has been implemented before any decisions can be made on how the Board's budget and fund will be impacted.

The Board's overall actual expenditures for FY 2013/2014, as of August 31, can be found on page BRD 9A-6, and pages BRD 9A-7 to 9A-9 show the budget report specifically for licensing, enforcement and the AG expenditures. The AG's office spending is back up, which may be indicative of the fact it has been able to fill several vacant positions. Page BRD 9A-12 provides the Board Members' expenditure report as of October 9, 2013 and page BRD 9A-14 provides the expenditures for FY 2012/2013.

BreEZe Update:
On October 8, 2013, the BreEZe system (the computer system to replace the legacy licensing and enforcement systems) went "live" for the Release 1 boards under the DCA. For two days prior to October 8, the Board staff were not able to process any applications, renewals, or enforcement tracking.

As the Board is already aware, staff spent a significant amount of time on the BreEZe project and will continue to do so as several changes still need to be made in the system, which requires testing by Board staff. At this time, staff are beginning to use the new system to process their documents and continue the licensing and enforcement processes. There will definitely be a learning curve over the next few months. Board management will make every effort to mitigate this possible slowdown in productivity while staff learns the new system.

The Board did have one problem arise that did impact the licensees of the Board. Due to an unexpected problem, physicians are not able to renew their license online at this time. The system should be fixed by November 2013 so licensees can again use the online system for their renewal. Notices were sent to individuals whose licenses expired in September and October who had email addresses with the Board notifying them of this issue. Additionally, information has been placed on the Board's Web site informing individuals of the issue.

0758 - Medical Board
Analysis of Fund Condition

(Dollars in Thousands)

FY 2014-15 Governor's Budget	ACTUAL 2012-13	CURRENT YEAR 2013-14	BY 2014-15	BY+1 2015-16	BY+2 2016-17
BEGINNING BALANCE	$ 24,612	$ 26,499	$ 20,271	$ 12,971	$ 4,722
Prior Year Adjustment	$ (38)	$ -	$ -	$ -	$ -
Adjusted Beginning Balance	$ 24,574	$ 26,499	$ 20,271	$ 12,971	$ 4,722
REVENUES AND TRANSFERS					
Revenues:					
125600 Other regulatory fees	$ 365	$ 288	$ 288	$ 288	$ 288
125700 Other regulatory licenses and permits	$ 6,174	$ 5,647	$ 5,647	$ 5,647	$ 5,647
125800 Renewal fees	$ 46,107	$ 45,481	$ 45,481	$ 45,481	$ 45,481
125900 Delinquent fees	$ 94	$ 98	$ 98	$ 98	$ 98
142500 Miscellaneous services to the public	$ 33	$ 30	$ 30	$ 30	$ 30
150300 Income from surplus money investments	$ 98	$ 60	$ 54	$ 71	$ 37
160400 Sale of fixed assets	$ 4	$ 5	$ 5	$ 5	$ 5
161000 Escheat of unclaimed checks and warrants	$ 15	$ -	$ -	$ -	$ -
161400 Miscellaneous revenues	$ 5	$ 16	$ 16	$ 16	$ 16
164300 Penalty assessments - Probation Monitoring		$ 900	$ 900	$ 900	$ 900
Totals, Revenues	$ 52,895	$ 52,525	$ 52,519	$ 52,536	$ 52,502
Transfers:					
TOTALS, REVENUES AND TRANSFERS	$ 52,895	$ 52,525	$ 52,519	$ 52,536	$ 52,502
TOTAL RESOURCES	$ 77,469	$ 79,024	$ 72,790	$ 65,507	$ 57,224
EXPENDITURES					
Disbursements:					
0840 State Controller (State Operations)	$ 33	$ -	$ -	$ -	$ -
8880 FSCU (State Operations)	$ -	$ -	$ -	$ -	$ -
FISCAL	$ 278	$ 259	$ -	$ -	$ -
1110 Program Expenditures (State Operations)	$ 50,659	$ 55,673	$ 56,810	$ 57,970	$ 59,153
2013-2014 and 2014-15 Approved Costs					
BreEZe Costs		$ 1,183			
CURES		$ 1,638			
Anticipated Future Costs					
Expert Review Rate Increase			$ 476	$ 476	$ 476
Anticipated BreEZe Cost			$ 1,183	$ 1,183	$ 1,183
Northern Operation Safe Medicine			$ 696	$ 550	$ 550
Establish Spending Authority for Midwifery			$ (13)	$ (13)	$ (13)
Enforcement Enhancements			$ 667	$ 619	$ 619
Totals, Disbursements	$ 50,970	$ 58,753	$ 59,819	$ 60,785	$ 61,968
FUND BALANCE					
Reserve for economic uncertainties	$ 26,499	$ 20,271	$ 12,971	$ 4,722	$ (4,744)
Months in Reserve	5.4	4.1	2.6	0.9	-0.9

NOTES:

A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED FOR 2015-16 AND BEYOND.

B. INTEREST ON FUND ESTIMATED AT .361%

$9 million was loaned to the General Fund by the Board in FY 11/12 and $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.

10/8/2013

0758 - Medical Board
Analysis of Fund Condition

(Dollars in Thousands) Fund condition with partial General Fund Loan Repayment

FY 2014-15 Governor's Budget	ACTUAL 2012-13	CURRENT YEAR 2013-14	BY 2014-15	BY+1 2015-16	BY+2 2016-17
BEGINNING BALANCE	$ 24,612	$ 26,499	$ 20,271	$ 12,971	$ 11,722
Prior Year Adjustment	$ (38)	$ -	$ -	$ -	$ -
Adjusted Beginning Balance	$ 24,574	$ 26,499	$ 20,271	$ 12,971	$ 11,722
REVENUES AND TRANSFERS					
Revenues:					
125600 Other regulatory fees	$ 365	$ 288	$ 288	$ 288	$ 288
125700 Other regulatory licenses and permits	$ 6,174	$ 5,647	$ 5,647	$ 5,647	$ 5,647
125800 Renewal fees	$ 46,107	$ 45,481	$ 45,481	$ 45,481	$ 45,481
125900 Delinquent fees	$ 94	$ 98	$ 98	$ 98	$ 98
142500 Miscellaneous services to the public	$ 33	$ 30	$ 30	$ 30	$ 30
150300 Income from surplus money investments	$ 98	$ 60	$ 54	$ 71	$ 37
160400 Sale of fixed assets	$ 4	$ 5	$ 5	$ 5	$ 5
161000 Escheat of unclaimed checks and warrants	$ 15	$ -	$ -	$ -	$ -
161400 Miscellaneous revenues	$ 5	$ 16	$ 16	$ 16	$ 16
164300 Penalty assessments - Probation Monitoring		$ 900	$ 900	$ 900	$ 900
Totals, Revenues	$ 52,895	$ 52,525	$ 52,519	$ 52,536	$ 52,502
Transfers:					
General Fund Loan Repayment				$ 7,000	$ 8,000
TOTALS, REVENUES AND TRANSFERS	$ 52,895	$ 52,525	$ 52,519	$ 59,536	$ 60,502
TOTAL RESOURCES	$ 77,469	$ 79,024	$ 72,790	$ 72,507	$ 72,224
EXPENDITURES					
Disbursements:					
0840 State Controller (State Operations)	$ 33	$ -	$ -	$ -	$ -
8880 FSCU (State Operations)	$ -	$ -	$ -	$ -	$ -
FISCAL	$ 278	$ 259	$ -	$ -	$ -
1110 Program Expenditures (State Operations)	$ 50,659	$ 55,673	$ 56,810	$ 57,970	$ 59,153
2013-2014 and 2014-15 Approved Costs					
BreEZe Costs		$ 1,183			
CURES		$ 1,638			
Anticipated Future Costs					
Expert Review Rate Increase			$ 476	$ 476	$ 476
Anticipated BreEZe Cost			$ 1,183	$ 1,183	$ 1,183
Northern Operation Safe Medicine			$ 696	$ 550	$ 550
Establish Spending Authority for Midwifery			$ (13)	$ (13)	$ (13)
Enforcement Enhancements			$ 667	$ 619	$ 619
Totals, Disbursements	$ 50,970	$ 58,753	$ 59,819	$ 60,785	$ 61,968
FUND BALANCE					
Reserve for economic uncertainties	$ 26,499	$ 20,271	$ 12,971	$ 11,722	$ 10,256
Months in Reserve	5.4	4.1	2.6	2.3	2.0

NOTES:

A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED FOR 2015-16 AND BEYOND.

B. INTEREST ON FUND ESTIMATED AT .361%

$9 million was loaned to the General Fund by the Board in FY 11/12 and $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.

10/8/2013

Medical Board of California
FY 13/14
Budget Expenditure Report
(As of August 31, 2013)
(17% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENSES/ ENCUMB	PERCENT OF BUDGET EXP/ENCUMB	UNENCUMB BALANCE
PERSONAL SERVICES				
Salary & Wages				
(Staff & Exec Director)	16,316,022	2,660,937	16.3	13,655,085
Board Members	31,500	0	0.0	31,500
Phy Fitness Incentive Pay	29,623	2,990	10.1	26,633
Temp Help	1,137,513	114,320	10.0	1,023,193
Overtime	12,143	8,368	68.9	3,775
Staff Benefits	8,095,907	1,272,684	15.7	6,823,223
BL 12-03 Blanket	0	8,967		0
TOTALS, PERS SERVICES	25,622,708	4,068,266	15.9	21,563,409
OPERATING EXP & EQUIP				
General Expense	652,370	242,233	37.1	410,137
Fingerprint Reports	333,448	27,357	8.2	306,091
Minor Equipment	24,300	0	0.0	24,300
Printing	294,000	56,298	19.1	237,702
Communications	372,190	8,586	2.3	363,604
Postage	282,511	33,622	11.9	248,889
Insurance	41,053	0	0.0	41,053
Travel In-State	401,298	10,406	2.6	390,892
Travel Out-of-State	7,000	0	0.0	7,000
Training	78,895	7,066	9.0	71,829
Facilities Operation (Rent)	2,702,140	2,274,909	84.2	427,231
Consult/Prof Services	1,606,594	782,465	48.7	824,129
Departmental Prorata	4,714,010	1,178,506	25.0	3,535,504
Interagency Services	5,142	0	0.0	5,142
Consolidated Data Center	650,230	41,209	6.3	609,021
Data Processing	129,492	141,820	109.5	(12,328)
Central Admin Svcs (Statewide Prorata)	2,417,774	665,701	27.5	1,752,073
Attorney General Services	13,347,280	2,213,933	16.6	11,133,347
Office of Administrative Hearings	1,525,080	0	0.0	1,525,080
Evidence/Witness	1,893,439	230,742	12.2	1,662,697
Court Reporter Services	225,000	191,127	84.9	33,873
Major Equipment	392,120	303,070	77.3	89,050
Other Items of Expense	40,000	27,934	69.8	12,066
Vehicle Operations	261,925	16,179	6.2	245,746
Court-ordered Payments	0	992		(992)
Board of Control Claim	0	0		0
TOTALS, OE&E	32,397,291	8,454,155	26.1	23,943,136
TOTALS, EXPENDITURES	58,019,999	12,522,421	21.6	45,497,578
Scheduled Reimbursements	(384,000)	(57,114)	14.9	(326,886)
Distributed Costs	(780,000)	(109,184)	14.0	(670,816)
NET TOTAL, EXPENDITURES	56,856,000	12,356,123	21.7	44,499,876
Unscheduled Reimbursements		(94,334)		
		12,261,789		

Budget Expenditure Report.xls
Date: Oct 07, 2013

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
BUDGET REPORT
JULY 1, 2013 - AUGUST 31, 2013

	FY 13/14 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	2,537,060	452,432	current
Staff Benefits	1,266,928	204,252	current
TOTAL PERSONAL SERVICES	3,803,988	656,684	
OPERATING EXPENSES & EQUIPMENT			
General Expense	47,000	31	1-2
Fingerprint Reports*	333,448	27,227	1-2
Printing	63,950	10,920	1-2
Communications	52,246	73	1-2
Postage	125,000	23,492	1-2
Travel In-State	14,758	6	1-2
Training	8,500	0	1-2
Facilities Operation	226,000	245,399	current
Consult/Professional Services	1,225,873	531,108	1-2
Departmental Services	539,283	134,821	current
Interagency Services	587	0	current
Data Processing	4,000	0	1-2
Statewide Pro Rata	276,593	69,148	current
Attorney General	190,000	9,842	current
Evidence/Witness Fees	7,500		1-2
Court Reporter Services	250	0	1-2
Major Equipment	0	0	1-2
Minor Equipment	0	0	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	3,114,988	1,052,067	
SCHEDULED REIMBURSEMENTS	(384,000)	(57,114)	
DISTRIBUTED COSTS	(31,131)	(6,246)	
TOTAL BUDGET/EXPENDITURES	**6,503,845**	**1,645,391** **	

*Department of Justice invoices for fingerprint reports, name checks, and subsequent arrest reports
** Includes Polysom
10/4/2013

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

	FY 13/14 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	10,574,567	1,640,480	current
Staff Benefits	4,733,110	746,695	current
TOTAL PERSONAL SERVICES	15,307,677	2,387,175	
OPERATING EXPENSE & EQUIPMENT			
General Expense/Fingerprint Reports	414,855	231,842	1-2
Printing	133,950	32,718	1-2
Communications	222,358	6,447	1-2
Postage	69,500	10,065	1-2
Insurance	38,235	0	current
Travel In-State	242,018	4,920	1-2
Travel Out-State	7,000	0	1-2
Training	31,000	1,571	1-2
Facililties Operations	2,064,940	1,750,892	current
Consultant/Professional Services	300,000	247,669	1-2
Departmental Services	3,324,791	831,434	current
Interagency Services	3,629	0	1-2
Data Processing	18,000	38,400	1-2
Statewide Pro Rata	1,705,256	487,571	current
Attorney General 1/	13,157,280	2,204,091	current
OAH	1,525,080	0	1
Evidence/Witness Fees	1,820,939	228,369	1-2
Court Reporter Services	224,750	191,127	1-2
Major Equipment	0	283,937	1-2
Other Items of Expense (Law Enf. Materials/Lab, etc.)	37,500	27,505	1-2
Vehicle Operations	210,925	14,060	1-2
Minor Equipment	0	0	1-2
Court-Ordered Payments	0	0	current
TOTAL OPERATING EXPENSES & EQUIPMENT	25,552,006	6,592,618	
DISTRIBUTED COSTS	(744,054)	(100,129)	
TOTAL BUDGET/EXPENDITURES	**40,115,629**	**8,879,664**	
Unscheduled Reimbursements		(18,336)	
		8,861,328	

1/See next page for monthly billing detail

MEDICAL BOARD OF CALIFORNIA
ATTORNEY GENERAL EXPENDITURES - FY 13/14
DOJ AGENCY CODE 003573 - ENFORCEMENT (6303)

		Number of Hours	Rate	Amount
July	Attorney Services	6,178.25	170.00	1,050,302.50
	Paralegal Services	289.25	120.00	34,710.00
	Auditor/Analyst Services	273.75	99.00	27,101.25
	Cost of Suit			0.00
				1,112,113.75
August	Attorney Services	6,042.50	170.00	1,027,225.00
	Paralegal Services	302.50	120.00	36,300.00
	Auditor/Analyst Services	233.75	99.00	23,141.25
	Cost of Suit			5,311.65
				1,091,977.90
September	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
				0.00
October	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
				0.00
November	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst	0.00	99.00	0.00
	Cost of Suit			0.00
				0.00
December	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst	0.00	99.00	0.00
	Cost of Suit			0.00
				0.00
			Total July-Dec =	**2,204,091.65**
			FY 13/14 Budget =	**13,157,280.00**

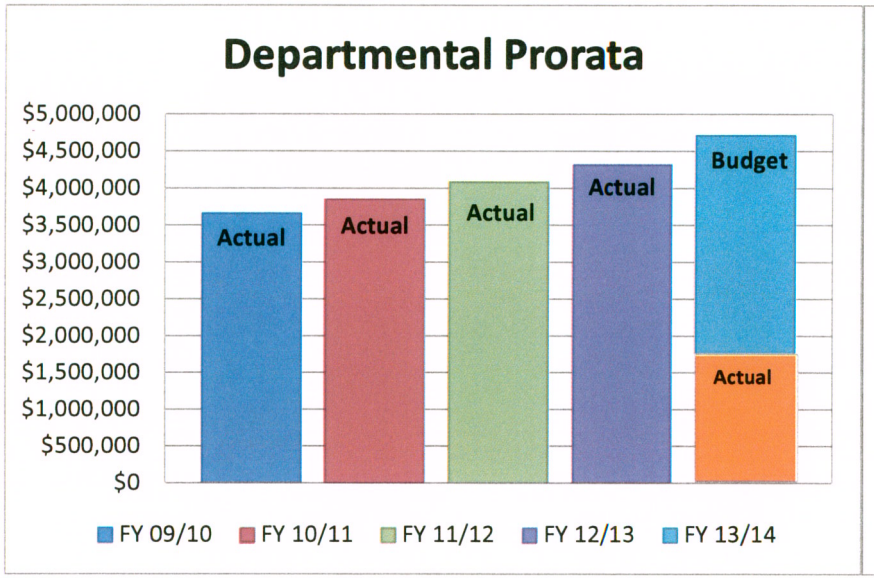
MEDICAL BOARD OF CALIFORNIA BUDGET OVERVIEW BY BOARD COMPONENT

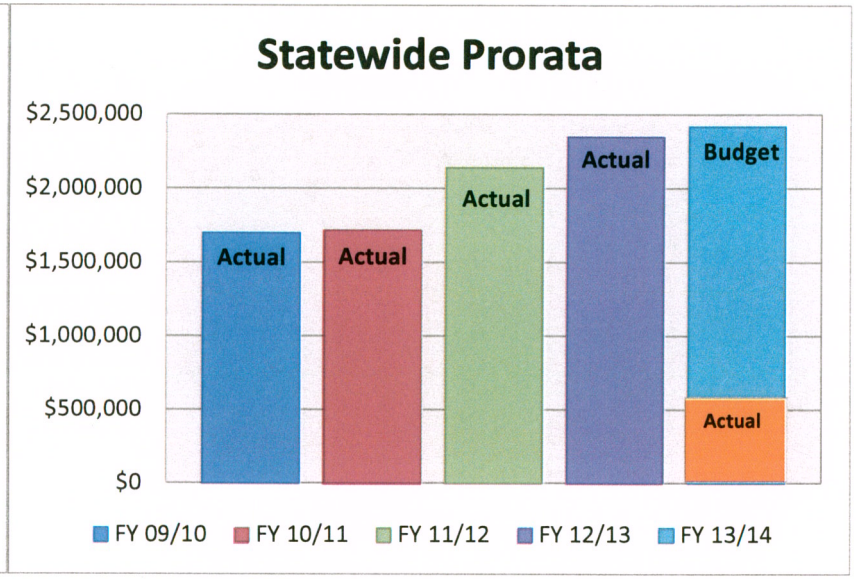
	EXEC	ENFORCE	OPERATION SAFE MEDICINE	LICENSING	ADMIN SERVICES	INFO SYSTEMS	PROBATION MONITORING	BOARD TOTAL
FY 10/11								
$ Budgeted	1,944,000	37,720,000	577,000	5,045,000	1,688,000	3,118,000	1,735,000	51,827,000
$ Spent *	1,771,000	34,420,000	651,000	5,061,000	1,564,000	2,948,000	487,000	46,902,000 *
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*	1,762,057	37,058,494	672,700	5,770,687	1,673,010	3,001,574	720,484	50,659,006 *
Positions Authorized	8.8	147.0	6.0	53.3	14.0	17.0	25.0	271.1
FY 13/14								
$ Budgeted	2,129,780	40,115,629	688,355	6,503,846	1,762,842	3,346,654	2,308,894	56,856,000
$ Spent thru 08/31*	343,744	8,861,328	138,766	1,645,391	290,461	631,090	351,009	12,261,789 *
Positions Authorized	8.8	147.0	6.0	53.3	14.0	17.0	25.0	271.1

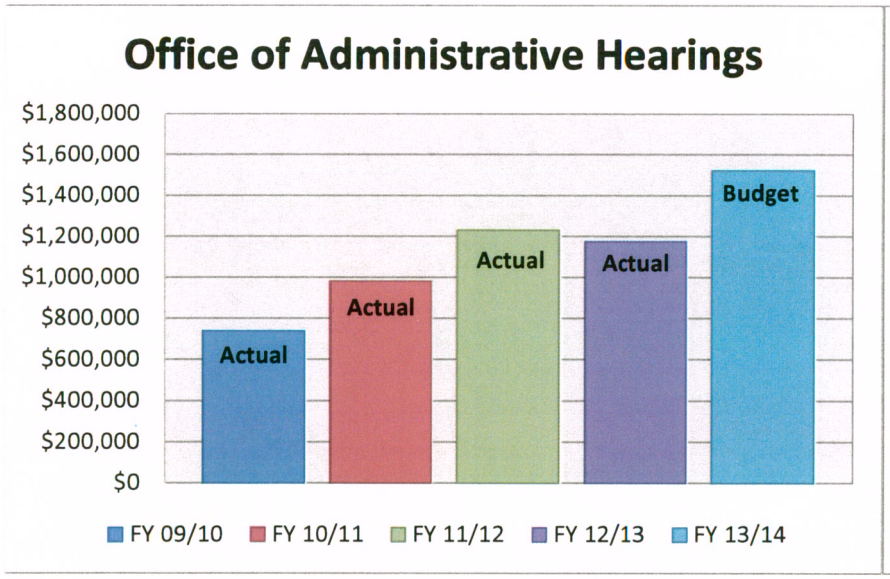
* net expenditures (includes unscheduled reimbursements)

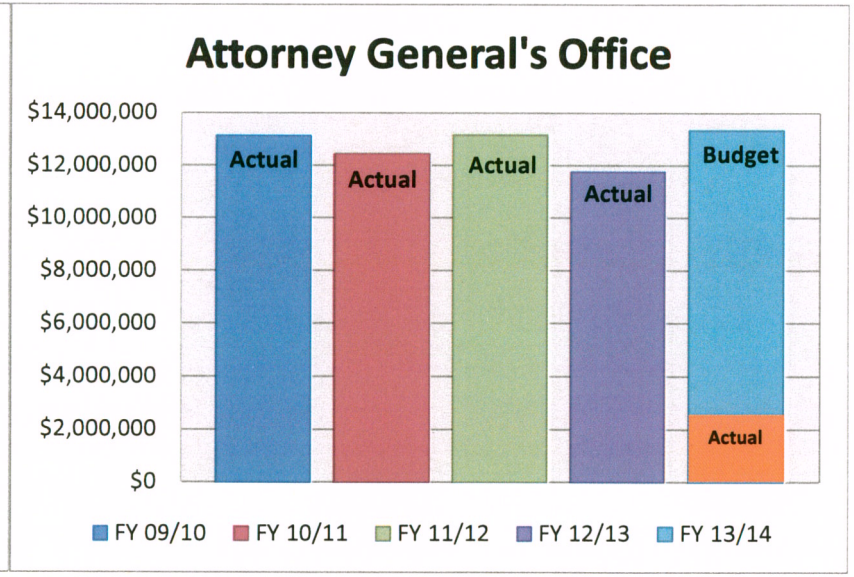
10/7/2013
Budget Overview by Program.xls

Strategic Plan Objective 5.3
External Agencies' Spending









Board Members' Expenditures - Per Diem/Travel
July 1, 2013 - June 30, 2014

NAMES	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APRIL	MAY	JUNE	YTD
DR. BISHOP - Per diem	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Travel	$ -		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
DR. DIEGO - Per diem	$ 500.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 500.00
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ 500.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 500.00**
DR GNANADEV - Per diem	$ 900.00	$ 1,300.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -			$ 2,200.00
Travel	$ 521.96			$ -	$ -	$ -	$ -	$ -					$ 521.96
	$ 1,421.96	$ 1,300.00	$ -	.	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 2,721.96**
Dr. KRAUSS - Per diem	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
DR. LEVINE - Per diem	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Travel	$ 477.16		$ -		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 477.16
	$ 477.16	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 477.16**
DR. LEWIS - Per diem	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
DR. LOW - Per diem	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
MS. PINES - Per diem	$ 1,500.00	$ 1,400.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,900.00
Travel	$ 771.58	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 771.58
	$ 2,271.58	$ 1,400.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 3,671.58**
DR. SALOMONSON - Per diem	$ 200.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 200.00
Travel	$ 679.36	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 679.36
	$ 879.36	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 879.36**
MS.SCHIPSKE - Per diem	$ 1,100.00	$ 1,000.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ 2,100.00
Travel	$ 742.37	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 742.37
	$ 1,842.37	$ 1,000.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 2,842.37**
MR. SERRANO SWELL- Per diem	$ 800.00	$ 500.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,300.00
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ 800.00	$ 500.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 1,300.00**
MR. TAGAMI - Per diem	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
MS.WRIGHT - Per diem	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
MS. YAROSLAVSKY - Per diem	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
MS. YIP - Per diem	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**

As of: 10/9/2013

TOTAL PER DIEM	$ 9,200.00
TOTAL TRAVEL	$ 3,192.43
TOTAL	**$ 12,392.43**

Medical Board of California
FY 12/13
Budget Expenditure Report
(As of June 30, 2013)
(100% 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	14,487,594	94.9	780,788
Board Members	31,500	63,984	203.1	(32,484)
Phy Fitness Incentive Pay	29,623	34,160	115.3	(4,537)
Temp Help	1,137,513	1,857,242	163.3	(719,729)
Overtime	12,143	67,486	555.8	(55,343)
Staff Benefits	7,775,513	7,075,275	91.0	700,238
Salary Savings	0			0
TOTALS, PERS SERVICES	24,254,674	23,585,741	97.2	668,933
OPERATING EXP & EQUIP				
General Expense	608,071	619,116	101.8	(11,045)
Fingerprint Reports	333,448	332,062	99.6	1,386
Minor Equipment	132,300	72,034	54.4	60,266
Printing	685,755	249,795	36.4	435,960
Communications	372,190	257,524	69.2	114,666
Postage	282,511	187,904	66.5	94,607
Insurance	41,053	17,491	42.6	23,562
Travel In-State	401,298	363,347	90.5	37,951
Travel Out-of-State	7,000	3,321	47.4	3,679
Training	78,895	92,881	117.7	(13,986)
Facilities Operation (Rent)	2,702,140	2,314,786	85.7	387,354
Consult/Prof Services	1,606,594	1,146,257	71.3	460,337
Departmental Prorata	4,540,957	4,318,128	95.1	222,829
Interagency Services	5,142	0	0.0	5,142
Consolidated Data Center	650,230	603,181	92.8	47,049
Data Processing	129,492	174,211	134.5	(44,719)
Central Admin Svcs (Statewide Prorata)	2,348,960	2,349,308	100.0	(348)
Attorney General Services	13,347,280	11,777,308	88.2	1,569,972
Office of Administrative Hearings	1,525,080	1,177,544	77.2	347,536
Evidence/Witness	1,893,439	2,147,381	113.4	(253,942)
Court Reporter Services	225,000	303,757	135.0	(78,757)
Major Equipment	652,000	658,818	101.0	(6,818)
Other Items of Expense	81	66,650	82,284.0	(66,569)
Vehicle Operations	261,925	339,402	129.6	(77,477)
Court-ordered Payments	0	22,486		(22,486)
Board of Control Claim	0	1,435		(1,435)
TOTALS, OE&E	32,830,841	29,596,127	90.1	3,234,714
TOTALS, EXPENDITURES	57,085,515	53,181,868	93.2	3,903,647
Scheduled Reimbursements	(384,000)	(353,230)	92.0	(30,770)
Distributed Costs	(780,000)	(627,762)	80.5	(152,238)
NET TOTAL, EXPENDITURES	55,921,516	52,200,876	93.3	3,720,639
Unscheduled Reimbursements		(1,541,870)		
		50,659,006		

Budget Expenditure Report.xls
Date: Oct 07, 2013

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		$ 300.00	$ 500.00	$ 5,900.00
Travel	$ 904.66		$ 517.90	$ 88.64			$ 866.32			$ 496.94			$ 2,874.46
	$2,004.66	$ 400.00	$1,117.90	$ 688.64	$ 600.00	$ 400.00	$1,466.32	$ 300.00	$ 500.00	$ 496.94	$ 300.00	$ 500.00	**$ 8,774.46**
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	$ 200.00	$ 500.00	$ 12,100.00
Travel	$ 244.80	$ 94.35		$ 619.76			$ 501.75	$ 320.35					$ 1,781.01
	$1,544.80	$ 894.35	$ 600.00	$ 2,419.76	$ 1,400.00	$ 1,100.00	$2,001.75	$1,120.35	$1,000.00	$1,100.00	$ 200.00	$ 500.00	**$ 13,881.01**
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	$ 800.00	$ 600.00	$ 1,000.00	$ 8,700.00
Travel	$ 601.02		$ -		$ -	$ -	$ 903.11			$ 434.45			$ 1,938.58
	$1,801.02	$ 900.00	$ 700.00	$ -	$ 700.00	$ 600.00	$1,803.11	$ 600.00	$ 700.00	$1,234.45	$ 600.00	$ 1,000.00	**$ 10,638.58**
DR. LEVINE - Per diem	$ -												$ -
Travel	$ 413.90		$ 285.72	$ 359.62		$ 243.82	$ 57.30	$ 325.71		$ 605.66		$ 860.39	$ 3,152.12
	$ 413.90	$ -	$ 285.72	$ 359.62	$ -	$ 243.82	$ 57.30	$ 325.71	$ -	$ 605.66	$ -	$ 860.39	**$ 3,152.12**
DR. LOW - Per diem													$ -
Travel												$ 300.86	$ 300.86
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 300.86	**$ 300.86**
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	$ 1,600.00	$ 15,900.00
Travel			$ 171.68	$ 365.64	$ 446.49		$ 269.24			$ 55.82		$ 395.16	$ 1,704.03
	$ -	$ -	$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	$ 1,995.16	**$ 17,604.03**
DR. SALOMONSON - Per diem	$ 400.00		$ 200.00	$ 500.00			$ 200.00	$ 500.00				$ 100.00	$ 1,900.00
Travel	$ 742.92		$ 462.73	$ 515.94			$ 894.25	$ 687.68				$ 514.74	$ 3,818.26
	$1,142.92	$ -	$ 662.73	$ 1,015.94	$ -	$ -	$1,094.25	$1,187.68	$ -	$ -	$ -	$ 614.74	**$ 5,718.26**
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	$ 1,100.00	$ 11,300.00
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	$ 1,100.00	**$ 12,322.24**
MR. SERRANO SWELL- Per diem			$ 600.00	$ 600.00		$ 600.00	$ 700.00	$ 800.00	$ 700.00	$ 700.00	$ 700.00	$ 600.00	$ 6,000.00
			$ 257.30	$ 774.36						$ 618.72		$ 148.22	$ 1,798.60
	$ -	$ -	$ 857.30	$ 1,374.36	$ -	$ 600.00	$ 700.00	$ 800.00	$ 700.00	$1,318.72	$ 700.00	$ 748.22	**$ 7,798.60**
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	$1,500.00	$1,700.00	$1,400.00	$ 1,100.00	$ 13,600.00
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	$2,898.35	$2,064.38	$1,400.00	$ 1,100.00	**$ 19,354.01**
MS. YIP - Per diem													$ -
Travel													$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**

As of: 10/09/2013

TOTAL PER DIEM	$ 78,200.00
TOTAL TRAVEL	$ 24,270.73
TOTAL	**$ 102,470.73**

MEDICAL BOARD OF CALIFORNIA
Executive Office

PROPOSED BOARD MEETING DATES AND LOCATIONS FOR 2014

February 13,14	San Francisco Bay Area (Dates approved 4/26/13)
May 1,2	Los Angeles Area (Dates approved 4/26/13)
July 24, 25	Sacramento Area
October 23, 24	San Diego Area

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	October 7, 2013
ATTENTION:	Board Members
SUBJECT:	Medical Assistants Performing Basic Pulmonary Function Testing
FROM:	Kerrie Webb, Staff Counsel

REQUESTED ACTION:

Staff Counsel recommends the Medical Board of California (Board) approve Option 1 as a way to obtain a definitive answer from the Attorney General's Office (AG). This would be a joint effort between the Respiratory Care Board (RCB) and the Board, so that the AG may make a well-informed decision that the respective parties will stand behind and respect.

ISSUE:

Are medical assistants legally permitted to perform basic pulmonary function testing, such as spirometry? The RCB has taken a position that they are not allowed to perform such basic screening tests. Staff at the Board, in consultation with a medical consultant, disagree.

BACKGROUND:

On June 28, 2013, Stephanie Nunez, Executive Officer for the RCB, wrote a letter to Ms. Kirchmeyer to inform the Board that the RCB has instructed its staff to begin educating the health care community that medical assistants are not allowed to perform spirometry and other basic pulmonary function tests. The Board was informed that this educational push was being instituted as a precursor to citation and fine of medical assistants performing these tests. As part of this educational effort, Ms. Nunez asked the Board to post a Frequently Asked Question and Answer on its Web site stating the following:

> **Question**: Are medical assistants allowed to conduct any level of pulmonary function testing, including, but not limited to, the most basic and limited type of testing, such as spirometry, peak flows, and lung volumes?
>
> **Response**: No. Pulmonary function testing is a component of the respiratory care practitioner scope of practice. The Respiratory Care Practice Act (Business and Professions Code, Section 3700, et seq.) provides that only licensed respiratory care practitioners may perform pulmonary function testing with limited exemptions provided to other *licensed* personnel. In addition, all levels of pulmonary function testing

> require assessment. Even the more basic and limited type of testing such as spirometry and peak flow are effort-dependent, as well as technically-dependent upon instruction and coaching patients for reliable results. Personnel performing these tests must assess whether the patient is providing the correct effort. Because pulmonary function testing requires assessment, and the Respiratory Care Practice Act prohibits this practice by unlicensed personnel, it must be performed by licensed and qualified personnel pursuant to the Respiratory Care Practice Act.

In response to the request, Board counsel, executive staff, and a medical consultant reviewed the matter. Based on this review, Board staff did not agree with the RCB's request for the reasons discussed below.

16 CCR 1366 RULEMAKING PROCESS

16 California Code of Regulations (CCR) section 1366 was adopted more than 20 years ago in response to thousands of inquiries from medical assistants, and the physicians who employed them, about what they are legally permitted to do. The Board noted that there were many simple tasks which were routinely performed in medical offices by medical assistants, but which were technically illegal. Throughout the rulemaking process, there was considerable controversy among other health professions about an appropriate scope of practice for medical assistants. In light of the controversy, it took several attempts over an approximate two-year period to adopt 16 CCR 1366.

Part of the rulemaking process included the recognition that many tasks are common to more than one health occupation. Such coincidental overlapping scopes of practice are accepted throughout the health care community. For example, the fact that a service may be performed by registered nurses does not automatically preclude its inclusion in the scope of practice for medical assistants.

Many comments were received and considered regarding scope of practice issues. Members of the Respiratory Care Examining Committee and RCB expressed opposition to the addition of the phrase "by inhalation" to a list of routes by which medical assistants may administer medications as part of additional supportive services. They argued that the inclusion of this phrase was in opposition to the Respiratory Care Practice Act (RCPA), section 3760, which states in part, "Except as otherwise provided in this chapter, no person shall engage in the practice of respiratory care, respiratory therapy or inhalation therapy…"

The Board did not agree that the administration of medications by inhalation constituted the practice of respiratory therapy any more than the administration of medications by injection constituted the practice of nursing. Moreover, since the law specifically allowed medical assistants to administer medications by the most potentially hazardous route – injections – it was not logical to prohibit administration by the less hazardous routes included in the regulation.

Members of the Respiratory Care Examining Committee and RCB also objected to the provision in 16 CCR 1366(b)(2) permitting medical assistants to perform plethysmography tests, stating

that this could be interpreted to permit body plethysmography, which requires extensive training. The Board agreed to prohibit medical assistants from performing full body plethysmography, but found that other forms of plethysmography were reasonable tasks for medical assistants to perform.

Plethysmography is frequently used to measure extremities, but can also be used to measure lung volume without employing full body testing. This is further evidence of an overlapping scope of practice between respiratory care therapists and medical assistants specifically permitted by law.

With the adoption of 16 CCR 1366, the Board did not attempt, nor would it have been feasible, to identify every simple, non-hazardous task, and variations thereof, that a medical assistant could perform. Through the rulemaking process, the Board worked to strike a balance between those who objected to rigid regulations, and the need to establish parameters in setting forth and describing the technical services that can be safely performed by a medical assistant. The applicable statutes and regulations provide structure so that procedures that are more complicated and invasive than those specifically permitted should be performed by licensed practitioners, and those that are in the equivalent range may be performed by appropriately-trained and supervised medical assistants, provided all the other requirements are met.

APPLICATION

Considering the tasks that medical assistants are specifically allowed to perform pursuant to statute and regulations, including, but not limited to, electrocardiograms, electroencephalograms, plethysmography tests, applying orthopedic appliances, drawing blood, and giving injections, the Board's counsel, consultant, and staff find that trained medical assistants are capable of performing basic pulmonary function tests, such as screening spirometry.

The Board's medical consultant pointed out that while not all office-based practices have the capacity for performing these pulmonary function tests, many offices do. Thus, to require patients needing a peak flow or spirometry test to see a respiratory care therapist would place an undue burden on patients, and create an unnecessary hurdle to access to care.

In order for a medical assistant to be able to perform any technical supportive service under 16 CCR 1366, the service has to be a usual and customary part of the medical practice where the medical assistant is employed. Accordingly, it is conceivable that a medical assistant may not perform such testing in a dermatologist's office, but may routinely do so in a primary care physician's or a pulmonologist's office. This provides another layer of quality assurance, to ensure proper training, experience, and oversight.

CURRENT STATUS OF DISCUSSIONS

Following initial discussions, the RCB agreed that medical assistants are capable of performing peak flow tests, but the Board and RCB have not yet reached an agreement on other types of basic pulmonary function tests.

OPTIONS:

Board staff have identified options for the members to consider, including the following:

1) Seek a joint, formal legal opinion from the Attorney General's Office with the RCB.

2) In the alternative, if Board members agree with the RCB that medical assistants should not perform basic pulmonary function tests, the members can instruct Board staff to assist the RCB in educating physicians and medical assistants, such as by posting a FAQ on the topic on the Board's Web site.

DATE REPORT ISSUED: October 10, 2013
DEPARTMENT: Medical Board of California
SUBJECT: Executive Summary-Enforcement
STAFF CONTACT: A. Renee Threadgill,
Chief of Enforcement

Program Update:

The third presentation of the Expert Reviewer training will be held November 2, 2013, on the campus of the University of California, San Diego Medical School in La Jolla. The training will begin at 8:30 a.m. and is scheduled to conclude at 5:00 p.m. Attendees will receive eight hours of continuing medical education credit. Members are welcome to attend this outstanding training experience.

There are currently 936 active experts on the list. 336 experts were utilized to review 641 cases calendar year to date. Attachment A includes the Expert Reviewer Program statistics. Additional experts are needed in the following specialties:

- Pain Medicine
- Addiction Medicine
- Psychiatry

The Enforcement program continues to work with the Administrative Law Judges to provide training regarding medical-related topics. In September Dr. Nuovo provided part l of an Anatomy and Physiology presentation (Part II will continue in November).

There are currently seven sworn investigator vacancies, which equates to an 8% vacancy rate. However, five individuals are in background for those positions, thus the vacancy rate is reduced to 4%. There are two supervising investigator vacancies, which is a 10% vacancy rate for this classification. The overall vacancy rate for sworn positions is 9% or 5%, if the vacancies with candidates in background are included. Five newly hired investigators are attending the Specialized Basic Academy in Orange County. They are scheduled to complete the Academy on December 12, 2013.

The Central Complaint Unit received 7,460 complaints in fiscal year 2012/2013. This is 537 more complaints than received in the previous fiscal year. The average/median Complaint Unit processing time was reduced from 83/64 days in fiscal year 2011/2012 to 67/54 days in fiscal year 2012/2013.

Statistical data is provided in Attachment B. This data reflects the following improvements when comparing fiscal year 2011/2012 to fiscal year 2012/2013:

- Average number of days from the complaint received by the Board to complaint closed or sent to investigation decreased by 23 days;
- Average days from receipt of complaint, to investigation, to case closed or referred for action decreased by 106 days; and
- The number of suspension orders increased from 74 to 78.

Medical Board of California
Expert Reviewer Program Report

Attachment A

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY

October 1, 2013

SPECIALTY	Number of cases reviewed/ sent to Experts (Jan-Sep, 2013)	Number of Experts Utilized (Jan-Sep, 2013)	Active List Experts 936
ADDICTION	11	**7 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	16 ↑
ALLERGY & IMMUNOLOGY (A&I)			4
ANESTHESIOLOGY (Anes)	12	**14 EXPERTS** 13 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	69 ↑
COLON & RECTAL SURGERY (CRS)	5	**2 EXPERTS** 1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 4 CASES	3
COMPLEMENTARY/ALTERNATIVE MEDICINE	18	**10 EXPERTS** 6 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 4 CASES	21↑
CORRECTIONAL MEDICINE	1	**1 EXPERT** 1 LIST EXPERT	28 ↑
DERMATOLOGY (D)	1	**1 EXPERT** 1 LIST EXPERT	10
EMERGENCY (EM)	17	**13 EXPERTS** 8 LIST EXPERTS REVIEWED 1 CASE 4 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	49
FAMILY (FM) *involved companion cases and included physical evaluations	87	**41 EXPERTS** 20 LIST EXPERTS REVIEWED 1 CASE 10 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES 3 LIST EXPERT REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES* 2 LIST EXPERTS REVIEWED 6 CASES* 2 LIST EXPERT REVIEWED 8 CASES* 1 LIST EXPERT REVIEWED 9 CASES*	74

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY

October 1, 2013

SPECIALTY	Number of cases reviewed/ sent to Experts (Jan-Sep, 2013)	Number of Experts Utilized (Jan-Sep, 2013)	Active List Experts 936
INTERNAL (General Internal Med) *companion cases and included physical evaluations	71	**43 EXPERTS** 32 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 5 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES 2 LIST EXPERTS REVIEWED 5 CASES* 2 LIST EXPERTS REVIEWED 9 CASES*	183 ↑
Cardiovascular Disease (Cv)	13	**9 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES	32 ↑
Gastroenterology (Ge)	7	**7 EXPERTS** 6 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	19 ↑
Medical Oncology (Onc)	4	**3 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	11
Nephrology (Nep)	1	**1 EXPERT** 1 LIST EXPERT	7 ↓
Rheumatology (Rhu)	1	**1 EXPERT** 1 LIST EXPERT	8
MIDWIFE REVIEWER	1	**1 EXPERT** 1 LIST EXPERT	6
NEUROLOGICAL SURGERY (NS)	13	**5 EXPERTS** 3 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 5 CASES	10 ↑
NEUROLOGY (N)	15	**9 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE 4 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	25 ↓
NEUROLOGY with Special Qualifications in Child Neurology (N/ChiN)			2

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
October 1, 2013

SPECIALTY	Number of cases reviewed/ sent to Experts (Jan-Sep, 2013)	Number of Experts Utilized (Jan-Sep, 2013)	Active List Experts 936
NUCLEAR MEDICINE (NuM)			5
OBSTETRICS & GYNECOLOGY (ObG) *short list of reviewers	49	**29 EXPERTS** 16 LIST EXPERTS REVIEWED 1 CASE 6 LIST EXPERTS REVIEWED 2 CASES 3 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES 2 LIST EXPERTS REVIEWED 7 CASES*	76 ↓
OCCUPATIONAL MEDICINE	2	**1 EXPERT** 1 LIST EXPERT REVIEWED 2 CASES	9
OPHTHALMOLOGY (Oph) *involved companion cases	14	**9 EXPERTS** 6 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 6 CASES*	31 ↓
ORAL & MAXILLOFACIAL SURGERY	1	**1 EXPERT** LIST EXPERT	1
ORTHOPAEDIC SURGERY (OrS)	14	**11 EXPERTS** 8 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	24 ↓
OTOLARYNGOLOGY (Oto)	2	**2 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE	19 ↓
PAIN MEDICINE (PM) *short list of reviewers	55	**19 EXPERTS** 7 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 3 LIST EXPERTS REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES* 3 LIST EXPERTS REVIEWED 6 CASES* 1 LIST EXPERT REVIEWED 7 CASES*	22 ↑

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
October 1, 2013

SPECIALTY	Number of cases reviewed/ sent to Experts (Jan-Sep, 2013)	Number of Experts Utilized (Jan-Sep, 2013)	Active List Experts 936
PATHOLOGY (Path)	5	**3 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES	9
PEDIATRICS (Ped)	8	**8 EXPERTS** 5 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	46 ↓
PHYSICAL MEDICINE & REHABILITATION (PMR)	2	**2 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE	10
PLASTIC SURGERY (PIS) *involved companion cases	26	**13 EXPERTS** 7 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 2 LIST EXPERTS REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 6 CASES*	50 ↑
PSYCHIATRY (Psyc) *included case reviews, evaluations and preparation/testimony (of cases previously reviewed)	101	**48 EXPERTS** 24 LIST EXPERTS REVIEWED 1 CASE 7 LIST EXPERTS REVIEWED 2 CASES 9 LIST EXPERT REVIEWED 3 CASES 3 LIST EXPERTS REVIEWED 4 CASES 2 LIST EXPERTS REVIEWED 5 CASES* 2 LIST EXPERTS REVIEWED 7 CASES* 1 LIST EXPERT REVIEWED 8 CASES*	81
RADIOLOGY (Rad)	8	**7 EXPERTS** 6 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	35 ↑
RADIATION ONCOLOGY	2	**1 EXPERT** 1 LIST EXPERT REVIEWED 2 CASES	4
SLEEP MEDICINE (S)			8
SURGERY (S)	29	**21 EXPERTS** 14 LIST EXPERTS REVIEWED 1 CASE 6 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	43

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
October 1, 2013

SPECIALTY	Number of cases reviewed/ sent to Experts (Jan-Sep, 2013)	Number of Experts Utilized (Jan-Sep, 2013)	Active List Experts 936
Vascular Surgery (VascS)	2	**1 EXPERT** 1 LIST EXPERT REVIEWED 2 CASES	8 ↓
THORACIC SURGERY (TS)	4	**3 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	16 ↑
(*MEDICAL) TOXICOLOGY*	1	**1 EXPERT** 1 LIST EXPERT	3
UROLOGY (U) *short list of reviewers	17	**8 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES*	17 ↑

TOTAL CASES SENT: Calendar Year to date (end of 3rd Quarter)	**641**
TOTAL LIST EXPERTS UTILIZED: Calendar Year to date (end of 3rd Quarter)	**336**
TOTAL ACTIVE LIST EXPERTS	**936**

/susan (10/1/13)

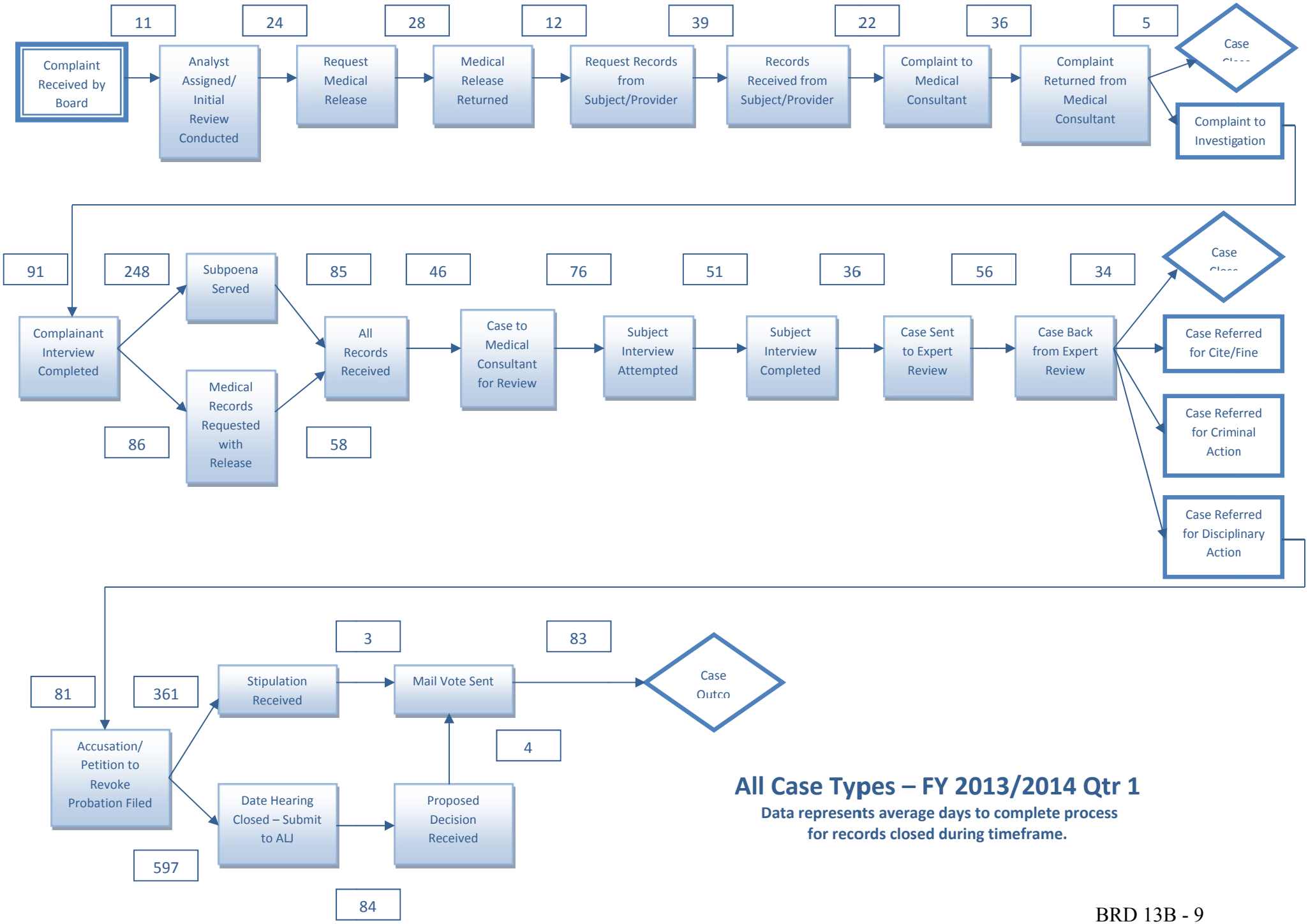
Enforcement Data Markers
All Case Types

Data represents average days to complete Complaint and Investigation processes for records closed during reported time frames.	FY 2008/2009		FY 2009/2010		FY 2010/2011		FY 2011/2012		FY 2012/2013		FY 2013/2014 1st Qtr	
	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records
Complaint Processes												
Complaint Received by Board → Analyst Assigned/Initial Review Conducted	10	6761	11	6869	9	7513	12	7699	9	7929	11	1980
Analyst Assigned/Initial Review Conducted → Request Medical Release	25	1216	24	1360	28	1567	42	1557	28	1419	24	395
Request Medical Release → Medical Release Returned	29	1044	26	1166	25	1321	27	1281	29	1233	28	353
Medical Release Returned → Request Records from Subject/Provider	7	687	7	802	11	888	17	865	16	775	12	207
Request Records from Subject/Provider → Records Received from Subject/Provider	39	1759	38	1879	35	1906	35	2015	34	1953	39	529
Records Received from Subject/Provider → Complaint to Medical Consultant	15	1617	16	1865	17	1768	21	1798	23	1621	22	457
Complaint to Medical Consultant → Complaint Returned from Medical Consultant	54	1934	54	2120	52	2129	45	2164	36	1935	36	553
Complaint Returned from Medical Consultant → Case Closed/Complaint to Investigation	7	1932	4	2114	5	2126	4	2151	5	1928	5	550
Investigative Processes												
Complaint to Investigation → Complainant Interview Completed	103	349	102	424	110	490	89	531	81	513	91	139
Complainant Interview Completed → Subpoena Served	173	42	237	43	172	44	202	45	155	61	248	22
Complainant Interview Completed → Medical Records Requested with Release	76	141	88	170	59	194	87	203	60	213	86	68
Subpoena Served → All Records Received	124	120	100	178	88	166	82	146	90	151	85	49
Medical Records Requested with Release → All Records Received	95	372	92	406	85	420	64	416	53	418	58	111
All Records Received → Case to Medical Consultant for Review	78	227	84	318	70	369	59	322	50	313	46	99
Case to Medical Consultant for Review → Subject Interview Attempted	110	374	109	488	77	558	76	532	74	477	76	145
Subject Interview Attempted → Subject Interview Completed	66	712	53	880	53	961	51	1046	48	1014	51	252
Subject Interview Completed → Case Sent to Expert Review	97	412	81	511	72	580	57	626	46	614	36	166
Case Sent to Expert Review → Case Back from Expert Review	79	510	72	601	63	658	61	701	61	706	56	183
Case Back from Expert Review → Case Closed or Referred for Action	39	495	31	585	30	656	29	705	33	697	34	181

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		FY 2013/2014 1st Qtr	
	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records
Case Referred for Action → Accusation/Petition to Revoke Probation Filed	121	239	113	237	103	219	129	284	108	304	81	73
Accusation/Petition to Revoke Probation Filed → Stipulation Received	330	159	291	173	318	142	329	202	333	198	361	47
Stipulation Received → Mail Vote Sent	6	136	6	132	4	124	5	153	4	141	3	35
Accusation/Petition to Revoke Probation Filed → Date Hearing Closed - Submit to ALJ	416	25	370	30	393	44	318	45	484	55	597	11
Date Hearing Closed - Submit to ALJ → Proposed Decision Received	28	35	98	43	39	58	40	63	50	86	84	15
Proposed Decision Received → Mail Vote Sent	5	54	5	53	6	60	6	72	5	88	4	15
Mail Vote Sent → Case Outcome	131	206	87	208	111	205	82	262	91	265	83	56

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		FY 2013/2014 1st Qtr	
	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records	Average Days	Number of Records
Complaint Received → Closure in Complaint Unit	84	5278	84	5247	80	5755	91	5687	75	5886	78	1526
Complaint Received → Closure at Field/Referred for Administrative or Criminal Action/Citation Issued	467	1585	464	1747	453	1861	419	2101	404	2143	455	480



All Case Types – FY 2013/2014 Qtr 1

Data represents average days to complete process for records closed during timeframe.

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	FY 13/14 *
Automatic Suspension Order	5	1	5	0	3	7	4	6	4	3
PC 23 Order	8	4	8	6	15	7	12	12	22	6
Out of State Suspension Order	15	14	8	11	18	18	21	17	9	3
Agreement - No Practice/Restriction	2	6	5	2	3	3	2	0	3	0
Suspension/Cease Practice Issued by Chief	5	5	3	1	2	1	3	4	6	2
Interim Suspension Order	31	32	22	18	22	22	28	35	34	11
Temporary Suspension Order	1	0	0	1	0	0	1	0	0	0
Totals	**67**	**62**	**51**	**39**	**63**	**58**	**71**	**74**	**78**	**25**

*** Suspensions Issued through 9/30/2013**

ENFORCEMENT TIMEFRAMES

Attachment B

FISCAL YEARS	2007 - 2008		2008- 2009		2009 - 2010		2010 - 2011		2011 - 2012		2012 - 2013		2013 - 2014 *	
	AVERAGE	MEDIAN	AVERAGE	MEDIAN	AVERAGE	MEDIAN	AVERAGE	MEDIAN	AVERAGE	MEDIAN	AVERAGE	MEDIAN	AVERAGE	MEDIAN
COMPLAINT PROCESSING	61	49	75	63	76	63	74	77	83	64	68	54	71	59
INVESTIGATION	324	272	349	309	328	292	312	283	264	225	267	244	291	273
TOTAL MBC														
DAYS	385	321	424	372	404	355	386	360	347	289	335	298	362	332
YEARS	1.05	0.88	1.16	1.02	1.11	0.97	1.06	0.99	0.95	0.79	0.92	0.82	0.99	0.91
AG PREP FOR ACC	121	58	103	63	106	66	107	72	104	78	90	75	118	99
OTHER LEGAL	471	324	381	311	368	312	417	324	396	351	434	360	479	432
TOTAL AG														
DAYS	592	382	484	374	474	378	524	396	500	429	524	435	597	531
YEARS	1.62	1.05	1.33	1.02	1.30	1.04	1.44	1.08	1.37	1.18	1.44	1.19	1.64	1.45
TOTAL MBC & AG														
DAYS	977	703	908	746	878	733	910	756	847	718	859	733	959	863
YEARS	2.68	1.93	2.49	2.04	2.41	2.01	2.49	2.07	2.32	1.97	2.35	2.01	2.63	2.36

Years calculated using 365 days per year
Data source: MBC Annual Reports, except 2012-2013

* Data through 9/30/2013

Medical Board of California

Investigation Prosecution Timeframes*

	2005	2006		2007		2008		2009		2010		2011	2012	2013 Qtr 1	2013 Qtr 2	2013 Qtr 3
	Prior to VE	All	VE	All	VE	All	VE	All	VE	All	VE	All	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	274
Median	252	285	134	304	269	335	324	346	346	298	297	273	230	246	255	567
Record Count	827	703	192	648	539	609	588	673	672	664	663	857	794	222	201	225
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	40
Median	17	3	2	22	23	10	10	23	23	1	1	17	24	29	33	26
Record Count	24	21	11	17	13	21	17	17	16	27	27	31	51	9	12	15
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	51
Median	32	31	26	31	31	28	28	32	32	29	29	30	28	34	29	35
Record Count	475	376	228	264	259	256	252	243	243	257	257	246	236	46	44	32
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	43
Median	36	42	38	37	36	41	42	37	37	34	34	38	35	37	31	28
Record Count	597	453	172	406	371	473	466	696	696	582	582	729	664	145	136	103
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	66
Median	41	35	31	36	35	39	38	36	35	37	37	39	38	36	36	42
Record Count	519	424	82	344	270	374	359	426	424	415	415	599	447	142	151	122
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	494
Median	525	504	120	523	339	541	486	575	569	616	616	533	457	530	469	455
Record Count	187	149	17	198	95	157	131	189	186	200	199	239	231	54	65	54
Calendar Day Age from Accusation Filed to Disciplinary Outcome**																
Average	608	602	85	576	188	561	243	473	339	426	340	425	449	459	476	476
Median	526	466	99	426	182	384	238	351	309	326	304	391	367	422	440	457
Record Count	212	195	3	226	29	203	80	198	145	171	156	190	237	51	59	63

*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

Attachment B

	2005	2006	2007	2008	2009	2010	2011	2012	2013 Qtr 1	2013 Qtr 2	2013 Qtr 3
***Citations Issued**	80	81	76	109	124	100	98	122	21	19	19
Citations Issued for Failure to Produce Records	0	6	3	3	2	5	6	3	3	0	2
Civil Actions Filed	3	3	1	1	2	1	6	0	0	0	0
Civil Actions Filed for Failure to Produce Records	2	2	1	1	0	0	3	0	0	0	0

*Excludes citations issued for failure to comply with CME audit and for failure to notify Board of change of address

MEDICAL BOARD OF CALIFORNIA
Enforcement Processing Timeframes
2012 Strategic Plan Objective 5.2

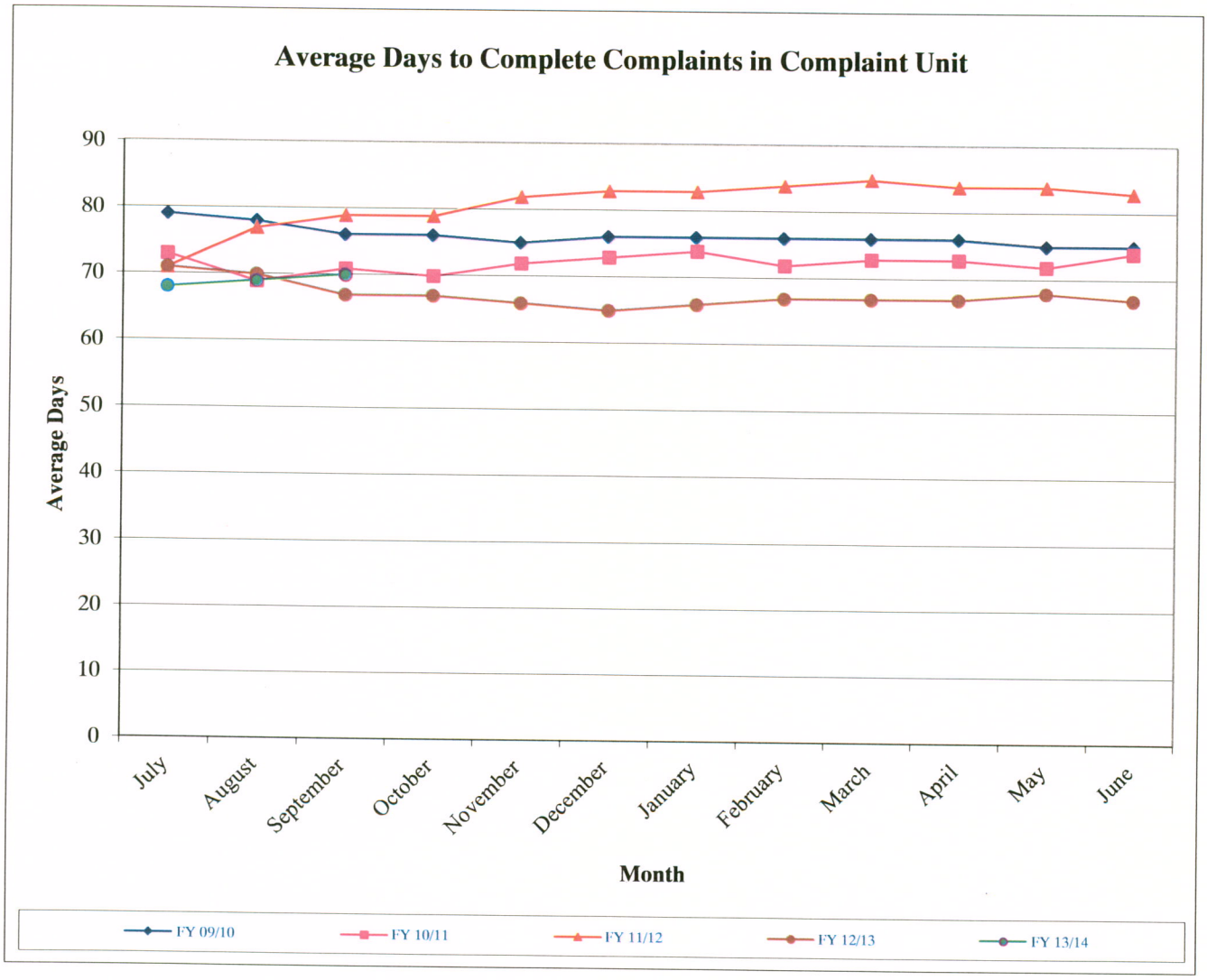
Enforcement Process	2008/2009		2009/2010		2010/2011		2011/2012		2012/2013		2013/2014 Qtr 1	
	Cases[1]	AVG[2]	Cases	AVG	Cases	AVG	Cases	AVG	Cases	AVG	Cases	AVG
Complaint	6426	75	6563	76	7008	74	7217	83	7408	67	1865	70
% of Complaints Below 50 days (Goal: 50-60%)	**43%**		**41%**		**35%**		**42%**		**48%**		**45%**	
Investigation	1100	349	1290	328	1411	312	1545	264	1551	267	360	290
Discipline												
AG Processing to Preparation of an Accusation	240	103	304	106	294	107	333	103	298	90	58	116
Other Stages of the Legal Process (e.g., after charges filed)	228	381	232	368	216	417	280	396	293	434	69	479

[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)**

Medical Board of California Enforcement Program
Average Days to Complete Complaint in Complaint Unit

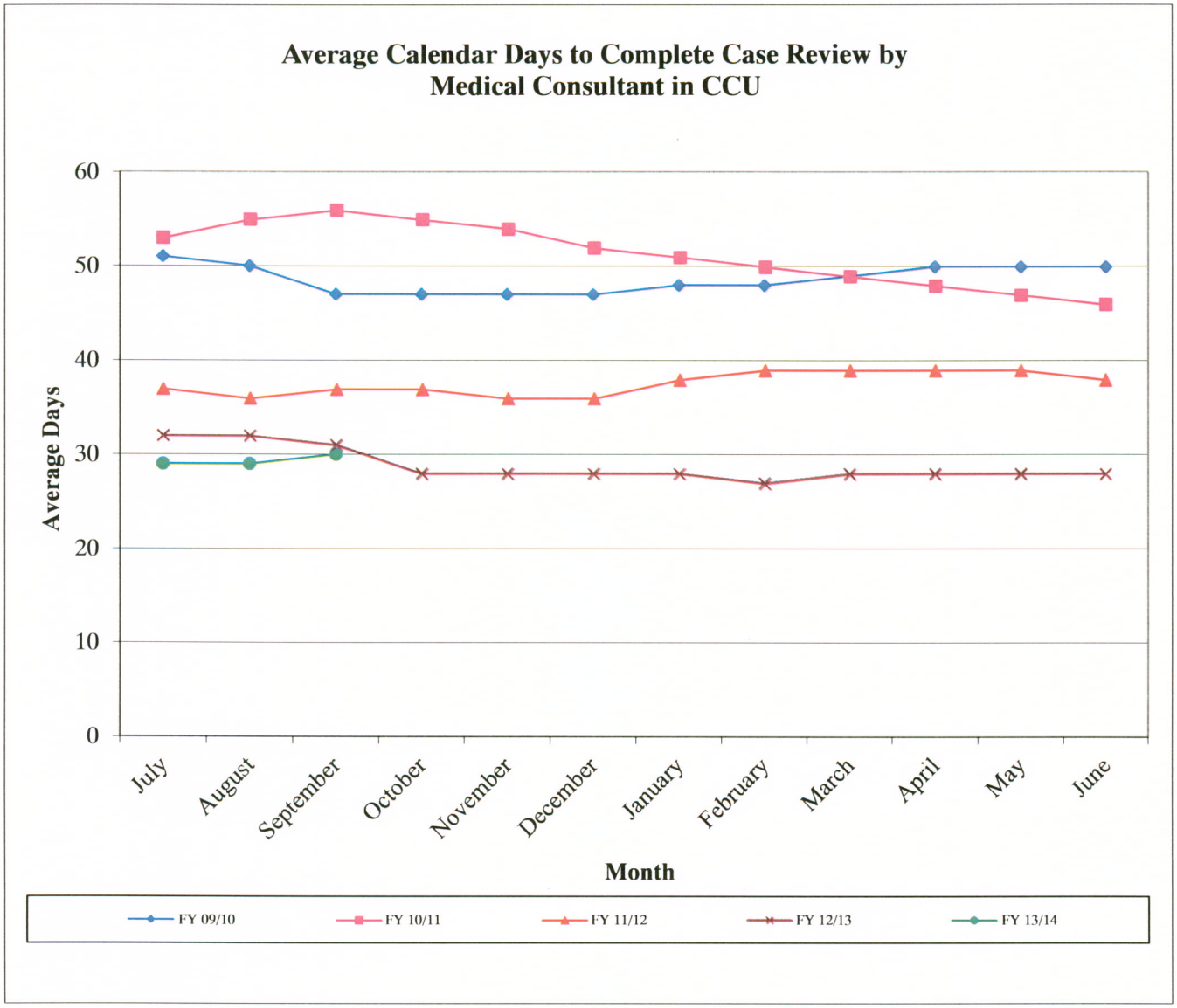
Month	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14
July	79	73	71	71	68
August	78	69	77	70	69
September	76	71	79	67	70
October	76	70	79	67	
November	75	72	82	66	
December	76	73	83	65	
January	76	74	83	66	
February	76	72	84	67	
March	76	73	85	67	
April	76	73	84	67	
May	75	72	84	68	
June	75	74	83	67	



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.

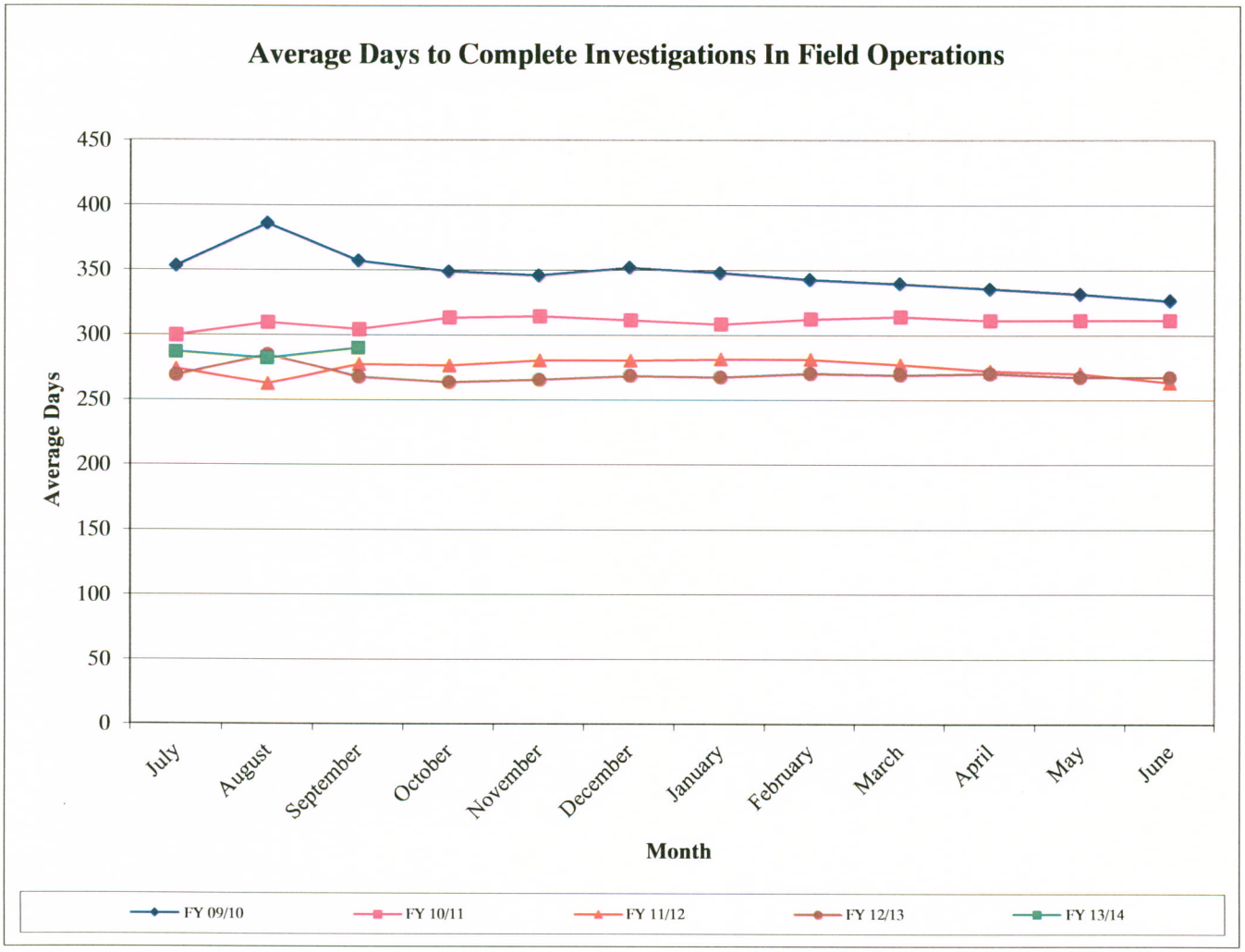
Medical Board of California Enforcement Program
Average Calendar Days to Complete Case Review by Medical Consultant in CCU

Month	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14
July	51	53	37	32	29
August	50	55	36	32	29
September	47	56	37	31	30
October	47	55	37	28	
November	47	54	36	28	
December	47	52	36	28	
January	48	51	38	28	
February	48	50	39	27	
March	49	49	39	28	
April	50	48	39	28	
May	50	47	39	28	
June	50	46	38	28	



Medical Board of California Enforcement Program
Average Days to Complete Investigations in Field Operations

Month	Fiscal Year FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14
July	353	300	274	269	287
August	386	310	263	285	282
September	357	305	278	268	290
October	349	314	277	264	
November	346	315	281	266	
December	352	312	281	269	
January	348	309	282	268	
February	343	313	282	271	
March	340	315	278	270	
April	336	312	273	271	
May	332	312	271	268	
June	327	312	264	268	



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

DATE REPORT ISSUED: October 10, 2013
ATTENTION: Board Members
SUBJECT: Executive Summary – Licensing Program
STAFF CONTACT: Curtis J. Worden, Chief of Licensing

STAFFING:
Staff have been doing an excellent job this first quarter of FY13/14. Licensing has had several staff out for various reasons, including extended leaves, position vacancies, and the numerous staff who have been working on the new Department of Consumer Affairs, BreEZe computer system.

Licensing currently has the following vacancies:

- OT - Front End - New employee with start on October 23, 2013.
- (.8) OA/OT Front End - New employee will start on October 14, 2013
- OT - Call Center - Position has been advertised
- MST - US/CAN Physician's and Surgeon's (P&S) Applications - Interviews have been conducted
- SSA - IMG P&S Applications - Submitted request to DCA for approval to advertise the position
- AGPA - Midwife, Outpatient Surgery Settings, Research Psychoanalyst and Medical Assistances

STATISTICS:
The statistics start on page BRD 16A - 4 through BRD 16A - 13.

Notable statistics include:

- Consumer Information Unit, telephone calls answered - 24,897 (BRD 16A - 4)
- P&S applications received - 1, 669 (BRD 16A - 4)
- P&S applications initial review completed - 1,238 (BRD 16A - 4)
- P&S applications pending - 4,089 (BRD 16A - 4)
- P&S licenses issued - 1,447 (BRD 16A - 4)

Licensing did not meet its goal of performing initial reviews of all new P&S applications within 45 days of being received by the Board for one of the 13 weeks in first quarter of FY 13/14 (page BRD 16A - 12). There were ten weeks, due to the large volume of mail for the amount of staff that were available to work, where the number of days to review new incoming mail was too high. The Licensing management will continue to monitor the review dates closely and to minimize this in the future. The amount of staff working on BreEZe had a significant impact on staffs' ability to meet the review date goals.

INTERNATIONAL MEDICAL SCHOOLS:
The statistics for the International Medical School Reviews are on page BRD 16A - 5.
The review of International Medical Schools continues to be a demanding workload for the Board. There are currently three Self-Assessment Reports that are being reviewed by Licensing Medical Consultants.

OUTPATIENT SURGERY SETTINGS:
Staff has been working on proposed changes to the Board's Outpatient Surgery Setting (OSS) Web pages to make the information easier to understand for consumers. When the OSS Task Force members met with Board staff on September 30, 2013, the members made some additional suggestions that will be incorporated with the other changes proposed by Board staff.

Please see the staff report regarding the OSS Task Force update on pages BRD 17 - 1 through 2.

SPONSORED FREE HEALTH CARE EVENTS:
The Board has received one application from a physician and surgeon licensed in another state to participate in the October 31 through November 3, 2013, Care Harbor / LA 2013 event at the Los Angeles Sports Arena, 3939 South Figueroa Ave., Los Angeles, CA.

PHYSICIAN SPECIALTY BOARD APPLICATIONS:
The Board previously had one pending application from a physician specialty board requesting approval by the Board. The Board received one new application from a different specialty board requesting approval by the Board.

LICENSING – BREEZE UPDATE:
The following Licensing staff classifications have been working on the BreEZe project:

- 4 Licensing Managers: at times three managers will be working on BreEZe at one time
- 6 AGPAs (lead analyst):
  - 1 - almost full time on the BreEZe project
  - 1 - almost 80% of the time on the BreEZe project
  - 1 - up to 50% of the time on the BreEZe project
  - 2 - up to 20% of the time on the BreEZe project
  - 1 - up to 10% of the time on the BreEZe project
- 1 MST works almost 50% of the time on the BreEZe project

The above does not include the other Licensing staff that assisted with BreEZe at various times during testing and/or training, especially since June 2013. The amount of Licensing staffs' time spent testing BreEZe, along with some other staffing issues, has resulted in an increase in the timeframes to perform the initial review of new applications and process mail. The Licensing management will continue to monitor and manage the workload to try to maintain its goals.

The BreEZe system went live on October 8, 2013, at approximately 3:15 p.m. The Licensing subject matter experts (specific managers, lead analysts and other staff) started working in the system to identify any specific areas of concerns. Additionally, they determined how to use the workarounds that are needed for the areas that are not functioning as expected. This is necessary

to in order to provide the rest of the Licensing staff with the correct procedures to use and to provide any training that has been identified.

Please note that staff has previously received training on more than one occasion. However, the training was done prior to the system's completion and therefore staff was not able to be trained on all areas of BreEZe at that time.

Licensing staff who are working on the BreEZe project are doing an excellent job with testing and now with BreEZe Go Live, with an unfading perseverance. The Board's ISB staff has and continues to provide outstanding service and assistance to the Licensing staff during the BreEZe project. The Consumer Information Unit is doing an excellent job with handling the increase in calls as a result of BreEZe going online.

WORKLOAD REPORT
as of September 30, 2013

CONSUMER INFORMATION UNIT FY 13/14					
	FY 13/14	Q1	Q2	Q3	Q4
Total Calls Answered	**24,897**	24,897			
Calls Requesting Call Back	**3,861**	3,861			
Calls Abandoned	**3,147**	3,147			
Address Changes Completed	**1,674**	1,674			

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

PHYSICIAN & SURGEON DATA FY 13/14					
	FY 13/14	Q1	Q2	Q3	Q4
Applications Received	**1,669**	1,669			
Initial Reviews Completed	**1,238**	1,238			
Total Pending	**N/A**	4,089			
Reviewed	**N/A**	3,279			
Not Reviewed	**N/A**	810			
(SR2s Pending)	**N/A**	49			
Licenses Issued	**1,447**	1,447			
Renewals Issued	**17,859**	17,859			

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

WORKLOAD REPORT
as of September 30, 2013

SR 2 - CATEGORIES FY 13/14					
	FY 13/14	Q1	Q2	Q3	Q4
Alcohol/Drugs	5	5			
PG/Medical Knowledge	19	19			
Convictions	11	11			
Other	29	29			

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

Unrecognized and Disapproved Medical School Applicants (2135.7) - FY 13/14					
	FY 13/14	Q1	Q2	Q3	Q4
Received	1	1			
Reviewed	1	1			
Not Eligible	0	0			
Licensed	0	0			

Unrecognized and Disapproved Medical School Applicants (2135.7) - FY 12/13					
	FY 12/13	Q1	Q2	Q3	Q4
Received	11	N/A	N/A	11	0
Reviewed	11	N/A	N/A	7	4
Not Eligible	7	N/A	N/A	3	4
Licensed	2	N/A	N/A	1	1

INTERNATIONAL MEDICAL SCHOOL APPLICATIONS FY 13/14					
	FY 13/14	Q1	Q2	Q3	Q4
Schools Pending Recognition at Beginning of Quarter	N/A	98			
Pending Self-Assessment Reports (included above)	N/A	9			
New Self-Assessment Reports Received	1	1			
New Unrecognized Schools Received	21	21			
School Recognized Pursuant to CCR 1314(a)(1)	18	18			
School Recognized Pursuant to CCR 1314(a)(2)	0	0			
TOTAL Schools Pending Recognition at End of Quarter	N/A	102			

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

WORKLOAD REPORT
as of September 30, 2013

RESEARCH PSYCHOANALYST FY 13/14					
	FY 13/14	Q1	Q2	Q3	Q4
RP Applications Received	1	1			
RP Licenses Issued	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

LICENSED MIDWIVES FY 13/14					
	FY 13/14	Q1	Q2	Q3	Q4
Applications Received	2	2			
Applications Pending	N/A	7			
Licenses Issued	1	1			
Licenses Renewed	35	35			

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

FICTITIOUS NAME PERMITS FY 13/14					
	FY 13/14	Q1	Q2	Q3	Q4
P&S - FNP Received	312	312			
P&S - FNP Issued	228	228			
P&S - FNP Pending	N/A	262			
P&S - FNP Renewed	1,353	1,353			
Podiatric FNP Received	7	7			
Podiatric FNP Issued	4	4			
Podiatric FNP Pending	N/A	8			
Podiatric FNP Renewed	34	34			

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

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OPTICAL REGISTRATIONS FY 13/14					
	FY 13/14	Q1	Q2	Q3	Q4
RDO - Business Registrations Issued	13	13			
RDO - Pending Applications Business	N/A	39			
CLS - Out-of-State - Business Registrations Issued	0	0			
CLS - Pending Out of State Applications -Business	N/A	1			
Spectacle Lens Registrations Issued	55	55			
Spectacle Lens - Pending Applications	N/A	34			
Contact Lens Registrations Issued	17	17			
Contact Lens - Pending Applications	N/A	12			
Spectacle Lens Registrations Renewed	196	196			
Contact Lens Registrations Renewed	102	102			

OPTICAL REGISTRATIONS FY 12/13					
	FY 12/13	Q1	Q2	Q3	Q4
Business Registrations Issued	41	0	9	15	17
Pending Applications Business	N/A	1	20	28	32
Out-of-State Business Registrations Issued	0	0	0	0	0
Pending Applications Out of State Bus.	N/A	1	1	1	1
Spectacle Lens Registrations Issued	204	66	32	42	64
Pending Applications-Spectacle Lens	N/A	59	24	30	36
Contact Lens Registrations Issued	90	33	14	11	32
Pending Applications-Contact Lens	N/A	20	7	9	11
Spectacle Lens Registrations Renewed	919	230	212	226	251
Contact Lens Registrations Renewed	410	94	110	106	100

POLYSOM FY 13/14					
	FY 13/14	Q1	Q2	Q3	Q4
Polysomnographic Trainee Applications Received	6	6			
Polysomnographic Trainee Registrations Pending	N/A	56			
Polysomnographic Trainee Registrations Issued	6	6			
Polysomnographic Technician Applications Received	11	11			
Polysomnographic Technician Registrations Pending	N/A	25			
Polysomnographic Technician Registrations Issued	10	10			
Polysomnogrpahic Technologist Applications Received	11	11			
Polysomnogrpahic Technologist Applications Pending	N/A	112			
Polysomnogrpahic Technologist Registrations Issued	53	53			

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

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SPECIALTY BOARD APPLICATIONS FY 13/14					
	FY 13/14	Q1	Q2	Q3	Q4
Applications Received	1	1			
Applications Pending	N/A	2			

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

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SPECIAL PROGRAMS
FY 13/14

Permit	Applications Received				Applications Reviewed				Permits Issued				Permits Renewed				Total Pending				Applications Withdrawn, Denied, or Closed			
	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	6				6				6				9				7				0			
2112	0				0				0				0				0				0			
2113	7				6				4				27				10				0			
2168	0				0				0				3				0				0			
2072	0				0				0				0				0				0			
1327	0				0				0				0				0				0			

SPECIAL PROGRAMS
FY 12/13

Permit	Applications Received				Applications Reviewed				Permits Issued				Permits Renewed				Total Pending				Applications Withdrawn, Denied, or Closed			
	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

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)

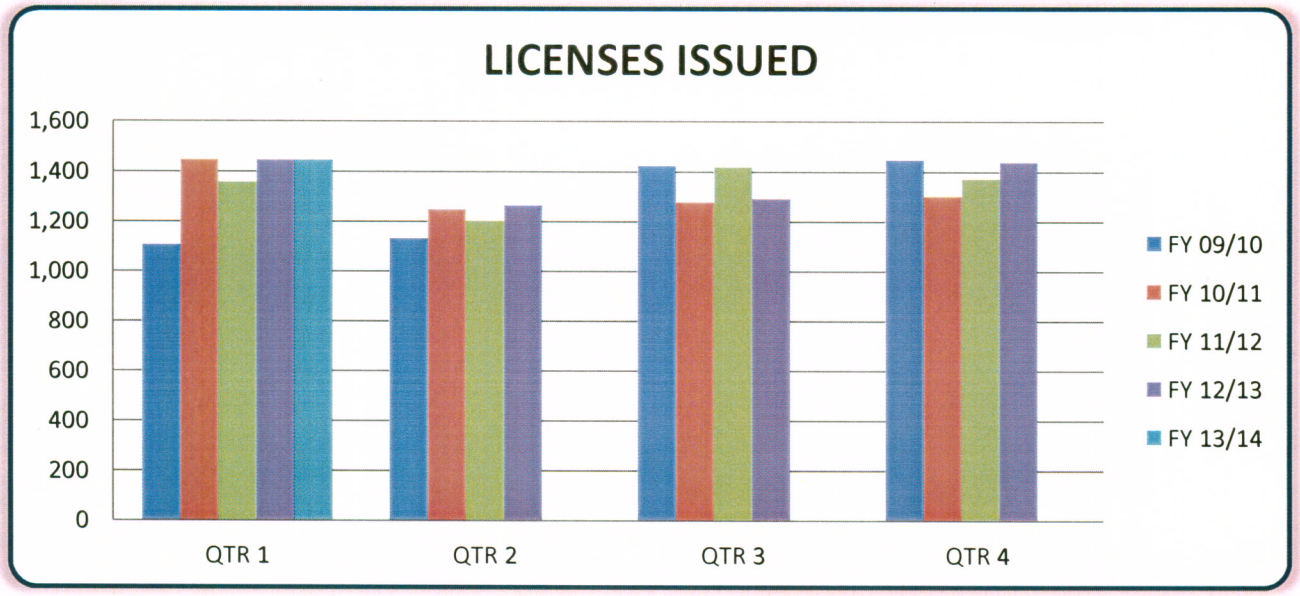
2168 - Special Faculty Permit (academically eminent; unrestricted practice within sponsoring medical school - not eligible for licensure)

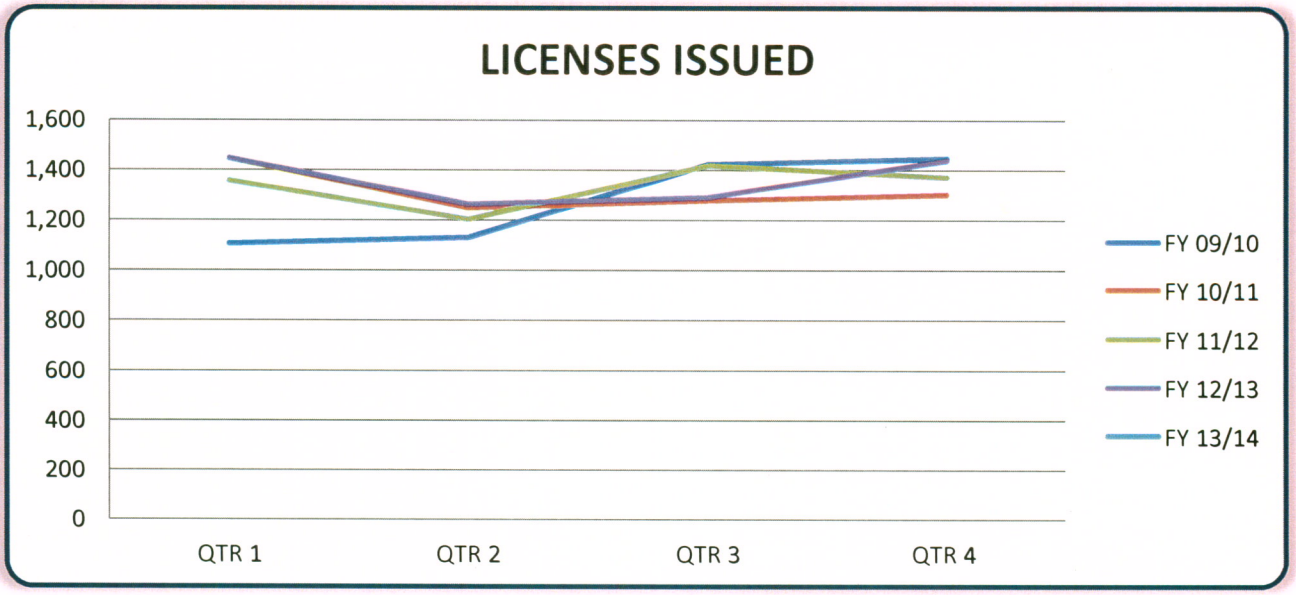
2072 - Special Permit - Correctional Facility

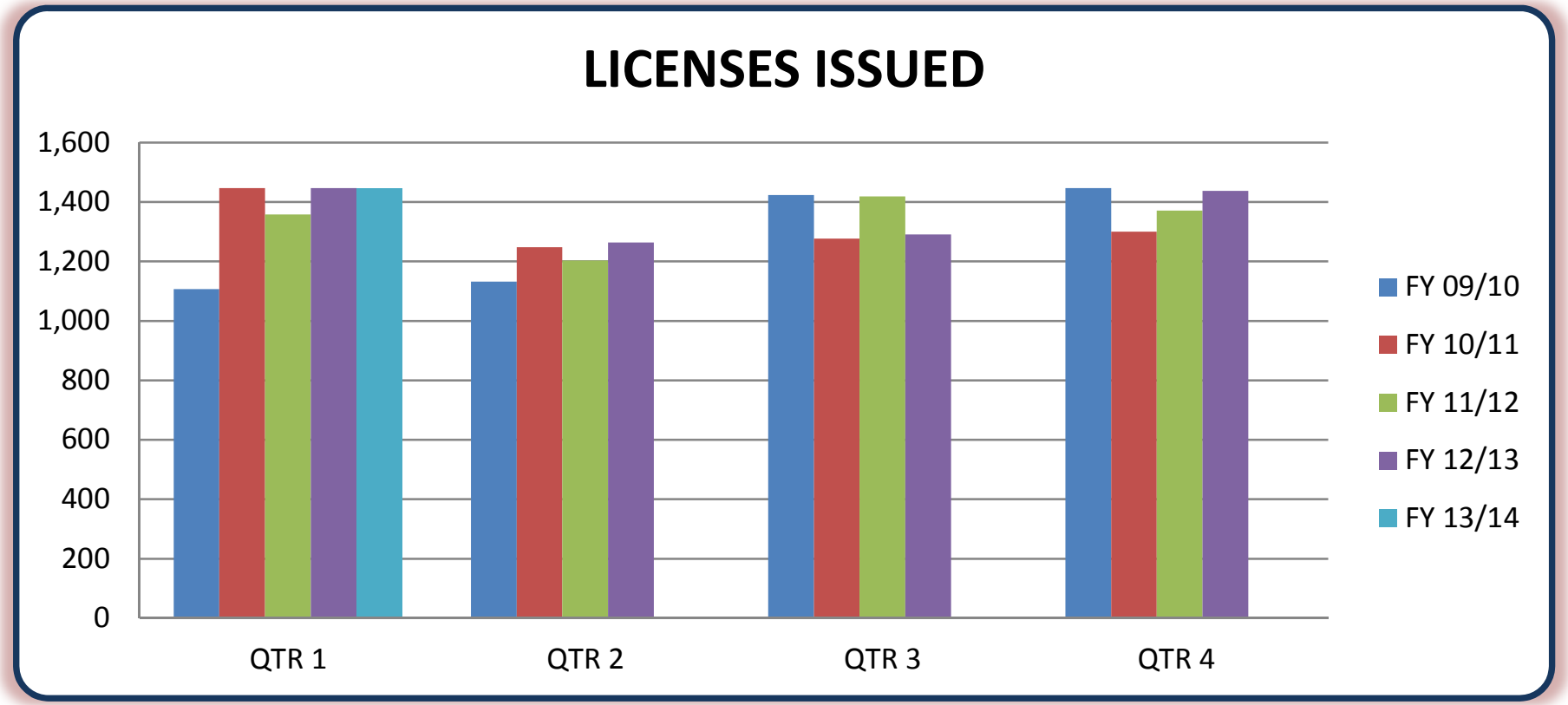
1327 - Medical Student Rotations - Non-ACGME Hospital Rotation

PHYSICIAN'S AND SURGEON'S LICENSES ISSUED
Five Fiscal Year History

Fiscal Year	QTR 1	QTR 2	QTR 3	QTR 4	TOTAL
FY 13/14	1,447				***1,447***
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***






LICENSES ISSUED
1,600
1,400
1,200
1,000
800
600
400
200
0
QTR 1
QTR 2
QTR 3
QTR 4
FY 09/10
FY 10/11
FY 11/12
FY 12/13
FY 13/14

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Fiscal Year - 2013/2014

Strategic Plan Goal 5: Organizational Effectiveness Objective 5.1: Licensing Applications to be Reviewed Within 45 Days					
	FY 13/14	**Q1**	**Q2**	**Q3**	**Q4**
Number of Weeks 45 Day Initial Review Goal Not Met	**1**	1			
Number of Weeks Per Quarter / Total Weeks	**13**	13			
Highest # of Days Initial Review Goal Exceeded	**N/A**	47			

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

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PHYSICIAN'S AND SURGEON'S APPLICATIONS RECEIVED AND LICENSES ISSUED

Fiscal Year - 2013/2014

2013 - 2014 -->	Applications Received (License & PTAL)					Percentage				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
US/CAN	894				894	53.57%				53.57%
IMG - License	267				267	16.00%				16.00%
IMG - PTAL	508				508	30.44%				30.44%
TOTAL	1,669	0	0	0	1,669	100.00%	0.00%	0.00%	0.00%	100.00%

2013 - 2014 -->	Licenses & PTAL Issued					Percentage				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
US/CAN	1,073				1,073	74.15%				74.15%
IMG - License	154				154	10.64%				10.64%
PTAL - License	220				220	15.20%				15.20%
TOTAL	1,447	0	0	0	1,447	100.00%	0.00%	0.00%	0.00%	100.00%
Total PTAL Issued	445				445					

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					

AGENDA ITEM 17

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	October 9, 2013
ATTENTION:	Medical Board of California
SUBJECT:	Outpatient Surgery Settings Task Force
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing

RECOMMENDED ACTION:

1) Authorize staff to hold an interested parties' meeting regarding proposed changes to statutes and regulations impacting accredited Outpatient Surgery Settings (OSS).

2) After the interested parties' meeting, authorize the OSS Task Force members to direct staff to draft proposed language to amend current Health and Safety Code statutes regarding OSSs to improve consumer protection.

3) After the interested parties meeting, authorize the OSS Task Force members to direct staff to draft proposed language to amend existing regulations and/or draft new regulations within the California Code of Regulations, Title 16, Division 13, to further clarify existing and/or new statutes pertaining to OSSs.

OUTPATIENT SURGERY SETTINGS – TASK FORCE MEMBERS:
Dev GnanaDev, M.D.
David Serrano Sewell, J.D.

OUTPATIENT SURGERY SETTINGS – TASK FORCE UPDATE:
The OSS Task Force members met with the following Board staff: Kimberly Kirchmeyer, Interim Executive Director; Curtis Worden, Chief of Licensing; and Kerrie Webb, Staff Counsel, on September 30, 2013. The purpose of the meeting was to review proposed changes to the Board's Web site and review current statutes and regulations to identify sections that could be amended to improve consumer protection.

The Task Force members reviewed staff's proposed changes to the Board's Web site regarding OSSs that are required to be accredited by a Board-approved Accreditation Agency. The Task Force members made some suggestions to provide further clarity on the first page of the OSS Web page. Staff is working on these recommendations.

The Task Force members reviewed Health and Safety Code (HSC) §1248.15 and identified some subsections that may need to be revised through a statute change and/or clarified through regulations. The Task Force members recommended deleting the least stringent method of qualifying for accreditation, since this method of qualification does not provide adequate consumer protection. This would also require an amendment to the subsection that references this method of qualification.

The Task Force reviewed HSC §1248.2 through §1248.3, and determined these statutes do not require amendments at this time.

The Task Force reviewed HSC §1248.35, and identified some subsections that may need to be revised through a statute change and/or clarified through regulations. The Task Force members are recommending unannounced inspections of the OSSs.

The Task Force reviewed HSC §1248.4 through §1248.5, and determined these statutes do not require amendments at this time.

The Task Force reviewed Business and Professions Code (BPC) §2216, and determined this statute does not require amendments at this time.

The Task Force reviewed California Code of Regulations, Title 16, Division 13, §1313.2 through §1313.3, and determined these sections do not require amendments at this time.

The Task Force reviewed California Code of Regulations, Title 16, Division 13, §1313.4, and determined that two of the subsections are no longer valid as a result of recent statute changes. This section needs to be amended accordingly.

The Task Force is also considering requiring the initial accreditation of an OSS to be for no more than two years. Currently, initial accreditation could be for up to three years. This would require a statute and/or regulatory change.

The Task Force identified that consumer protection may be enhanced if all accredited OSSs have mandatory peer review of procedures performed, regardless of how many practitioners are at an OSS and/or how many procedures are performed, including an OSS used by a single practitioner.

The Task Force plans to fully vet these proposed changes by holding an interested parties' meeting.

TO: Members
Medical Board of California

FROM: Glenn L. Mitchell, Jr., Executive Officer
Physician Assistant Board

DATE: October 8, 2013

SUBJECT: Regulatory Proposal - Title 16, California Code of Regulations, section 1399.541 Medical Services Performable

The Medical Board of California, rather than the Physician Assistant Board (PA Board), must adopt, amend, or repeal all regulations that affect the scope of practice of physician assistants.

Please see the attached proposed language to amend Title 16 of the California Code of Regulations section 1399.541 regarding the personal presence of the physician while the physician assistant acts as a first or second assistant in surgery. The purpose of this regulatory change is to update and clarify supervision requirements while the physician assistant acts as a first or second assistant in surgery.

In 2011, a concern was raised to the PA Board (then the PA Committee); it was determined that the regulation should be amended to reflect current medical standards with regard to this practice.

A proposed regulation was submitted to the Medical Board in May, 2012, for consideration. However, the Medical Board had concerns about the breadth of the regulation and asked the PA Committee to reconsider the language. After considering the Medical Board's concerns, PA Board staff started over and began to develop a different regulatory proposal.

In late July, 2013, PA Board staff shared the draft language with Medical Board staff and legal counsel to anticipate any concerns the members of the Medical Board may have. None were identified. At its August 26, 2013 meeting, the PA Board voted to approve the proposed regulatory language and submit the proposal to the Medical Board.

The PA Board respectfully requests that the Medical Board authorize staff to begin the formal rulemaking process to adopt the proposed language (attached).

On behalf of the PA Board, I wish to thank you for taking the time to consider this important matter.

Attachment: Proposed language

PHYSICIAN ASSISTANT BOARD
Proposed Regulatory Amendment
Title 16, C.C.R., § 1399.541

Strikeout indicates deletions; underline indicates additions to current text.

1. Amend heading of division 13.8 of title 16 as follows:

Division 13.8. Physician Assistant Board ~~Examining Committee of the Medical Board of California~~

2. Amend section 1399.541 of article 4 of division 13.8 as follows:

§ 1399.541. Medical Services Performable.

Because physician assistant practice is directed by a supervising physician, and a physician assistant acts as an agent for that physician, the orders given and tasks performed by a physician assistant shall be considered the same as if they had been given and performed by the supervising physician. Unless otherwise specified in these regulations or in the delegation or protocols, these orders may be initiated without the prior patient specific order of the supervising physician.

In any setting, including for example, any licensed health facility, out-patient settings, patients' residences, residential facilities, and hospices, as applicable, a physician assistant may, pursuant to a delegation and protocols where present:

(a) Take a patient history; perform a physical examination and make an assessment and diagnosis therefrom; initiate, review and revise treatment and therapy plans including plans for those services described in Section 1399.541(b) through Section 1399.541(i) inclusive; and record and present pertinent data in a manner meaningful to the physician.

(b) Order or transmit an order for x-ray, other studies, therapeutic diets, physical therapy, occupational therapy, respiratory therapy, and nursing services.

(c) Order, transmit an order for, perform, or assist in the performance of laboratory procedures, screening procedures and therapeutic procedures.

(d) Recognize and evaluate situations which call for immediate attention of a physician and institute, when necessary, treatment procedures essential for the life of the patient.

(e) Instruct and counsel patients regarding matters pertaining to their physical and mental health. Counseling may include topics such as medications, diets, social habits, family planning, normal growth and development, aging, and understanding of and long-term management of their diseases.

(f) Initiate arrangements for admissions, complete forms and charts pertinent to the patient's medical record, and provide services to patients requiring continuing care, including patients at home.

(g) Initiate and facilitate the referral of patients to the appropriate health facilities, agencies, and resources of the community.

(h) Administer or provide medication to a patient, or issue or transmit drug orders orally or in writing in accordance with the provisions of subdivisions (a)-(f), inclusive, of Section 3502.1 of the Code.

(i)(1) Perform surgical procedures without the personal presence of the supervising physician which are customarily performed under local anesthesia. Prior to delegating any such surgical procedures, the supervising physician shall review documentation which indicates that the physician assistant is trained to perform the surgical procedures. All other surgical procedures requiring other forms of anesthesia may be performed by a physician assistant only in the personal presence of an approved supervising physician.

(2) A physician assistant may also act as first or second assistant in surgery under the supervision of a~~n approved~~ supervising physician. The physician assistant may so act without the personal presence of the supervising physician if the supervising physician is immediately available to the physician assistant. “Immediately available” means able to return to the patient, without delay, upon the request of the physician assistant or to address any situation requiring the supervising physician’s services.

Note: Authority cited: Sections 2018, 3502 and 3510, Business and Professions Code. Reference: Sections 2058, 3502 and 3502.1, Business and Professions Code.

TITLE 16. Medical Board of California

NOTICE IS HEREBY GIVEN that the Medical Board of California (hereinafter referred to as the "Board") is proposing to take the action described in the Informative Digest. Any person interested may present statements or arguments orally or in writing relevant to the action proposed at a hearing to be held at The Mission Inn, 3649 Mission Inn Avenue, Riverside, CA 92501 at 9:00 a.m., on October 25, 2013. Written comments, including those sent by mail, facsimile, or e-mail to the addresses listed under Contact Person in this Notice, must be received by the Board at its office not later than 5:00 p.m. on October 22, 2013, or must be received at the hearing. The Board, upon its own motion or at the instance of any interested party, may thereafter adopt the proposals substantially as described below or may modify such proposals if such modifications are sufficiently related to the original text. With the exception of technical or grammatical changes, the full text of any modified proposal will be available for 15 days prior to its adoption from the person designated in this Notice as contact person and will be mailed to those persons who submit written or oral testimony related to this proposal or who have requested notification of any changes to the proposal.

Authority and Reference: Pursuant to the authority vested by section 2018 of the Business and Professions Code, and to implement, interpret or make specific sections 315, 315.2, and 315.4 of said Code, the Medical Board of California is considering changes to Division 13 of Title 16 of the California Code of Regulations as follows:

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

A. Informative Digest

A proposal to implement SB 1441 was heard on July 19, 2013, at the Board's quarterly meeting held in Sacramento, CA. The Board granted the proposal to amend section 1361 in Article 4, Chapter 2, Division 13 and add section 1361.5 entitled "Uniform Standards for Substance-Abusing Licensees."

The Board currently regulates approximately 125,000 physicians and surgeons. The Board's highest priority is the protection of the public when exercising its licensing, regulatory, and disciplinary functions. The primary methods by which the Board achieves this goal are: issuing licenses to eligible applicants; investigating complaints against licensees; disciplining licensees for violations of the Medical Practice Act (Act); and monitoring licensees whose licenses have been placed on probation for substance abuse, focusing on the areas of intake and how licensees are monitored as they come into probation and compliance.

Existing law requires the Department of Consumer Affairs (DCA) to establish Uniform Standards regarding substance-abusing licenses, focusing on the areas of intake and how licensees are monitored as they come into probation and compliance.

Existing law, Business and Professions Code (Code) section 2018 authorizes the Board to adopt, amend, or repeal such rules and regulations as may be reasonably necessary to enable the Board to carry into effect the provisions of the Medical Practice Act.

Existing law, Code section 315, established the Substance Abuse Coordination Committee (SACC) within the DCA and required the SACC to formulate uniform and specific standards in sixteen specified areas for each healing arts board to use in dealing with substance-abusing licensees, whether or not a board chooses to have a formal diversion program.

Existing law, Code section 315.2, specifies that a healing arts board within the DCA is required to order a licensee to cease practice if the licensee tests positive for any substance that is prohibited under the terms of the licensee's probation or diversion program. The cease-practice order pursuant to this section does not constitute disciplinary action and is not subject to adjudicative hearings.

Existing law, Code section 315.4, authorizes healing arts boards within the Department to order a licensee on probation or in a diversion program to cease practice for major violations and when the board orders a licensee to undergo a clinical diagnostic evaluation pursuant to the uniform and specific standards adopted and authorized under section 315. The cease-practice order pursuant to this section does not constitute disciplinary action and is not subject to adjudicative hearings.

Existing law, Government Code section 11400.20, authorizes an agency to adopt regulations to govern an adjudicative proceeding.

The main purpose for this proposal is to amend section 1361 and add section 1361.5 of Title 16 of the California Code of Regulations. The proposed language is necessary to aid the Board in the discipline of substance-abusing licensees to provide better public protection to the people of California.

B. Policy Statement Overview/Anticipated Benefits of Proposal

This regulation will incorporate the Uniform Standards for Substance Abusing Healing Arts Licensees, as required by SB 1441 by proposing to add the standards, which shall be adhered to in all cases in which a licensee is placed on probation due, in part, to a substance abuse problem. These standards shall be followed in all instances, but will also allow the Board to impose more restrictive conditions, if necessary, to protect the public.

C. Consistency and Compatibility with Existing State Regulations

The Board considered other possible related regulations and we find that these are the only regulations dealing in this subject area. Therefore, the Board finds that these proposed regulations are compatible and consistent with the intent of the Legislature in implementing SB 1441, as well as with existing State

regulations.

FISCAL IMPACT ESTIMATES

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

Nondiscretionary Costs/Savings to Local Agencies: None

Local Mandate: None

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

Business Impact:

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

Cost Impact on Representative Private Person or Business:

Implementation of the proposed regulation will not impact all physicians licensed by the Board, nor will it impact all physicians on probation. Instead, this regulation would impact only those physicians on probation who are identified as "substance abusing" and subject to the Uniform Standards for Substance-Abusing Licensees. Once so designated, this subset of licensees on probation could be impacted by a temporary removal from practice based on either a positive biological fluid test and/or the requirement to undergo the clinical diagnostic evaluation. Under the proposed regulation, no licensee shall be returned to practice until he or she has at least 30 days of negative biological fluid tests.

The Board has access to a report issued by Merritt Hawkins, "*2012 Review of Physician Recruiting Incentives*." This report provides an overview of the salaries, bonuses, and other incentives customarily used to recruit physicians. This data is national; there is no commensurate report focusing only on California. Section 8 of the report offers a breakdown of the "low," "average," and "high" base salary for the income offered to the "Top 20 Recruited Specialties." The average is $27,250 per physician.

The Board also anticipates that this proposed regulation could create an additional fiscal impact to licensees on probation who test positive for a banned substance in that another clinical diagnostic evaluation can be ordered to ensure the licensee is considered "safe to practice".

The cost of the "clinical diagnostic evaluation" is estimated to be approximately $2,000-5,000 per evaluation.

Therefore, the Board estimates that the annual cost will be $29,250 to $32,250 per impacted licensee, times the two (2) physicians (the average of those that tested positive in the last five years) not allowed to practice for 30 days, for an annual total of $58,500 to $64,500.

This proposed regulation will enhance and strengthen the Board's ability to closely monitor physicians with substance-abuse issues and quickly remove them from practice when appropriate. The Board's mission and mandate is to provide protection for the public and the proposed regulation supports this mandate. Removing physicians from practice who have been found to be a danger to the public will enhance consumer protection.

Effect on Housing Costs: None

EFFECT ON SMALL BUSINESS

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

RESULTS OF ECONOMIC IMPACT ASSESSMENT/ANALYSIS:

Impact on Jobs/Businesses:

The Board has determined that this regulatory proposal will not have a significant adverse economic impact on the creation of jobs or new businesses or the elimination of jobs or existing businesses or the expansion of businesses in the State of California.

Benefits of the Regulation:

The Board has determined that this proposed regulation will benefit California consumers by enhancing and strengthening the Board's ability to closely monitor physicians with substance-abuse issues and quickly remove them from practice, when appropriate, thus providing the consumer with enhanced protection from physicians with substance abuse problems.

CONSIDERATION OF ALTERNATIVES

The Board must determine that no reasonable alternative has been identified and brought to its attention that would be more effective in carrying out the purpose for which the action is proposed, would be as effective and less burdensome to affected private persons than the proposal described in this Notice, or would be more cost-effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

Any interested person may present statements or arguments orally or in writing relevant to the above determinations at the above-mentioned hearing.

INITIAL STATEMENT OF REASONS AND INFORMATION

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

TEXT OF PROPOSAL

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

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

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

You may obtain a copy of the final statement of reasons once it has been prepared, by making a written request to the contact person named below or by accessing the Web site below.

CONTACT PERSON

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

Name:	Susan Cady Medical Board of California
Address:	2005 Evergreen Street, Suite 1200 Sacramento, CA 95815
Telephone No.:	(916) 263-2644
Fax No.:	(916) 263-2387
E-Mail Address:	regulations@mbc.ca.gov

The backup contact person is:

Name:	Christine Valine Medical Board of California
Address:	2005 Evergreen Street, Suite 1200 Sacramento, CA 95815
Telephone No.:	(916) 263-2466
Fax No.:	(916) 263-2387
E-Mail Address:	chris.valine@mbc.ca.gov

Web site Access: Materials regarding this proposal can be found at http://www.mbc.ca.gov/laws/regulations_proposed.html.

MEDICAL BOARD OF CALIFORNIA

INITIAL STATEMENT OF REASONS

Hearing Date:

Subject Matter of Proposed Regulations:
To amend the *Manual of Model Disciplinary Orders and Disciplinary Guidelines* to incorporate the Uniform Standards for Substance-Abusing Healing Arts Licensees as required by SB 1441.

Section(s) Affected:
Amend Section 1361 in Article 4 of Chapter 2, Division 13 and add Section 1361.5 entitled "Uniform Standards for Substance-Abusing Licensees"

Specific purpose of each adoption, amendment, or repeal:
In September 2008, SB 1441 was signed into law. The Legislature declared that substance abuse monitoring programs, particularly for health care professionals, must operate with the highest level of integrity and consistency. Patient protection is paramount. The legislation, in part, mandated that the Department of Consumer Affairs (Department) establish a Substance Abuse Coordination Committee (Committee), subject to the Bagley-Keene Open Meeting Act, comprised of the Executive Officers of the Department's healing arts boards, a representative of the California Department of Alcohol and Drug Programs, and chaired by the Director of the Department. The Committee was charged with developing consistent and uniform standards and best practices in sixteen specific areas for use in dealing with substance abusing licensees, whether or not a Board chooses to have a formal diversion program. The Committee developed sixteen uniform standards as required by SB 1441. The Board is proposing to implement Uniform Standards 1-12 in its Disciplinary Guidelines through the regulatory process. Uniform Standards 13, 14, and 15 only apply to Boards with diversion programs and are not incorporated in these guidelines because the Board does not have a diversion program. Uniform Standard 16 is also omitted because it is each Board's reporting criteria to the Department and not pertinent to the Disciplinary Guidelines.

Factual Basis/Rationale:
In order to comply with SB 1441, the Board proposes to add the following standards, which shall be adhered to in every case where a licensee is placed on probation due, in part, to a substance abuse problem. These standards are not guidelines and shall be followed in all instances, except that the Board may impose more restrictive conditions, if necessary, to protect the public.

Standard 1. Notice of Employment Information

Requires a licensee who has an employer to provide the Board with the names, physical addresses, mailing addresses and phone numbers of all employers and supervisors. This standard also requires that the licensee provide written consent to allow Board staff to

communicate with the employer about the licensee's work status, performance and monitoring.

The purpose of this standard is to allow the Board and employers to stay in contact in order to ensure that the licensee is complying with his or her probation. It is widely known that it is best for a person entering recovery to be honest with their employer about their addiction and the steps they are taking to overcome it. Open channels of communication will give the Board the ability to quickly intervene and take the necessary action in order to keep the licensee on track and protect patients, especially if the licensee is using illegal substances or alcohol on the job.

Standard 2. Clinical Diagnostic Evaluation and Reports

Requires that if a licensee is ordered to undergo a clinical diagnostic evaluation, the evaluation must be conducted by a licensed practitioner who holds a valid, unrestricted license to conduct clinical diagnostic evaluations, has three (3) years of experience in providing evaluations of health care professionals with substance abuse disorders and is approved by the Board. This standard also identifies the information that must be addressed or contained in the evaluation report and timeframes for submitting the report to the Board.

The purpose of this standard is to increase consumer protection by: 1) specifying requirements for a clinical diagnostic evaluation of the licensee and the required qualifications for the providers charged with evaluating the licensee along with timeframes for completing the clinical diagnostic evaluation; 2) ensuring that the Board is notified quickly if the licensee is a threat to himself or herself or the public; 3) ensuring the Board is provided with a professional opinion as to whether the licensee has a substance abuse problem, and whether the licensee is a threat to himself or herself or others; and 4) prohibiting personal, financial and business relationships between the evaluator and licensee, thereby ensuring objectivity in assessments.

Because of the complexity of an addictive disease, professional substance abuse evaluations are needed to assist the Board in making informed decisions regarding a licensee's ability to practice safely. Many individuals who have substance abuse issues also have other mental problems/diagnoses. The evaluator can present recommendations for a therapeutic treatment plan. The treatment recommendations may be incorporated into a Board order as elements for monitoring. By specifying that the Board be provided with expert recommendations for treatment and practice restrictions, the standard also ensures that licensees who have undergone treatment and have made steps towards recovery can safely return to practice.

Standard 3. Worksite Monitor Requirements and Responsibilities

Requires the Board to determine if a worksite monitor is necessary for a particular licensee and outlines the requirements the proposed monitor must meet in order to be approved by the Board to serve as a monitor. In addition, this standard outlines the duties and responsibilities a worksite monitor must perform.

SB 1441 required the Department to establish monitor requirements and standards, including, but not limited to: (1) required qualifications of monitors, (2) required methods of monitoring by monitors, and (3) required reporting by monitors. The worksite monitor's role is to have face-to-face contact with a licensee who has a substance abuse history to ensure that the licensee is not abusing drugs and/or alcohol. The monitor is also responsible for reporting to the Board whether patient safety may be at risk and any change in the licensee's behavior that may be cause for suspected substance abuse.

The licensee and the worksite monitor must sign and submit consent forms in order for the Board to communicate with the monitor regarding the licensee's performance while at work. Implementing this standard provides (1) ongoing documentation of the licensee's behavior and would ensure the public's safety, and (2) immediate notification to the Board if a licensee is suspected of working under the influence of drugs and/or alcohol.

The monitor should not have any financial or personal relationship with the licensee. This will ensure that the monitor is providing impartial evaluations. The standard does contain a provision to allow the Board to waive this requirement as some licensees may only have an employer available to serve as a worksite monitor. Frequent face-to-face contact with the licensee is important in order to assess any changes in appearance and behavior which may suggest substance abuse or impairment. The monitor needs to interview the staff in the office to detect any changes in the licensee's behavior and review the attendance records in order to provide adequate reports to the Board on the licensee's performance in the work environment. Most importantly, this standard identifies the timeline for reporting to the Board any possible substance abuse by the licensee and details what information must be included in the monitor's report.

Standard 4. Group Support Meetings

Requires that if the Board orders a licensee to participate in group support meetings, the criteria established in the uniform standards must be used to determine the frequency of group meeting attendance and to verify that the meeting facilitators are experienced, mental health professionals.

The purpose of this standard is to increase consumer protection by:

- Holding licensees placed on probation due to substance abuse accountable for attending meetings and being active in their own recovery;
- Allowing the group meeting facilitator and the Board to work together to assist in the licensee's recovery and quickly prevent relapse with open channels of communication; and
- Ensuring that licensees are receiving professional help from a person not related to them in any way that will allow for objectivity and balance during their recovery.

Standard 5. Biological Fluid Testing

Requires the Board to randomly test a licensee whose license is placed on probation due to substance abuse and establishes guidelines for the testing frequency. This standard

also outlines standards for testing, specimen collection and handling and requirements for the laboratories who perform the handling and processing of test results.

Randomness is a very important component in drug testing. The testing frequency schedule being proposed by the Board allows for appropriate randomness in testing (without regular interval or pattern), preventing licensees from gauging when they will be tested. By establishing minimum testing frequency "ranges" and employing randomness in testing, licensees will not be able to consider one or more days as a "safety period" following the submission of a biological sample for testing. Requiring a licensee to submit a specimen on the same day as directed will eliminate the ability of a licensee to "flush" their system overnight. The standard is broad enough to allow the Board to evaluate each licensee's situation on a case-by-case basis, if appropriate. For example, one of the exemptions allows the Board to adjust the testing frequency schedule in cases where a licensee who is an admitted recovered substance abuser or addict, has already participated in a rehabilitation program before being placed on probation. In cases where there is evidence that the person has randomly tested and has maintained sobriety, some flexibility should be granted to the Board in determining the duration of high frequency testing, that is equivalent to the proposed testing schedule. Allowing exceptions will not only protect the public and fit each licensee's needs, but it will ensure successful rehabilitation of the licensee by providing a plan that is manageable and realistic.

Standard 6. Results of Biological Fluid Tests

Requires the Board to suspend the licensee if he or she tests positive for a banned substance and notify the licensee's employers that he or she cannot provide medical services while the suspension or cease practice order is in place .

Protection of the public is the highest priority of the Board in exercising its licensing, regulatory and disciplinary functions. In order to carry out this mandate, it is appropriate for the Board to immediately suspend a licensee's license if he or she tests positive for a banned substance until he or she has been assessed and the results interpreted. It is also appropriate for the Board to notify the licensee's employer that the licensee may not practice until the suspension is lifted. Testing positive for a banned substance is a violation of their probation and in the past, many licensees have continued to work until the Board could pursue disciplinary action based on the probation violation.

Standard 7. Actions by Licensees and Consequences Thereof

In compliance with SB 1441, major and minor violations and consequences are being defined. If a licensee commits a major violation, the Board could issue an immediate cease practice order and refer the matter for disciplinary action or other action as determined by the Board. If a licensee commits a minor violation, the Board would be required to determine what action is appropriate based on the violation.

Protection of the public is the highest priority of the Board in exercising its licensing, regulatory and disciplinary functions. The Board protects the public through its Practice Act, regulations and related statutes. Major violations would result in consequences that would be the maximum allowed by law under the Board's Practice Act and regulations.

Minor violations would result in consequences determined appropriate by the Board, e.g., issuing a cease practice order or issuing a citation, which is not considered discipline.

Standard 8. Request to Return to Full or Partial Practice

In compliance with SB 1441, this standard defines the criteria that a licensee must meet in order to return to practice after practice restrictions were deemed appropriate by the evaluator performing a clinical diagnostic evaluation or following the issuance of a cease practice order.

This standard would increase consumer protection because it requires the licensee to be completely compliant with the conditions in their recovery program and/or probation before the Board will even consider this type of request. All licensees will be held to the same standard.

Underlying Data:

1. Senate Bill 1441 (Chapter 548, Statutes of 2008) authored by Senator Ridley-Thomas
2. The Substance Abuse Coordination Committee's "Uniform Standards Regarding Substance-Abusing Healing Arts Licensees, April 2011"
3. Uniform Standard #4 Subcommittee – Proposed Amendments and Rationale, March 10, 2011
4. Merritt Hawkins "2012 Review of Physician Recruiting Incentives"

Business Impact/Specific Technologies or Equipment:

This regulation will not have a significant adverse economic impact on businesses, specific technologies, or equipment. This regulation only impacts licensees disciplined by the Medical Board. This regulation does not mandate the use of specific technologies or equipment.

Economic Impact Assessment:

This regulation will not have a significant adverse economic impact on businesses. This initial determination is based on the fact that the regulation will only impact physicians who have been placed on probation who are ordered to cease practice for testing positive for drugs and/or alcohol use.

This regulatory proposal benefits the health and welfare of California residents because it will provide better protection to California residents because it requires the licensee to be completely compliant with the conditions in their recovery program and/or probation or the Board can issue a cease practice order.

Specific Technologies or Equiment:

This regulation does not mandate the use of specific technologies or equipment.

Consideration of Alternatives:
No reasonable alternative to the regulation would be either more effective in carrying out the purpose for which the action is proposed, or would be as effective and less burdensome to affected private persons than the proposed regulation.

TITLE 16. MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

PROPOSED LANGUAGE

(1) Amend title of Article 4, Division 13 of Title 16 of the California Code of Regulations to read as follows:

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

(2) Section 1361 of Division 13 of Title 16 of the California Code of Regulations is amended to read:

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 Procedure Act (Government Code Section 11400 et seq.), the Medical Board of California shall consider the disciplinary guidelines entitled "Manual of Model Disciplinary Orders and Disciplinary Guidelines" (11th Edition/2011), which are hereby incorporated by reference. Deviation from these orders and guidelines, including the standard terms of probation, is appropriate where the ~~Medica~~l Board ~~of California~~ in its sole discretion determines by adoption of a proposed decision or stipulation that the facts of the particular case warrant such 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.

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

(3) Section 1361.5 is added to Division 13 of 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.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	October 7, 2013
ATTENTION:	Board Members
SUBJECT:	Implementation of SB 1441 Uniform Standards Regarding Substance-Abusing Healing Arts Licensees
FROM:	Susan Cady, Staff Services Manager II Kerrie Webb, Staff Counsel

REQUESTED ACTION:

After review and consideration of the attached proposed language providing for the implementation of SB 1441 Uniform Standards Regarding Substance-Abusing Healing Arts Licensees, approve the language and recommend that Board staff do a 15-day public notice on the new language. If no negative comments are received, authorize the Executive Director to finalize the rulemaking package and submit it to the Office of Administrative Law.

BACKGROUND:

At the July 2013 Board meeting, staff introduced proposed language providing for the implementation of SB 1441 Uniform Standards Regarding Substance-Abusing Healing Arts Licensees. Public comment was offered at that meeting pointing out that some provisions of the Uniforms Standards were not included in the proposed language. The Board authorized staff to proceed with instituting the formal rulemaking process, acknowledging that staff would re-review the standards, and the proposed language would be amended where appropriate.

Attached is the amended proposed language with the newly incorporated changes identified by **bold double underline**. New deletions are identified by ~~double strikethrough~~.

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

Modified Text

Changes to the originally proposed language are identified by **bold double underline** for new text and ~~double strikethrough~~ for deleted text.

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 **U**niform **S**tandards for **S**ubstance-**A**busing **L**icensees 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~~ **undergo random biological fluid testing** 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. **No licensee shall be returned to practice until he or she has at least 30 days of negative biological fluid tests.**

(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~~ **undergo random biological fluid testing** 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 **does not** suffer~~s~~ 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~~ **Biological fluid** testing may be required on any day, including weekends and holidays. **Prior to vacation or absence, alternative biological fluid testing location(s) must be approved by the Board.**

(iii) The scheduling of **biological fluid** 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 **biological fluid** testing is required. **Licensees shall be ~~drug~~ tested on the date of notification as directed by the Board.**

(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 **shall** ~~may elect to have the tests performed by an entity under~~ contract with **a laboratory or service approved in advance by** the Board ~~or by another entity~~, provided that the **laboratory or service** ~~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) **business** days of receipt of the specimen. **The 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.**

(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**, if any, and workplace monitor, if any,** 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 **fluid** 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~~ **biological fluid** 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~~ **biological fluid** screening reports for at least six (6) months, two (2) positive worksite monitor reports, and complete compliance with other terms and conditions of probation.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: October 7, 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:
The first meeting of the Task Force was held on September 23, 2013 in Sacramento. The meeting was attended by prescribers (physicians, osteopathic physicians, etc.) and dispensers (pharmacists), as well as representatives from the Attorney General's Office, Drug Enforcement Administration, consumer groups, US Department of Justice, California Medical Association, California Pharmacy Association, California Society of Health System Pharmacists, California Society of Addiction Medicine, California Society of Anesthesiology, California Pharmacy Lawyers, Department of Health Care Services, Costco, Purdue, Walgreens, California Retailers Association, Assembly Business and Professions Committee, Office of Senate Research, Department of Justice CURES Program, Los Angeles County District Attorney's Office, other regulatory boards (Board of Pharmacy, Board of Optometry, Registered Nursing Board, Physician Assistant Board, Osteopathic Medical Board, and Dental Board), and other interested parties. The meeting had approximately 80 participants, including staff.

The issues discussed at this meeting were specific to identifying appropriate patient information that can be shared/discussed between the prescriber and the pharmacist. Michael Bishop, M.D. and Barbara Yaroslavsky chaired the meeting, in coordination with Stan Weisser from the Board of Pharmacy. The meeting started with a PowerPoint presentation by Laura Sweet depicting how pain management has evolved over the last 50 years. Ms. Sweet also outlined the physician's responsibilities in prescribing by reviewing the Board's Pain Management Guidelines. The attendees also heard a presentation from Joshua Room, Deputy Attorney General, regarding a Board of Pharmacy precedential decision that was recently adopted. This precedential decision focused on a pharmacist's corresponding responsibility in assuring appropriate prescribing.

The attendees broke into groups and were tasked with identifying patient information that could be appropriately shared between the prescriber and the dispenser. In obtaining the prescribers and dispensers perspectives, some of the groups were asked to "exchange hats" and to provide their responses as if they were a member of the opposite profession. Although complete consensus was not obtained on all items, the group did agree on several items that should be shared, including diagnosis, information regarding the patient's treatment plan, validation of the information on the prescription, reasons for unusual prescribing, and the pain management contract.

The groups were also requested to identify problems and solutions for improvement in the communication between prescribers and dispensers. Several problems and solutions were identified, which can be categorized into three main topics:

- Education to the prescribers and dispensers regarding:
  - Prescribers' and dispensers' roles and responsibilities in order to obtain mutual respect of each other's roles
  - HIPAA
  - Red Flags

- Education to consumers
- An enhanced, fully functioning CURES system

Based upon the voluminous information obtained during this first meeting, the Prescribing Task Force will be meeting with the other regulatory Boards to develop a document that can provide guidance to the prescribers and dispensers regarding information that can be shared and other educational tips. Once this document is completed it can be placed into the Board's Newsletter and on the Board's Web site.

The next meeting of the Task Force will be focused on best practices for prescribing, including a review of the Board's Pain Management Guidelines. The Board has asked, and will continue to request, input from the experts in the field prior to the next meeting on what the top five issues that should be addressed in order to alleviate the overprescribing epidemic and solutions that may mitigate the overprescribing epidemic. Several meetings may be required in order to obtain information and identify potential edits to the Guidelines. The Task Force plans to convene another meeting between November and February to begin this process of identifying best practices.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: October 7, 2013
ATTENTION: Medical Board of California (Board)
SUBJECT: Midwifery Advisory Council (MAC) Vacancies
STAFF CONTACT: Curtis J. Worden, Chief of Licensing

STAFF RECOMMENDATION:
Staff recommends that the Board accept this request to appoint California licensed midwife, Tosi Marceline to a three-year term with the MAC.

EXECUTIVE SUMMARY:
Business and Professions Code Section 2509 states the Board shall create and appoint a Midwifery Advisory Council consisting of licensees of the Board in good standing, who need not be members of the Board, and members of the public who have an interest in midwifery practice, including, but not limited to, home births. At least one-half of the MAC members shall be California licensed midwives.

On June 19, 2013, a MAC Member Interest Form was mailed to all California licensed midwives and individuals on the interested parties mailing list. An application was also posted on the Board's Web site. Seven applications for the California licensed midwife position were received. At the August 8, 2013, MAC meeting, applicants were given the opportunity to address the MAC. Of the applicants, Tosi Marceline was the only applicant to make a statement.

California licensed midwife, Tosi Marceline is a homebirth midwife practicing in Yolo, Solano, and Sacramento counties. She began attending births in 1975, assisting teenagers with hospital birth support. She attended, and then taught at the Holistic Childbirth Institute in San Francisco in the late 70's and early 80's, while also holding a public school teaching job in a teen parent program. She taught childbirth classes in English and Spanish and trained labor support volunteers for the Davis Community Clinic for 15 years. She began her apprenticeship in midwifery in 1981 and assumed primary partnership in 1984. She has worked with the California Association of Midwives (CAM) Certification Committee, the CAM Legislative Committee, and the MAC helping to pass and implement California's Midwifery Practice Act and related midwifery legislation.

The MAC members voted to recommend Tosi Marceline, L.M., for appointment to the full Board.

MEDICAL BOARD OF CALIFORNIA

FULL BOARD MEETING

OCT 24-25, 2013

LEGISLATIVE PACKET

2013 LEGISLATION

MEDICAL BOARD OF CALIFORNIA - 2013 TRACKER LIST
October 17, 2013

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 154	Atkins	Healing Arts: Reproductive Health Care	Chaptered, #662	Neutral	6/24/13
AB 186	Maienschein	Professions & Vocations: Military Spouses: Temporary Licenses	Sen. B&P	Support - 2-year Bill	6/24/13
AB 496	Gordon	Task Force: LGBT Cultural Competency	Inactive File	Support – 2-year Bill	6/25/13
AB 512	Rendon	Sponsored Health Care Events: Sunset Extension	Chaptered, #111	Support	Intro.
AB 565	Salas	California Physician Corps Program	Chaptered, #378	Support	9/3/13
AB 589	Fox	Underrepresented Medical Specialties	Asm. Health	2-year Bill	Intro.
AB 635	Ammiano	Drug Overdose Treatment: Liability	Chaptered, #707	Support	8/22/13
AB 809	Logue	Healing Arts: Telehealth	Sen. Health	Support – 2-year Bill	6/25/13
AB 831	Bloom	Drug Overdoses	Held in Approps.	Support –2-year Bill	4/3/13
AB 860	Perea	Medical School Scholarships	Held in Approps.	Support –2-year Bill	4/8/13
AB 916	Eggman	Healing Arts: False or Misleading Advertising	Sen. B&P	Support – 2-year Bill	Intro.
AB 1000	Wieckowski	Physical Therapists: Direct Access to Services	Chaptered, #620	Neutral	9/6/13
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 –2-year Bill	4/23/13
AB 1182	Brown	Medically Underserved Areas	Assembly	SPOT	Intro.
AB 1269	Gray	Medicine: Special Faculty Permit	Asm. B&P	SPOT	Intro.

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

MEDICAL BOARD OF CALIFORNIA - 2013 TRACKER LIST
October 17, 2013

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 1278	Hueso	Integrative Cancer Treatment	Now SB 117		SB 117
AB 1288	Perez, V.	Medical Board of California: Licensing Application	Chaptered, #307	Neutral	6/6/13
AB 1308	Bonilla	Midwifery	Chaptered, #665	Support if Amended	9/6/13
ACR 40	Perez	Donate Life California Day	Chaptered, #19	Support	4/8/13
SB 20	Hernandez	Health Care: Workforce Training	Held in Approps.	Support – 2-year Bill	2/14/13
SB 21	Roth	UC Riverside Medical School: Funding	Chaptered, #203	Support	8/5/13
SB 62	Lieu	Coroners: Reporting Requirements: Prescription Drug Use	Vetoed	Support	9/3/13
SB 117	Hueso	Integrative Cancer Treatment	Sen. B&P	Neutral – 2-year Bill	4/30/13
SB 304	Lieu	Healing Arts: Sunset Bill	Chaptered, #515	Support if Amended	9/6/13
SB 305	Lieu	Healing Arts: Boards	Chaptered, #516	Support	9/6/13
SB 352	Pavley	Medical Assistants: Supervision	Chaptered, #286	Support	6/19/13
SB 410	Yee	Anesthesiologist Assistants	Senate	2-year Bill	4/30/13
SB 439	Steinberg	Medical Marijuana	Asm. Health	2-year Bill	8/5/13
SB 491	Hernandez	Nurse Practitioners	Held in Approps.	Oppose – 2-year Bill	8/14/13
SB 492	Hernandez	Optometrist Practice: Licensure	Asm. B&P	OUA – 2-year Bill	8/5/13
SB 493	Hernandez	Pharmacy Practice	Chaptered, #469	Support	9/6/13

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

MEDICAL BOARD OF CALIFORNIA - 2013 TRACKER LIST
October 17, 2013

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
SB 670	Steinberg	Physicians and Surgeons: Drug Prescribing Privileges	Chaptered, #399	Support	9/11/13
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	Chaptered, #400	Support if Amended	9/3/13
SCR 8	DeSaulnier	Prescription Drug Abuse Awareness Month	Chaptered, #26	Support	4/18/13

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

ABA154

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 154
Author:	Atkins
Chapter:	662
Bill Date:	June 24, 2013, Amended
Subject:	Reproductive Health Care
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

DESCRIPTION OF CURRENT LEGISLATION:

This bill eliminates the distinction in existing law between "surgical" and "nonsurgical" abortions and allows 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 requires NPs and CNMs to adhere to standardized procedures, and for PAs to comply with protocols, that include specific information in order to perform abortion by aspiration techniques. This bill specifies 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 codifies 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 requires 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 requires NPs and CNMs to adhere to standardized procedures and for PAs to comply with protocols, that include the following information, in order to perform 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 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 were classified as major complications.
- The most common type of minor abortion-related complications 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; Asian Communities for Reproductive Justice; Bay Area Communities for Health Education; Board of Registered Nursing; Business and Professional Women of Nevada County; California Academy of Physician Assistants; California Association for Nurse Practitioners; California Church IMPACT; California Family Health Council; California Medical Association; California National Organization for Women; California Nurse-Midwives Association; California Women's Health Alliance; California Women's Law Center; Cardea Institute; Center on Reproductive Rights and Justice at UC Berkeley School of Law; Choice USA; Citizens for Choice; 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 Association of Social Workers, California Chapter; 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 Advocacy Project of Los Angeles County; 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; SEIU; Six Rivers Planned Parenthood; Students for Reproductive Justice at Stanford University; Women's Community Clinic; and Women's Health Specialists of California

OPPOSITION: California Catholic Conference; Capitol Resource Family Impact; 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; Life Legal Defense Fund; Pro-Life Mission: International; San Jose State Students

for Life; Traditional Values Coalition; and University of Southern California Students for Life

IMPLEMENTATION:

- Newsletter Article
- Notify/Train Board Staff

Assembly Bill No. 154

CHAPTER 662

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.

[Approved by Governor October 9, 2013. Filed with Secretary of State October 9, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

AB 154, 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 functions necessary for a nonsurgical abortion. Under existing law, nonsurgical abortion includes termination of pregnancy through the use of pharmacological agents.

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

This bill would instead make it a public offense, punishable by a fine not exceeding $10,000 or imprisonment, or both, for a person to perform an abortion if the person does not have a valid license to practice as a physician and surgeon, except that it would not be a public offense for a person to perform an abortion by medication or aspiration techniques in the first trimester of pregnancy if he or she holds a license or certificate authorizing him or her to perform the functions necessary for an abortion by medication or aspiration techniques. The bill would also require a nurse practitioner, certified nurse-midwife, or physician assistant to complete training, as specified, and to comply with standardized procedures or protocols, as specified, in order to perform an abortion by aspiration techniques, and

Health Workforce Pilot Project (HWPP) No. 171 through the Office of Statewide Health Planning and Development shall be used.

(b) In order to perform an abortion by aspiration techniques pursuant to Section 2253, a person with a license or certificate to practice as a nurse practitioner or a certified nurse-midwife shall adhere to standardized procedures developed in compliance with subdivision (c) of Section 2725 that specify all of the following:

(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 are available.

(5) The method of periodic review of the provisions of the standardized procedures.

(c) A nurse practitioner or certified nurse-midwife who has completed training and achieved clinical competency through HWPP No. 171 shall be authorized to perform abortions by aspiration techniques pursuant to Section 2253, in adherence to standardized procedures described in subdivision (b).

(d) It is unprofessional conduct for any nurse practitioner or certified nurse-midwife to perform an abortion by aspiration techniques pursuant to Section 2253 without prior completion of training and validation of clinical competency.

SEC. 3. Section 3502.4 is added to the Business and Professions Code, to read:

3502.4. (a) In order to receive authority from his or her supervising physician and surgeon to perform an abortion by aspiration techniques pursuant to Section 2253, a physician assistant shall complete training either through training programs approved by the board pursuant to Section 3513 or by training to perform medical services which augment his or her current areas of competency pursuant to Section 1399.543 of Title 16 of the California Code of Regulations. Beginning January 1, 2014, and until January 1, 2016, the training and clinical competency protocols established by Health Workforce Pilot Project (HWPP) No. 171 through the Office of Statewide Health Planning and Development shall be used as training and clinical competency guidelines to meet this requirement.

(b) In order to receive authority from his or her supervising physician and surgeon to perform an abortion by aspiration techniques pursuant to Section 2253, a physician assistant 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.

AB512

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 512
Author: Rendon
Chapter: 111
Bill Date: February 20, 2013, Introduced
Subject: Sponsored Health Care Events: Sunset Extension
Sponsor: Los Angeles County Board of Supervisors
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill extends 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) allowed health care practitioners, including physicians, who are not licensed to practice in California, but who 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 enables 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 helps 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 State Board of Pharmacy
Medical Board of California

OPPOSITION: California Nurses Association
American Nurses Association of California

IMPLEMENTATION:

- Newsletter Article
- Notify Board staff of sunset extension
- Continue to process requests for authorizations from physicians licensed in other states until 2018.

Assembly Bill No. 512

CHAPTER 111

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

[Approved by Governor August 16, 2013. Filed with Secretary of State August 16, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

AB 512, Rendon. Healing arts: licensure exemption.

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

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

This bill would delete the January 1, 2014, date of repeal, and instead allow the exemption to operate until January 1, 2018.

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

SECTION 1. Section 901 of the Business and Professions Code is amended to read:

901. (a) For purposes of this section, the following provisions apply:

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

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

(A) To uninsured or underinsured persons.

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

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

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

(c) The board may deny a health care practitioner authorization to practice without a license if the health care practitioner fails to comply with this section or for any act that would be grounds for denial of an application for licensure.

(d) A sponsoring entity seeking to provide, or arrange for the provision of, health care services under this section shall do both of the following:

(1) Register with each applicable board under this division for which an out-of-state health care practitioner is participating in the sponsored event by completing a registration form that shall include all of the following:

(A) The name of the sponsoring entity.

(B) The name of the principal individual or individuals who are the officers or organizational officials responsible for the operation of the sponsoring entity.

(C) The address, including street, city, ZIP Code, and county, of the sponsoring entity's principal office and each individual listed pursuant to subparagraph (B).

(D) The telephone number for the principal office of the sponsoring entity and each individual listed pursuant to subparagraph (B).

(E) Any additional information required by the board.

(2) Provide the information listed in paragraph (1) to the county health department of the county in which the health care services will be provided, along with any additional information that may be required by that department.

(e) The sponsoring entity shall notify the board and the county health department described in paragraph (2) of subdivision (d) in writing of any change to the information required under subdivision (d) within 30 calendar days of the change.

(f) Within 15 calendar days of the provision of health care services pursuant to this section, the sponsoring entity shall file a report with the board and the county health department of the county in which the health care services were provided. This report shall contain the date, place, type, and general description of the care provided, along with a listing of the health care practitioners who participated in providing that care.

AB 565

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 565
Author: Salas
Chapter: 378
Bill Date: September 3, 2013, Amended
Subject: California Physician Corps Program
Sponsor: California Medical Association
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

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

ANALYSIS:

The STLRP was created in 2002 via legislation which was co-sponsored by the Medical Board of California (Board). The STLRP encourages recently licensed physicians to practice in underserved locations in California by authorizing a plan for repayment of their student loans (up to $105,000) in exchange for a minimum three years of service. In 2006, the administration of STLRP was transitioned from the Board to the Health Professions Education Foundation (HPEF). Since 1990, HPEF has administered statewide scholarship and loan repayment programs for a wide range of health professions' students and recent graduates, 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 amends 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 deletes the existing guideline that would seek to place the most qualified applicants in the areas with the greatest need and replaces 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 also requires 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.

This bill adds 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 50 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.

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

IMPLEMENTATION:

- Newsletter Article

Assembly Bill No. 565

CHAPTER 378

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

[Approved by Governor September 27, 2013. Filed with Secretary of State September 27, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

AB 565, Salas. California Physician Corps Program.

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

This bill would delete the requirement that the guidelines seek to place the most qualified applicants in the areas of greatest need. The bill would require the guidelines for the selection and placement of program applicants to include criteria that would give priority consideration to program applicants who have 3 years of experience providing health care services to medically underserved populations or in a medically underserved area, as defined. The bill would require the guidelines to give priority to applicants who agree to practice in those areas and serve a medically underserved population, and would require the guidelines to give priority consideration to applicants from rural communities who agree to practice in a physician owned and operated medical practice setting, as defined.

Existing law requires the foundation, in consultation with the Medical Board of California, Office of Statewide Planning and Development, and an advisory committee, to use guidelines developed by the Medical Board of California for selection and placement of applicants until the office adopts other guidelines by regulation.

This bill would instead require the foundation and the office to develop guidelines using specified criteria for selection and placement of applicants.

Existing law defines "practice setting," for these purposes, to include a community clinic, as defined, a clinic owned and operated by a public hospital and health system, or a clinic owned and operated by a hospital

Code, which is located in a medically underserved area and at least 50 percent of whose patients are from a medically underserved population.

(2) A physician owned and operated medical practice setting that provides primary care located in a medically underserved area and has a minimum of 50 percent of 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 federal poverty level.

(j) "Primary specialty" means family practice, internal medicine, pediatrics, or obstetrics/gynecology.

(k) "Program" means the Steven M. Thompson Physician Corps Loan Repayment Program.

(*l*) "Selection committee" means a minimum three-member committee of the board, that includes a member that was appointed by the Medical Board of California.

SEC. 2. Section 128553 of the Health and Safety Code is amended to read:

128553. (a) Program applicants shall possess a current valid license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act.

(b) The foundation and the office shall develop guidelines using the criteria specified in subdivision (c) for selection and placement of applicants. The foundation shall interpret the guidelines to apply to both osteopathic and allopathic physicians and surgeons.

(c) The guidelines shall meet all of the following criteria:

(1) Provide priority consideration to applicants that are best suited to meet the cultural and linguistic needs and demands of patients from medically underserved populations and who meet one or more of the following criteria:

(A) Speak a Medi-Cal threshold language.

(B) Come from an economically disadvantaged background.

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

(D) Have three years of experience providing health care services to medically underserved populations 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.

AB 635

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 635
Author:	Ammiano
Chapter:	707
Bill Date:	August 22, 2013, Amended
Subject:	Drug Overdose Treatment: Liability
Sponsor:	Harm Reduction Coalition California Society of Addiction Medicine
Position:	Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill allows health care providers to prescribe, dispense, and issue standing orders for an opioid antagonist to persons at risk of overdose, or their family member, friend, or other person in a position to assist persons at risk, without making them professionally, civilly or criminally liable, if acting within reasonable care. It also extends this same liability protection to individuals assisting in dispensing, distributing, or administering the opioid antagonist during an overdose. This bill requires a person who is prescribed or possesses an opioid antagonist pursuant to a standing order to receive training provided by an opioid overdose prevention and treatment training program.

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 allows 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 also extends this same liability protection to individuals assisting in dispensing, distributing, or administering the opioid antagonist during an overdose.

This bill requires a person who is prescribed or possesses an opioid antagonist 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.

This bill does not require a person who is prescribed an opioid antagonist directly from a licensed prescriber to receive training from an opioid prevention and treatment training program.

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. The Board is supportive of this bill, as it will encourage

licensed health care providers to begin prescribing naloxone to patients on chronic opioid pain medications in order to help address the prescription drug overdose epidemic. This is one element of many to address the issue of drug related overdose deaths in California, and will help to further the Board's mission of consumer protection.

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

IMPLEMENTATION:

- Newsletter Article
- Notify/Train Board staff

Assembly Bill No. 635

CHAPTER 707

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

[Approved by Governor October 10, 2013. Filed with Secretary of State October 10, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

AB 635, Ammiano. Drug overdose treatment: liability.

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

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

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

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

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

(2) A person who is prescribed an opioid antagonist directly from a licensed prescriber shall not be required to receive training from an opioid prevention and treatment training program.

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

(f) Notwithstanding any other law, a person who possesses or distributes an opioid antagonist pursuant to a prescription or standing order shall not be subject to professional review, be liable in a civil action, or be subject to criminal prosecution for this possession or distribution. Notwithstanding any other law, a person not otherwise licensed to administer an opioid antagonist, but trained as required under paragraph (1) of subdivision (d), who acts with reasonable care in administering an opioid antagonist, in good faith and not for compensation, to a person who is experiencing or is suspected of experiencing an overdose shall not be subject to professional review, be liable in a civil action, or be subject to criminal prosecution for this administration.

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ABC 1000

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 1000
Author:	Wieckowski and Maienschein
Chapter:	620
Bill Date:	September 6, 2013, Amended
Subject:	Physical Therapists: Direct Access to Services: Professional Corporations
Sponsor:	California Physical Therapy Association
Position:	Neutral

DESCRIPTION OF CURRENT LEGISLATION:

This bill allows a physical therapist (PT) to see a patient for a specified period of time and requires the PT to provide specified notice to the patient regarding the direct PT services. This bill specifies that it does not restrict or alter the scope of practice of any other health care professional.

This bill also incorporates the language from AB 1003 (Maienschein), which the Board had taken a position of support. The language from AB 1003 specifies 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 specifies 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 also adds physical therapists, and other licensed professionals, to the listing in the Corporations Code.

ANALYSIS:

This bill allows 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 allows 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's condition, and if indicated, testing by the physician, osteopathic physician, or podiatrist.

This bill specifies 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 specifies that it does not require a health care service plan, insurer, worker's compensation insurance plan, employer, or state program to provide coverage for direct access to treatment by a PT. This bill also specifies that it does not restrict or alter the scope of practice of any other health care professional.

This bill requires 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 specifies 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 also adds 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 now codifies 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.

Although this bill allows patients to directly access PT services, it imposes 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 requires the patient to get an in-patient examination and evaluation before the plan of care can be approved and signed off. This bill also requires the patient to be provided information on the requirements in this bill regarding time limits for receiving direct PT services and requires the patient to sign the notice before the PT can provide services. This bill includes language that has been negotiated by interested parties. The Board believes this bill includes adequate safeguards to ensure consumer protection; as such, the Board has taken a neutral position on this bill.

FISCAL: None

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

OPPOSITION:
California Association of Physician Groups
California Board of Chiropractic Examiners
California Chiropractic Association
Independent Physical Therapists of California
Physical Therapy Business Alliance

IMPLEMENTATION:

- Newsletter Article
- Notify/Train Board Staff

Assembly Bill No. 1000

CHAPTER 620

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.

[Approved by Governor October 7, 2013. Filed with Secretary of State October 7, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1000, 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 has a condition requiring treatment or services beyond that scope of practice or if the patient is not progressing, to disclose to the patient any financial interest he or she has in treating the patient, and, with the patient's written authorization, to notify the patient's physician and surgeon, if any, that the physical therapist is treating the patient. The bill would prohibit a physical therapist from treating a patient who initiated services directly for the lesser of more than 45 calendar days or 12 visits, except as specified, and would prohibit a physical therapist from performing services on that patient before obtaining the patient's signature on a specified notice regarding these limitations on treatment. The bill would provide that failure to comply with these provisions constitutes unprofessional conduct subject to disciplinary action by the board.

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

The Moscone-Knox Professional Corporation Act provides for the organization of a corporation under certain existing law for the purposes of qualifying as a professional corporation under that act and rendering professional services. The act authorizes specified healing arts practitioners to be shareholders, officers, directors, or professional employees of a designated professional corporation, subject to certain limitations relating

to ownership of shares. Existing law also defines a medical corporation or podiatry corporation that is authorized to render professional services as long as that corporation and its shareholders, officers, directors, and employees rendering professional services who are physicians, psychologists, registered nurses, optometrists, podiatrists or, in the case of a medical corporation only, physician assistants, are in compliance with the act.

This bill would specify that those provisions do not limit employment by a professional corporation of only those specified licensed professionals. The bill would authorize any person duly licensed under the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act to be employed to render professional services by a professional corporation. The bill would expressly add physical therapists and occupational therapists to the list of healing arts professionals who may be professional employees of a medical corporation or podiatry corporation, and would add licensed physical therapists to the list of healing arts practitioners who may be shareholders, officers, or directors of a medical corporation or a podiatric 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.

This bill would incorporate additional changes to Section 2660 of the Business and Professions Code proposed by SB 198 that would become operative if this bill and SB 198 are enacted and this bill is chaptered last.

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.

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

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

SEC. 2. Section 2406 of the Business and Professions Code is amended to read:

2406. A medical corporation or podiatry corporation is a corporation that is authorized to render professional services, as defined in Section 13401 of the Corporations Code, so long as that corporation and its shareholders, officers, directors, and employees rendering professional services who are physicians and surgeons, psychologists, registered nurses, optometrists, podiatrists, chiropractors, acupuncturists, naturopathic doctors, physical therapists, occupational therapists, or, in the case of a medical corporation only, physician assistants, marriage and family therapists, clinical counselors,

or clinical social workers, are in compliance with the Moscone-Knox Professional Corporation Act, the provisions of this article, and all other statutes and regulations now or hereafter enacted or adopted pertaining to the corporation and the conduct of its affairs.

With respect to a medical corporation or podiatry corporation, the governmental agency referred to in the Moscone-Knox Professional Corporation Act is the board.

SEC. 3. Section 2406.5 is added to the Business and Professions Code, to read:

2406.5. (a) When a physician and surgeon, podiatrist, or other referring practitioner refers a patient to receive services by a physical therapist employed by a professional corporation as defined in Section 13401 of the Corporations Code, the referring practitioner shall comply with Article 6 (commencing with Section 650) of Chapter 1, and shall provide notice of the following to the patient, orally and in writing, in at least 14-point type and signed by the patient:

(1) That the patient may seek physical therapy treatment services from a physical therapy provider of his or her choice who may not necessarily be employed by the medical or podiatry corporation.

(2) If the patient chooses to be treated by an employed physical therapist, any financial interest the referring practitioner has in the corporation.

(b) This section shall not apply to a physician and surgeon, podiatrist, or other referring practitioner who is in a medical group with which a health care service plan, that is licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) and is also exempt from federal taxation pursuant to Section 501(c)(3) of the Internal Revenue Code, exclusively contracts to provide professional medical services for its enrollees.

SEC. 4. Section 2620.1 is added to the Business and Professions Code, to read:

2620.1. (a) In addition to receiving those services authorized by Section 2620, a person may initiate physical therapy treatment directly from a licensed physical therapist if the treatment is within the scope of practice of physical therapists, as defined in Section 2620, and all of the following conditions are met:

(1) If, at any time, the physical therapist has reason to believe that the patient has signs or symptoms of a condition that requires treatment beyond the scope of practice of a physical therapist or the patient is not progressing toward documented treatment goals as demonstrated by objective, measurable, or functional improvement, the physical therapist shall refer the patient to a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California or to a person licensed to practice dentistry, podiatric medicine, or chiropractic.

(2) The physical therapist shall 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) (1) 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.

(2) This section does not restrict or alter the scope of practice of any other health care professional.

(d) Nothing in this section shall be construed to require a health care service plan, insurer, workers' compensation insurance plan, employer, or state program to provide coverage for direct access to treatment by 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:

"Direct Physical Therapy Treatment Services

You are receiving direct physical therapy treatment services from an individual who is a physical therapist licensed by the Physical Therapy Board of California.

Under California law, you may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, from a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California, or 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 and that an in-person patient examination and evaluation was conducted by the physician and surgeon or podiatrist.

_____
Patient's Signature/Date"

SEC. 5. Section 2660 of the Business and Professions Code is amended to read:

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

(a) Advertising in violation of Section 17500.

(b) Fraud in the procurement of any license under this chapter.

(c) Procuring or aiding or offering to procure or aid in criminal abortion.

(d) Conviction of a crime that substantially relates to the qualifications, functions, or duties of a physical therapist or physical therapist assistant. The record of conviction or a certified copy thereof shall be conclusive evidence of that conviction.

(e) Habitual intemperance.

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

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

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

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

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

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

(*l*) Except for good cause, the knowing failure to protect patients by failing to follow infection control guidelines of the board, thereby risking transmission of 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.

SEC. 5.5. Section 2660 of the Business and Professions Code is amended to read:

2660. Unprofessional conduct constitutes grounds for citation, discipline, denial of a license, or issuance of a probationary license. The board may, after the conduct of appropriate proceedings under the Administrative Procedure Act (Chapter 4.5 (commencing with Section 11400) of Part 1 of Division 3 of Title 2 of the Government Code), issue a citation, impose discipline, deny a license, suspend for not more than 12 months, or revoke, or impose probationary conditions upon any license issued under this chapter for unprofessional conduct that includes, in addition to other provisions of this chapter, 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, any regulations duly adopted under this chapter, or the Medical Practice Act (Chapter 5 (commencing with Section 2000)).

(b) Advertising in violation of Section 17500.

(c) Obtaining or attempting to obtain a license by fraud or misrepresentation.

(d) Practicing or offering to practice beyond the scope of practice of physical therapy.

(e) Conviction of a crime that substantially relates to the qualifications, functions, or duties of a physical therapist or physical therapist assistant. The record of conviction or a certified copy thereof shall be conclusive evidence of that conviction.

(f) Unlawful possession or use of, or conviction of a criminal offense involving, a controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug as defined in Article 2 (commencing with Section 4015) of Chapter 9, as follows:

(1) Obtaining or possessing in violation of law, or except as directed by a licensed physician and surgeon, dentist, or podiatrist, administering to himself or herself, or furnishing or administering to another, any controlled substances or any dangerous drug.

(2) Using any controlled substance or any dangerous drug.

(3) Conviction of a criminal offense involving the consumption or self-administration of, or the possession of, or falsification of a record

pertaining to, any controlled substance or any dangerous drug, in which event the record of the conviction is conclusive evidence thereof.

(g) Failure to maintain adequate and accurate records relating to the provision of services to his or her patients.

(h) Gross negligence or repeated acts of negligence in practice or in the delivery of physical therapy care.

(i) Aiding or abetting any person to engage in the unlawful practice of physical therapy.

(j) 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.

(k) 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.

(*l*) The commission of verbal abuse or sexual harassment.

(m) Engaging in sexual misconduct or violating Section 726.

(n) Permitting a physical therapist assistant or physical therapy aide under one's supervision or control to perform, or permitting the physical therapist assistant or physical therapy aide to hold himself or herself out as competent to perform, professional services beyond the level of education, training, and experience of the physical therapist assistant or aide.

(o) The revocation, suspension, or other discipline, restriction, or limitation imposed by another state upon a license or certificate to practice physical therapy issued by that state, or the revocation, suspension, or restriction of the authority to practice physical therapy by any agency of the federal government.

(p) Viewing a completely or partially disrobed patient in the course of treatment if the viewing is not necessary to patient evaluation or treatment under current standards.

(q) Engaging in any act in violation of Section 650, 651, or 654.2.

(r) Charging a fee for services not performed.

(s) Misrepresenting documentation of patient care or deliberate falsifying of patient records.

(t) Except as otherwise allowed by law, the employment of runners, cappers, steerers, or other persons to procure patients.

(u) The willful, unauthorized violation of professional confidence.

(v) Failing to maintain confidentiality, except as otherwise required or permitted by law, of all information that has been received from a patient in confidence during the course of treatment and all information about the patient that is obtained from tests or other means.

(w) Habitual intemperance.

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

SEC. 6. Section 13401.5 of the Corporations Code is amended to read:

13401.5. Notwithstanding subdivision (d) of Section 13401 and any other provision of law, the following licensed persons may be shareholders, officers, directors, or professional employees of the professional corporations designated in this section so long as the sum of all shares owned by those licensed persons does not exceed 49 percent of the total number of shares of the professional corporation so designated herein, and so long as the number of those licensed persons owning shares in the professional corporation so designated herein does not exceed the number of persons licensed by the governmental agency regulating the designated professional corporation. This section does not limit employment by a professional corporation designated in this section of only those licensed professionals listed under each subdivision. Any person duly licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act may be employed to render professional services by a professional corporation designated in this section.

(a) Medical corporation.

(1) Licensed doctors of podiatric medicine.

(2) Licensed psychologists.

(3) Registered nurses.

(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.

(12) Licensed physical therapists.

(b) Podiatric medical corporation.

(1) Licensed physicians and surgeons.

(2) Licensed psychologists.

(3) Registered nurses.

(4) Licensed optometrists.

(5) Licensed chiropractors.

(6) Licensed acupuncturists.

(7) Naturopathic doctors.

(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.
(3) Licensed marriage and family therapists.
(4) Registered nurses.
(5) Licensed chiropractors.
(6) Licensed acupuncturists.
(7) Naturopathic doctors.
(8) Licensed professional clinical counselors.
(i) Physician assistants corporation.
(1) Licensed physicians and surgeons.

(2) Registered nurses.
(3) Licensed acupuncturists.
(4) Naturopathic doctors.
(j) Optometric corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Licensed psychologists.
(4) Registered nurses.
(5) Licensed chiropractors.
(6) Licensed acupuncturists.
(7) Naturopathic doctors.
(k) Chiropractic corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Licensed psychologists.
(4) Registered nurses.
(5) Licensed optometrists.
(6) Licensed marriage and family therapists.
(7) Licensed clinical social workers.
(8) Licensed acupuncturists.
(9) Naturopathic doctors.
(10) Licensed professional clinical counselors.
(*l*) Acupuncture corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Licensed psychologists.
(4) Registered nurses.
(5) Licensed optometrists.
(6) Licensed marriage and family therapists.
(7) Licensed clinical social workers.
(8) Licensed physician assistants.
(9) Licensed chiropractors.
(10) Naturopathic doctors.
(11) Licensed professional clinical counselors.
(m) Naturopathic doctor corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.
(3) Registered nurses.
(4) Licensed physician assistants.
(5) Licensed chiropractors.
(6) Licensed acupuncturists.
(7) Licensed physical therapists.
(8) Licensed doctors of podiatric medicine.
(9) Licensed marriage and family therapists.
(10) Licensed clinical social workers.
(11) Licensed optometrists.
(12) Licensed professional clinical counselors.

(n) Dental corporation.
(1) Licensed physicians and surgeons.
(2) Dental assistants.
(3) Registered dental assistants.
(4) Registered dental assistants in extended functions.
(5) Registered dental hygienists.
(6) Registered dental hygienists in extended functions.
(7) Registered dental hygienists in alternative practice.
(o) Professional clinical counselor corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.
(3) Licensed clinical social workers.
(4) Licensed marriage and family therapists.
(5) Registered nurses.
(6) Licensed chiropractors.
(7) Licensed acupuncturists.
(8) Naturopathic doctors.
(p) Physical therapy corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Licensed acupuncturists.
(4) Naturopathic doctors.
(5) Licensed occupational therapists.
(6) Licensed speech-language therapists.
(7) Licensed audiologists.
(8) Registered nurses.
(9) Licensed psychologists.
(10) Licensed physician assistants.

SEC. 7. Section 5.5 of this bill incorporates amendments to Section 2660 of the Business and Professions Code proposed by both this bill and Senate Bill 198. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2014, (2) each bill amends Section 2660 of the Business and Professions Code, and (3) this bill is enacted after Senate Bill 198, in which case Section 5 of this bill shall not become operative.

SEC. 8. 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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AJB 1288

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 1288
Author:	Perez, V.
Chapter:	307
Bill Date:	June 6, 2013, Amended
Subject:	Medical Board & Osteopathic Medical Board: Licensing: Application Processing
Sponsor:	California Medical Association
Position:	Neutral

DESCRIPTION OF CURRENT LEGISLATION:

This bill requires 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 allows 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. This bill also includes provisions that 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 requires 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 allows 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 usually 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.

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

IMPLEMENTATION:

- Newsletter Article
- Notify/Train Board Staff
- Develop a process for priority review status
- Revise the licensing application
- Inform postgraduate training programs

Assembly Bill No. 1288

CHAPTER 307

An act to add Sections 2092 and 2099.6 to the Business and Professions Code, relating to healing arts.

[Approved by Governor September 9, 2013. Filed with Secretary of State September 9, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1288, 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 medically underserved population.

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

SECTION 1. Section 2092 is added to the Business and Professions Code, to read:

2092. (a) The board shall develop a process to give priority review status to the application of an applicant for a physician and surgeon's certificate who can demonstrate that he or she intends to practice in a medically underserved area or serve a medically underserved population as defined in Section 128565 of the Health and Safety Code.

(b) An applicant may 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 stating the start date.

SEC. 2. Section 2099.6 is added to the Business and Professions Code, to read:

2099.6. (a) The Osteopathic Medical Board of California shall develop a process to give priority review status to the application of an applicant for an osteopathic physician and surgeon's certificate who can demonstrate that he or she intends to practice in a medically underserved area or serve a medically underserved population as defined in Section 128565 of the Health and Safety Code.

(b) An applicant may 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 stating the start date.

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AJB 1308

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 1308
Author:	Bonilla
Chapter:	665
Bill Date:	September 6, 2013, Amended
Subject:	Midwifery
Sponsor:	American Congress of Obstetricians and Gynecologists (ACOG), District IX
Position:	Support if Amended

DESCRIPTION OF CURRENT LEGISLATION:

This bill removes the physician supervision requirement for licensed midwives (LMs) and requires LMs to only accept clients that meet the criteria for normal pregnancy and childbirth, as specified in this bill. If a potential client does not meet the criteria for normal pregnancy and childbirth, then the LM can refer that client to a physician trained in obstetrics and gynecology for examination; the LM can only accept the client if the physician examines the client and determines that the risk factors are not likely to significantly affect the course of pregnancy and childbirth.

This bill also allows LMs 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 the LMs scope of practice. This bill requires LMs to obtain informed consent, as specified in this bill.

This bill requires LMs to provide records and speak to the receiving physician if the client is transferred to a hospital. This bill requires the hospital to report each transfer of a planned out-of-hospital birth to the Medical Board of California (Board) and the California Maternal Quality Care Collaborative, using a form developed by the Board.

This bill requires all LMs to complete midwifery education programs and does not allow new licensees to substitute clinical experience for formal didactic education beginning January 1, 2015. This bill allows the Board, with input from the Midwifery Advisory Council (MAC), to look at the data elements required to be reported by LMs, to better coordinate with other reporting systems, including the reporting system of the Midwives Alliance of North America (MANA).

Lastly, this bill allows LMs to attend births in alternative birth centers (ABCs) and changes the standards of certification that must be met by an ABC to those established by the American Association of Birth Centers.

ANALYSIS

Background

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.

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.

AB 1308 Provisions

This bill removes the physician supervision requirement for licensed midwives (LMs) and requires LMs to only accept clients that meet the criteria for normal pregnancy and childbirth, which this bill defines as meeting the following conditions:

- There is an absence of both of the following:
  - Any preexisting maternal disease or condition likely to affect the pregnancy – this bill requires the Board to adopt regulation specifying these conditions.
  - Significant disease arising from the pregnancy.
- There is a singleton fetus.

- There is a cephalic presentation.
- The gestational age of the fetus is greater than 37 0/7 weeks and less than 42 0/7 completed weeks of pregnancy.
- Labor is spontaneous or induced in an outpatient setting.

This bill specifies that if a potential midwifery client meets the conditions of a normal pregnancy, but has a preexisting maternal disease or condition likely to affect the pregnancy or significant disease arising from the pregnancy, the LM must refer the potential client to a physician trained in obstetrics and gynecology for examination; the LM can only accept the client if the physician examines the client and determines that the risk factors are not likely to significantly affect the course of pregnancy and childbirth. This bill further specifies that, if at any point during the pregnancy, childbirth, or postpartum care a client's condition deviates from normal, the LM shall immediately refer or transfer the client to a physician. The LM may consult and remain in consultation with the physician after the referral or transfer. If the physician determines that the client's condition or concern has been resolved and is not likely to affect the course of pregnancy or childbirth, the LM may resume primary care of the client. If the physician determines that the client's condition or concern is not resolved, the LM may provide concurrent care with the physician, and if the client authorizes, be present during labor and childbirth and resume postpartum care, if appropriate.

This bill allows LMs 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 the LMs scope of practice.

This bill also requires LMs to obtain specific informed consent, orally and in writing, and as part of the client care plan, which must be signed and be part of the client's medical record. This information includes the following: the client is retaining a LM; license information for the LM; that many physicians do not have liability insurance coverage for planned out-of-hospital births; failure to consult with a physician, when advised, may affect the client's legal rights in any professional negligence actions; there are conditions outside the scope of a LM that will result in referral to a physician; the specific arrangements for referral to a physician; recommendations for preregistration at a hospital most likely to receive a transfer; if the client is informed that she has a condition mandating a transfer, the LM shall initiate the transfer; the availability of the text laws regulating LMs on the Board's Web site; that consultation with a physician does not alone create a physician-patient relationship or any other relationship with a physician; and that the LM is independently licensed and is solely responsible for the services provided to the client.

This bill requires LMs to provide records and speak to the receiving physician about labor up to the point of transfer if the client is transferred to a hospital. This bill requires the hospital to report each transfer of a planned out-of-hospital birth to the Board and the California Maternal Quality Care Collaborative, using a form developed by the Board.

This bill requires all LMs to complete midwifery education programs and does not allow new licensees to substitute clinical experience for formal didactic education beginning January 1, 2015; this deletes the challenge mechanism from statute.

This bill allows the Board, with input from the MAC, to look at the data elements required to be reported by LM to better coordinate with other reporting systems, including the reporting system of the MANA. This provision does not require any reporting changes, but only allows the Board and the MAC to look at potential changes.

This bill specifies that failure of a LM to consult with a physician, refer a client to a physician, or transfer a client to a hospital when necessary, constitutes unprofessional conduct.

Lastly, this bill allows LMs to attend births in alternative birth centers (ABCs) and changes the standards of certification that must be met by an ABC to those established by the American Association of Birth Centers.

Board Information

The Board, through the 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, the lab order and medical supplies/medication issues needs to be addressed through the legislative process.

This bill addresses the physician supervision issue, which is of utmost importance for protection of consumers, and is the reason for all of the barriers to care that LMs currently face. This bill will only allow LMs to accept clients that meet the conditions of a normal pregnancy, which is more stringent than existing practice, as clients now can consent to receive services from LMs even if they do not meet criteria for a normal pregnancy. This bill requires a client to be examined by a physician and for the physician to approve care by a LM for clients that do not meet the normal pregnancy criteria. This bill also increases communication between LMs, physicians, and hospitals, if referral of care or a hospital transfer is required, which will also help to significantly increase consumer protection. This bill adds many items to the informed consent that LMs must provide to clients in order to increase transparency and provide more information to potential clients. This bill requires all LMs, starting in 2015, to

complete a formal midwifery education program, as this bill deletes the existing challenge mechanism that allows a LM to pass a test in lieu of completing a formal education program. This bill will help to ensure that consumers are protected and provided the best midwifery care possible and will also help the Board to more effectively regulate LMs.

FISCAL: Minimal and absorbable

SUPPORT: ACOG, District IX (sponsor)
Birth Network of Monterey County
California Association of Midwives
California Families for Access to Midwives
Central California Alliance for Health
International Cesarean Awareness Network
Medical Board of California (if amended)

OPPOSITION: None on File

IMPLEMENTATION:

- Newsletter article and notification to LMs
- Notify/Train Board staff
- Update the Board's Web site with changes to the law
- Work with interested parties and stakeholders to develop regulations specifying any preexisting maternal disease or condition likely to affect the pregnancy and any other regulations needed to implement this bill
- Develop processes and procedures for hospital reporting of each transfer of a planned out-of-hospital birth to the Board and develop a form for this reporting
- Place on the MAC's agenda a review of the existing reporting data elements and possible changes to coordinate with other reporting systems, including MANA
- Provide outreach to new LM applicants that the challenge mechanism will no longer be available effective January 1, 2015

Assembly Bill No. 1308

CHAPTER 665

An act to amend Sections 2507, 2508, 2513, 2516, and 2519 of, and to add Section 2510 to, the Business and Professions Code, and to amend Section 1204.3 of the Health and Safety Code, relating to professions and vocations.

[Approved by Governor October 9, 2013. Filed with Secretary of State October 9, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1308, 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. The act requires a midwife to immediately refer all complications to a physician and surgeon. Under the act, a licensed midwife is required to make certain oral and written disclosures to prospective clients. Under the act, the board is authorized to suspend or revoke the license of a midwife for specified conduct, including unprofessional conduct consisting of, among other things, incompetence or gross negligence in carrying out the usual functions of a licensed midwife. A violation of the act is a crime.

This bill would, among other things, no longer require a physician and surgeon to supervise a licensed midwife. The bill would require, if a potential midwife client fails to meet the conditions of a normal pregnancy or childbirth, as defined, but still desires to be a client, that the licensed midwife refer the woman to a physician and surgeon for examination. The bill would require the board to adopt regulations specifying certain of those conditions. The bill would authorize the licensed midwife to assist the woman only if the physician and surgeon determines, after examination, that the risk factors presented by the woman's disease or condition are not likely to significantly affect the course of pregnancy and childbirth. The bill would require a licensed midwife to immediately refer or transfer the client to a physician and surgeon if at any point during pregnancy, childbirth, or postpartum care a client's condition deviates from normal. The bill would authorize the licensed midwife to resume primary care of the client if the physician and surgeon determines that the client's condition or concern has been resolved, and to provide concurrent care if the client's condition or concern has not been resolved, as specified.

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. The bill would require a licensed midwife to make additional disclosures to prospective clients, including, among other things, the specific arrangements for referral of complications to a physician and surgeon, and to obtain written, informed consent of those disclosures, as prescribed. By increasing the duties of a licensed midwife under the Licensed Midwifery Practice Act of 1993, the violation of which is a crime, the bill would impose a state-mandated local program. The bill would authorize the board to suspend or revoke the license of a licensed midwife for failing, when required, to consult with a physician and surgeon, to refer a client to a physician and surgeon, or to transfer a client to a hospital. The bill would require, if a client is transferred to a hospital, that the hospital report each transfer of a planned out-of-hospital birth to, among others, the board, using a form developed by the board.

Existing law requires a licensed midwife who assists, or supervises a student midwife in assisting, in childbirth that occurs in an out-of-hospital setting to annually report specified information to the Office of Statewide Health Planning and Development.

This bill would authorize the board, with input from the Midwifery Advisory Council, to adjust the data elements required to be reported to better coordinate with other reporting systems, as specified.

Existing law requires an approved midwifery education program to offer the opportunity for students to obtain credit by examination for previous midwifery education and clinical experience.

This bill would, beginning January 1, 2015, prohibit new licensees from substituting clinical experience for formal didactic education.

Existing law requires a licensed alternative birth center, and a licensed primary care clinic that provides services as an alternative birth center, to meet specified requirements, including the presence of at least 2 attendants during birth, one of whom shall be either a physician and surgeon or a certified nurse-midwife.

This bill would provide that a licensed midwife may also satisfy that requirement.

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.

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

SECTION 1. The Legislature finds and declares the following:

(a) Licensed midwives have been authorized to practice since 1993 under Senate Bill 350 (Chapter 1280 of the Statutes of 1993), which was authored

by Senator Killea. Additional legislation, Senate Bill 1950 (Chapter 1085 of the Statutes of 2002), which was authored by Senator Figueroa, was needed in 2002 to clarify certain practice issues. While the midwifery license does not specify or limit the practice setting in which licensed midwives may provide care, the reality is that the majority of births delivered by licensed midwives are planned as home births.

(b) Planned home births are safer when care is provided as part of a collaborative delivery model in which medical professionals may freely consult on patient care to maximize patient safety and positive outcomes. For a variety of reasons, this integration does not always occur, and creates a barrier to the best and safest care possible.

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

2507. (a) The license to practice midwifery authorizes the holder to attend cases of normal pregnancy and childbirth, as defined in paragraph (1) of subdivision (b), 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 to assist a woman in childbirth as long as progress meets criteria accepted as normal.

(1) Except as provided in paragraph (2), a licensed midwife shall only assist a woman in normal pregnancy and childbirth, which is defined as meeting all of the following conditions:

(A) There is an absence of both of the following:

(i) Any preexisting maternal disease or condition likely to affect the pregnancy.

(ii) Significant disease arising from the pregnancy.

(B) There is a singleton fetus.

(C) There is a cephalic presentation.

(D) The gestational age of the fetus is greater than 37 $^{6}/_{7}$ weeks and less than 42 $^{6}/_{7}$ completed weeks of pregnancy.

(E) Labor is spontaneous or induced in an outpatient setting.

(2) If a potential midwife client meets the conditions specified in subparagraphs (B) to (E), inclusive, of paragraph (1), but fails to meet the conditions specified in subparagraph (A) of paragraph (1), and the woman still desires to be a client of the licensed midwife, the licensed midwife shall provide the woman with a referral for an examination by a physician and surgeon trained in obstetrics and gynecology. A licensed midwife may assist the woman in pregnancy and childbirth only if an examination by a physician and surgeon trained in obstetrics and gynecology is obtained and the physician and surgeon who examined the woman determines that the risk factors presented by her disease or condition are not likely to significantly affect the course of pregnancy and childbirth.

(3) The board shall adopt regulations pursuant to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part of 1

of Division 3 of Title 2 of the Government Code) specifying the conditions described in subparagraph (A) of paragraph (1).

(c) (1) If at any point during a pregnancy, childbirth, or postpartum care a client's condition deviates from normal, the licensed midwife shall immediately refer or transfer the client to a physician and surgeon. The licensed midwife may consult and remain in consultation with the physician and surgeon after the referral or transfer.

(2) If a physician and surgeon determines that the client's condition or concern has been resolved such that the risk factors presented by a woman's disease or condition are not likely to significantly affect the course of pregnancy or childbirth, the licensed midwife may resume primary care of the client and resume assisting the client during her pregnancy, childbirth, or postpartum care.

(3) If a physician and surgeon determines the client's condition or concern has not been resolved as specified in paragraph (2), the licensed midwife may provide concurrent care with a physician and surgeon and, if authorized by the client, be present during the labor and childbirth, and resume postpartum care, if appropriate. A licensed midwife shall not resume primary care of the client.

(d) A licensed midwife shall not provide or continue to provide midwifery care to a woman with a risk factor that will significantly affect the course of pregnancy and childbirth, regardless of whether the woman has consented to this care or refused care by a physician or surgeon, except as provided in paragraph (3) of subdivision (c).

(e) The practice of midwifery does not include the assisting of childbirth by any artificial, forcible, or mechanical means, nor the performance of any version of these means.

(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) This article does not authorize a midwife to practice medicine or to perform surgery.

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

2508. (a) A licensed midwife shall disclose in oral and written form to a prospective client as part of a client care plan, and obtain informed consent for, all of the following:

(1) All of the provisions of Section 2507.

(2) The client is retaining a licensed midwife, not a certified nurse-midwife, and the licensed midwife is not supervised by a physician and surgeon.

(3) The licensed midwife's current licensure status and license number.

(4) The practice settings in which the licensed midwife practices.

(5) If the licensed midwife does not have liability coverage for the practice of midwifery, he or she shall disclose that fact. The licensed midwife shall disclose to the client that many physicians and surgeons do not have liability

insurance coverage for services provided to someone having a planned out-of-hospital birth.

(6) The acknowledgment that if the client is advised to consult with a physician and surgeon, failure to do so may affect the client's legal rights in any professional negligence actions against a physician and surgeon, licensed health care professional, or hospital.

(7) There are conditions that are outside of the scope of practice of a licensed midwife that will result in a referral for a consultation from, or transfer of care to, a physician and surgeon.

(8) The specific arrangements for the referral of complications to a physician and surgeon for consultation. The licensed midwife shall not be required to identify a specific physician and surgeon.

(9) The specific arrangements for the transfer of care during the prenatal period, hospital transfer during the intrapartum and postpartum periods, and access to appropriate emergency medical services for mother and baby if necessary, and recommendations for preregistration at a hospital that has obstetric emergency services and is most likely to receive the transfer.

(10) If, during the course of care, the client is informed that she has or may have a condition indicating the need for a mandatory transfer, the licensed midwife shall initiate the transfer.

(11) The availability of the text of laws regulating licensed midwifery practices and the procedure for reporting complaints to the Medical Board of California, which may be found on the Medical Board of California's Internet Web site.

(12) Consultation with a physician and surgeon does not alone create a physician-patient relationship or any other relationship with the physician and surgeon. The informed consent shall specifically state that the licensed midwife and the consulting physician and surgeon are not employees, partners, associates, agents, or principals of one another. The licensed midwife shall inform the patient that he or she is independently licensed and practicing midwifery and in that regard is solely responsible for the services he or she provides.

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

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

SEC. 4. Section 2510 is added to the Business and Professions Code, to read:

2510. If a client is transferred to a hospital, the licensed midwife shall provide records, including prenatal records, and speak with the receiving physician and surgeon about labor up to the point of the transfer. The hospital shall report each transfer of a planned out-of-hospital birth to the Medical Board of California and the California Maternal Quality Care Collaborative using a standardized form developed by the board.

SEC. 5. Section 2513 of the Business and Professions Code is amended to read:

2513. (a) An approved midwifery education program shall offer the opportunity for students to obtain credit by examination for previous midwifery education and clinical experience. The applicant shall demonstrate, by practical examination, the clinical competencies described in Section 2514 or established by regulation pursuant to Section 2514.5. The midwifery education program's credit by examination policy shall be approved by the board, and shall be available to applicants upon request. The proficiency and practical examinations shall be approved by the board. Beginning January 1, 2015, new licensees shall not substitute clinical experience for formal didactic education.

(b) Completion of clinical experiences shall be verified by a licensed midwife or certified nurse-midwife, and a physician and surgeon, all of whom shall be current in the knowledge and practice of obstetrics and midwifery. Physicians and surgeons, licensed midwives, and certified nurse-midwives who participate in the verification and evaluation of an applicant's clinical experiences shall show evidence of current practice. The method used to verify clinical experiences shall be approved by the board.

(c) Upon successful completion of the requirements of paragraphs (1) and (2), the applicant shall also complete the licensing examination described in paragraph (1) of subdivision (a) of Section 2512.5.

SEC. 6. Section 2516 of the Business and Professions Code is amended to read:

2516. (a) Each licensed midwife who assists, or supervises a student midwife in assisting, in childbirth that occurs in an out-of-hospital setting shall annually report to the Office of Statewide Health Planning and Development. The report shall be submitted no later than March 30, for the prior calendar year, in a form specified by the board and shall contain all of the following:

(1) The midwife's name and license number.

(2) The calendar year being reported.

(3) The following information with regard to cases in California in which the midwife, or the student midwife supervised by the midwife, assisted during the previous year when the intended place of birth at the onset of care was an out-of-hospital setting:

(A) The total number of clients served as primary caregiver at the onset of care.

(B) The number by county of live births attended as primary caregiver.

(C) The number, by county, of cases of fetal demise, infant deaths, and maternal deaths attended as primary caregiver at the discovery of the demise or death.

(D) The number of women whose primary care was transferred to another health care practitioner during the antepartum period, and the reason for each transfer.

(E) The number, reason, and outcome for each elective hospital transfer during the intrapartum or postpartum period.

(F) The number, reason, and outcome for each urgent or emergency transport of an expectant mother in the antepartum period.

(G) The number, reason, and outcome for each urgent or emergency transport of an infant or mother during the intrapartum or immediate postpartum period.

(H) The number of planned out-of-hospital births at the onset of labor and the number of births completed in an out-of-hospital setting.

(I) The number of planned out-of-hospital births completed in an out-of-hospital setting that were any of the following:

(i) Twin births.

(ii) Multiple births other than twin births.

(iii) Breech births.

(iv) Vaginal births after the performance of a cesarean section.

(J) A brief description of any complications resulting in the morbidity or mortality of a mother or a neonate.

(K) Any other information prescribed by the board in regulations.

(b) The Office of Statewide Health Planning and Development shall maintain the confidentiality of the information submitted pursuant to this section, and shall not permit any law enforcement or regulatory agency to inspect or have copies made of the contents of any reports submitted pursuant to subdivision (a) for any purpose, including, but not limited to, investigations for licensing, certification, or regulatory purposes.

(c) The office shall report to the board, by April 30, those licensees who have met the requirements of subdivision (a) for that year.

(d) The board shall send a written notice of noncompliance to each licensee who fails to meet the reporting requirement of subdivision (a). Failure to comply with subdivision (a) will result in the midwife being unable to renew his or her license without first submitting the requisite data to the Office of Statewide Health Planning and Development for the year for which that data was missing or incomplete. The board shall not take any other action against the licensee for failure to comply with subdivision (a).

(e) The board, in consultation with the office and the Midwifery Advisory Council, shall devise a coding system related to data elements that require coding in order to assist in both effective reporting and the aggregation of data pursuant to subdivision (f). The office shall utilize this coding system in its processing of information collected for purposes of subdivision (f).

(f) The office shall report the aggregate information collected pursuant to this section to the board by July 30 of each year. The board shall include this information in its annual report to the Legislature.

(g) The board, with input from the Midwifery Advisory Council, may adjust the data elements required to be reported to better coordinate with other reporting systems, including the reporting system of the Midwives Alliance of North America (MANA), while maintaining the data elements unique to California. To better capture data needed for the report required by this section, the concurrent use of systems, including MANA's, by licensed midwives is encouraged.

(h) Notwithstanding any other law, a violation of this section shall not be a crime.

SEC. 7. Section 2519 of the Business and Professions Code is amended to read:

2519. The board may suspend or revoke the license of a midwife for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, all of the following:

(1) Incompetence or gross negligence in carrying out the usual functions of a licensed midwife.

(2) Conviction of a violation of Section 2052, in which event, the record of the conviction shall be conclusive evidence thereof.

(3) The use of advertising that is fraudulent or misleading.

(4) Obtaining or possessing in violation of law, or prescribing, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administering to himself or herself, or furnishing or administering to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug as defined in Article 8 (commencing with Section 4210) of Chapter 9 of Division 2 of the Business and Professions Code.

(5) The use of any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug as defined in Article 8 (commencing with Section 4210) of Chapter 9 of Division 2 of the Business and Professions Code, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

(6) Conviction of a criminal offense involving the prescription, consumption, or self-administration of any of the substances described in paragraphs (4) and (5), or the possession of, or falsification of, a record pertaining to, the substances described in paragraph (4), in which event the record of the conviction is conclusive evidence thereof.

(7) Commitment or confinement by a court of competent jurisdiction for intemperate use of or addiction to the use of any of the substances described in paragraphs (4) and (5), in which event the court order of commitment or confinement is prima facie evidence of such commitment or confinement.

(8) Falsifying, or making grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a).

(b) Procuring a license by fraud or misrepresentation.

(c) Conviction of a crime substantially related to the qualifications, functions, and duties of a midwife, as determined by the board.

(d) Procuring, aiding, abetting, attempting, agreeing to procure, offering to procure, or assisting at, a criminal abortion.

(e) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any provision or term of this chapter.

(f) Making or giving any false statement or information in connection with the application for issuance of a license.

(g) Impersonating any applicant or acting as proxy for an applicant in any examination required under this chapter for the issuance of a license or a certificate.

(h) Impersonating another licensed practitioner, or permitting or allowing another person to use his or her license or certificate for the purpose of providing midwifery services.

(i) Aiding or assisting, or agreeing to aid or assist any person or persons, whether a licensed physician or not, in the performance of or arranging for a violation of any of the provisions of Article 12 (commencing with Section 2221) of Chapter 5.

(j) Failing to do any of the following when required pursuant to Section 2507:

(1) Consult with a physician and surgeon.

(2) Refer a client to a physician and surgeon.

(3) Transfer a client to a hospital.

SEC. 8. Section 1204.3 of the Health and Safety Code is amended to read:

1204.3. (a) An alternative birth center that is licensed as an alternative birth center specialty clinic pursuant to paragraph (4) of subdivision (b) of Section 1204 shall, as a condition of licensure, and a primary care clinic licensed pursuant to subdivision (a) of Section 1204 that provides services as an alternative birth center shall, meet all of the following requirements:

(1) Be a provider of comprehensive perinatal services as defined in Section 14134.5 of the Welfare and Institutions Code.

(2) Maintain a quality assurance program.

(3) Meet the standards for certification established by the American Association of Birth Centers, or at least equivalent standards as determined by the state department.

(4) In addition to standards of the American Association of Birth Centers regarding proximity to hospitals and presence of attendants at births, meet both of the following conditions:

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

O

ACR 40

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: ACR 40
Author: Perez
Chapter: 19
Bill Date: April 8, 2013, amended
Subject: Donate Life California Day
Sponsor: Donate Life California
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This resolution makes findings and declarations regarding the importance of organ donation. This resolution proclaims April 9, 2013, as Department of Motor Vehicles (DMV)/Donate Life California Day and April as DMV/Donate Life California Month in California. This resolution encourages all Californians to register with the Donate Life California Registry when applying for or renewing a driver's license or identification card.

ANALYSIS:

This resolution makes the following findings and declarations:

- More than 117,000 individuals nationwide and more than 21,000 Californians are currently on the national organ transplant wait list. While about one-third of these patients receive a transplant each year, another third die while waiting, due to a shortage of donated organs.
- An individual's donation of heart, lungs, liver, kidneys, pancreas, and small intestine can save up to eight lives.
- The donation of tissue can save and enhance the lives of up to 50 others, and a single blood donation can help three people in need.
- Californians by the millions are joining together to save and enhance lives by becoming registered donors and nearly nine million Californians have signed up with the state-authorized Donate Life California Organ and Tissue Donor Registry to ensure that their wishes to be an organ, eye, and tissue donor are honored.
- A California resident can register with the Donate Life California Registry when applying for or renewing his or her driver's license or identification card at the DMV.

The Board voted to be the honorary state sponsor of Donate Life California's specialized license plate, which will help to increase awareness and raise money for organ and tissue donation, education and outreach. This resolution will also help to raise awareness by proclaiming April 9, 2013 as DMV/Donate Life California Day and April as DMV/Donate Life California Month; as such, the Board supports this resolution.

FISCAL: None

SUPPORT: Donate Life California (Sponsor)
DMV

OPPOSITION: None on file

POSITION: Support

IMPLEMENTATION:

- Newsletter Articles

Assembly Concurrent Resolution No. 40

RESOLUTION CHAPTER 19

Assembly Concurrent Resolution No. 40—Relative to organ donation.

[Filed with Secretary of State April 19, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

ACR 40, John A. Pérez. Donate Life California Day: driver's license.

This measure would designate April 9, 2013, as DMV/Donate Life California Day in the State of California, and April 2013 as DMV/Donate Life California Month in the State of California, and would encourage all Californians to sign up with the Donate Life California Organ and Tissue Donor Registry.

WHEREAS, Organ, tissue, eye, and blood donations are compassionate and life-giving acts looked upon and recognized with the highest regard; and

WHEREAS, More than 117,000 individuals nationwide and more than 21,000 Californians are currently on the national organ transplant wait list. While about one-third of these patients receive a transplant each year, another one-third die while waiting due to a shortage of donated organs; and

WHEREAS, A single individual's donation of heart, lungs, liver, kidneys, pancreas, and small intestine can save up to eight lives. The donation of tissue can save and enhance the lives of up to 50 others, and a single blood donation can help three people in need; and

WHEREAS, Millions of lives each year are saved and enhanced by donors of organs, tissue, eyes, and blood; and

WHEREAS, Californians by the millions are joining together to save and enhance lives by becoming registered donors. Nearly nine million Californians have signed up with the state-authorized Donate Life California Organ and Tissue Donor Registry to ensure that their wishes to be an organ, eye, and tissue donor are honored; and

WHEREAS, A California resident can register with the Donate Life California Registry when applying for or renewing his or her driver's license or identification card at the Department of Motor Vehicles; now, therefore, be it

Resolved by the Assembly of the State of California, the Senate thereof concurring, That in recognition of April as National Donate Life Month, the Legislature proclaims April 9, 2013, as DMV/Donate Life California Day in the State of California, and April 2013 as DMV/Donate Life California Month in the State of California. In doing so, the Legislature encourages all Californians to check "YES" when applying for or renewing a driver's license or identification card or by signing up at

www.donateLIFEcalifornia.org or www.doneVIDAcalifornia.org; and be it further

Resolved, That the Chief Clerk of the Assembly transmit copies of this resolution to the author for appropriate distribution.

O

SIB 21

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 21
Author: Roth
Chapter: 203
Bill Date: August 5, 2013, amended
Subject: UC Riverside Medical School: Funding
Sponsor: California Medical Association & California Association of Physician Groups
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill lists a variety of findings and declarations. This bill requires the University of California (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 Physician Corps Loan Repayment Program (STLRP).

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 the 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 enabled prospective students to begin applying to the UC Riverside School of Medicine in order to enroll in August 2013.

This Bill requires 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 STLRP. This bill previously included language that would have appropriated $15,000,000 to UC Riverside School of Medicine. However, it was 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. SB 21 now references AB 94 and the appropriation.

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.

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

This bill 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 this bill.

FISCAL: None to the Board

SUPPORT: California Medical Association (co-sponsor); California Association of Physician Groups (co-sponsor); Insurance Commissioner Dave Jones; Superintendent of Public Instruction Tom Torlakson; United States Congressmember Mark Takano; 23rd District PTA; Accounting Principals; AFSCME, AFL-CIO; Alexandria Smitz-R.C.P.R. Commission; All Temperature Air Inc.; All Temperature Air and Solar; Altura Credit Union; Alvaro Unified School District; Arlington High School; Artesian Design, Inc.; Associated Specialist in Hearing Disorder; Beautiful Women of God Seminars, International; Best & Krieger LLP; Bourns, Inc.; Bright Star Health Care, Menifee; Bud's Tire and Wheel, Inc.; Business Academy; Business Network International; California American College of Emergency Physicians; California Podiatric Medical Association; Central Counseling Center; Cheers Group, LLC; Cities of Jurupa Valley, Murrieta, Palm Desert, and Riverside; Citizens University Committee, University of California, Riverside; City of Riverside Council Member, Chris Mac Arthur; City of Riverside Fire Department; Community Connect; County of San Bernardino; Courtyard by Marriott, Riverside; D.S.L - The Boeing Company; EmbroidMe Riverside; Enterprise Media/The Press Telegram; Fine Touch Paint & Builder Inc.; Fox Performing Arts Center; Fox Riverside Theater Foundation; Gary

Christmas Consulting; Gram's BBQ; Greater Riverside Chambers of Commerce; Greshan Sonage; Home Instead Senior Care; Hyatt Place, Riverside; Inland Empire Architectural Specialties, Inc.; Inland Empire Economic Partnership; Jaguar Computer Systems; Johnson Machinery Co.; Kaiser Permanente; Karen Allen Salon and Spa; Latino Lawyers Association, Inc.; League of California Cities, Riverside Division; League of Women Voters, Riverside; Let's Network; Lexus of Riverside; Linda Lawyer Insurance Solutions; Luminex Software Inc.; March Joint Powers Authority; Martin Luther King, Jr. High School; Medical Board of California; Monoprice, Inc.; Olive Crest; Parkview Community Hospital; Premier Service Bank; ProAbition; PSOMAS Engineering, Inland Empire; Pur-a-Life Water Solutions; Quality Printing; Raceway Ford; Raincross Hospitality Corporation; Regional Properties Inc.; Remax Kings Realty; Rick Engineering; Riverside Art Museum; Riverside City Council; Riverside Community Health Foundation; Riverside Community Police Review Commission; Riverside Convention Center; Riverside County of Superintendent of Schools; Riverside County Outlaws; Riverside County P.O.M.S; Riverside County Peace Officers Memorial Foundation; Riverside Eye Specialist; Riverside Medical Clinic; Riverside Physician Network; Riverside Sport Hall of Fame; Riverside Unified School District; RLM Wealth Corporation, Inc.; Secure Care Self Storage; Security Bank of California; Sharp Business System; Smart Riverside; Southwest California Legislative Council; Southwest Riverside County Association of Realtors; Successful Physicians Monthly; Sylvan Learning; The Harijan Company; The Mission Hotel and Spa; The Wright Image; Thompson Engineering; Tri County Eye Institute; United Way of the Inland Valleys; University of California Deans of Schools of Medicine; University of California Office of the President; University of California Riverside Alumni Association; Villa Healthcare Center; Visiting Angels Home Care; Visiting Angels of Riverside County; Waddell and Reed, Inc.; Western and Satten; Western Municipal Water District; Western Riverside Council of Governments; and Zonta Club of Riverside

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter Article

Senate Bill No. 21

CHAPTER 203

An act relating to the University of California.

[Approved by Governor September 6, 2013. Filed with Secretary of State September 6, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

SB 21, Roth. University of California: UC Riverside Medical 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.

The bill would request the School of Medicine at the University of California, Riverside, 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 Program.

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

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

(a) California's supply of primary care physicians is below what is considered sufficient to meet patient needs. In the rapidly growing and ethnically diverse area of inland southern California, the shortage is particularly severe, with just 40 primary care physicians per 100,000 patients, which is far fewer than the recommended range of 60 to 80 primary care physicians per 100,000 patients. Furthermore, Latinos, African Americans, and Native Americans are vastly underrepresented in the physician workforce.

(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 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 Program established pursuant to Article 5 (commencing with Section 128550) of Chapter 5 of Part 3 of Division 107 of the Health and Safety Code.

(i) The appropriation of state funding in the annual Budget Act, in accordance with Section 16 of Assembly Bill 94 of the 2013–14 Regular Session, to the UCR medical school will add more physicians to underserved areas in inland southern California and help California meet the objectives of the federal Patient Protection and Affordable Care Act (Public Law 111-148) in the short term and the long term by expanding the physician workforce.

SEC. 2. The School of Medicine at the University of California, Riverside, 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 Program established pursuant to Article 5 (commencing with Section 128550) of Chapter 5 of Part 3 of Division 107 of the Health and Safety Code.

O

SB 62

OFFICE OF THE GOVERNOR

SEP 27 2013

To the Members of the California State Senate:

I am returning Senate Bill 62 without my signature.

The bill would require a county coroner to make a report to the Medical Board whenever a Schedule II, III or IV drug was found to be the cause of death.

While I am concerned about the harm caused by prescription drug misuse and overdose, the bill creates an unfunded mandate for the state, potentially in the millions of dollars.

Instead, I am signing SB 670, which gives the Medical Board better access to information needed to investigate suspicious deaths. I am also signing SB 809, which modestly increases practitioners' licensing fees to fund a sorely needed overhaul of the state's Controlled Substance Utilization Review and Evaluation System and Prescription Drug Monitoring Program.

I expect that these measures, along with more vigorous efforts by the Board, will help detect and prevent prescription drug abuse without further burdening taxpayers.

Sincerely,

Edmund G. Brown Jr.

GOVERNOR EDMUND G. BROWN JR. • SACRAMENTO, CALIFORNIA 95814 • (916) 445-2841

Senate Bill No. 62

Passed the Senate September 10, 2013

_____

Secretary of the Senate

Passed the Assembly September 9, 2013

_____

Chief Clerk of the Assembly

This bill was received by the Governor this _____ day of _____, 2013, at _____ o'clock ____M.

_____

Private Secretary of the Governor

CHAPTER _____

An act to amend, repeal, and add Section 802.5 of, and to add and repeal Section 2220.09 of, the Business and Professions Code, relating to coroners.

LEGISLATIVE COUNSEL'S DIGEST

SB 62, Lieu. 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, until January 1, 2018, would additionally require a coroner, when he or she receives information that indicates that the cause of death is due to a Schedule II, III, or IV drug, to provide that information, including whether the decedent was undergoing treatment for a terminal illness or chronic condition, if known, to the Medical Board of California on a form provided by the board and developed in consultation with the California State Coroners' Association. The bill would require that this form be submitted within 90 days, or as soon as possible, once the coroner's investigation is complete, and would provide that this form is confidential. By increasing the duties of county officers, this bill would create a state-mandated local program.

Existing law requires that any complaint against a physician and surgeon that is determined to involve quality of care meet certain criteria before it is referred to a field office for further investigation, except as specified.

This bill, until January 1, 2018, would require that any information received from a coroner pursuant to the provisions of this bill, that may be treated as a complaint against a physician

and surgeon and may be determined to involve quality of care, meet these criteria before referral to a field office for further investigation.

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

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

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

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

802.5. (a) When a coroner receives information that is based on findings that were reached by, or documented and approved by, a pathologist indicating that a death may be the result of a physician and surgeon's, podiatrist's, or physician assistant's gross negligence or incompetence, a report shall be filed with the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, or the Physician Assistant Board. The initial report shall include the name of the decedent, date and place of death, attending physicians, podiatrists, or physician assistants, and all other relevant information available. The initial report shall be followed, within 90 days or as soon as possible once the coroner's final report of investigation is complete, by copies of the coroner's report, autopsy protocol, and all other relevant information.

(b) When a coroner receives information that is based on findings that were reached by, or documented and approved by, a pathologist indicating that the cause of death is due to a Schedule II, III, or IV drug, the information regarding the death of the decedent, including whether the decedent was undergoing treatment for a terminal illness or chronic condition, if known, shall be provided by the coroner to the Medical Board of California. The information shall be submitted on a form provided by the board, which shall be developed in consultation with the California State Coroners' Association. The form shall be submitted within 90

days, or as soon as possible, once the coroner's investigation is complete. The form may be submitted electronically.

(c) A report required by subdivision (a), and the form provided by the coroner pursuant to subdivision (b), shall be confidential. No coroner, physician and surgeon, or medical examiner, nor any authorized agent, shall be liable for damages in any civil action as a result of his or her acting in compliance with subdivision (a) or (b). No pathologist, nor any authorized agent, shall be liable for damages in any civil action as a result of his or her providing information under subdivision (a) or (b).

(d) 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. 2. Section 802.5 is added to the Business and Professions Code, to read:

802.5. (a) When a coroner receives information that is based on findings that were reached by, or documented and approved by, a pathologist indicating that a death may be the result of a physician and surgeon's, podiatrist's, or physician assistant's gross negligence or incompetence, a report shall be filed with the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, or the Physician Assistant Board. The initial report shall include the name of the decedent, date and place of death, attending physicians, podiatrists, or physician assistants, and all other relevant information available. The initial report shall be followed, within 90 days or as soon as possible once the coroner's final report of investigation is complete, by copies of the coroner's report, autopsy protocol, and all other relevant information.

(b) A report required by subdivision (a) shall be confidential. No coroner, physician and surgeon, or medical examiner, nor any authorized agent, shall be liable for damages in any civil action as a result of his or her acting in compliance with subdivision (a). No pathologist, nor any authorized agent, shall be liable for damages in any civil action as a result of his or her providing information under subdivision (a).

(c) This section shall be operative on January 1, 2018.

SEC. 3. Section 2220.09 is added to the Business and Professions Code, to read:

2220.09. (a) In the case of information received from a coroner pursuant to subdivision (b) of Section 802.5 that may be treated as a complaint and may be determined to involve quality of care, the board shall follow the criteria provided in Section 2220.08 for the information that involves quality of care before referral to a field office for further investigation.

(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. 4. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

SIB 304

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 304
Author: Lieu
Chapter: 515
Bill Date: September 6, 2013, Amended
Subject: Healing Arts: Boards
Sponsor: Author
Position: Support if Amended

DESCRIPTION OF CURRENT LEGISLATION:

This is the Board's sunset bill, which includes language on a portion of the new issues from the Board's 2012 Sunset Review Report, and will extend the Board's sunset date for four years until July 1, 2018. This bill would also remove the sunset date from the provisions in existing law related to vertical enforcement.

There are some issues that are included in this bill that are not issues raised in the Board's sunset report. This bill requires the DCA director to approve the employment of the Board's selection of an Executive Director, if hired after January 1, 2014. This bill amends existing law regarding international medical graduates who have attended a disapproved school. Existing law passed in 2012 required these individuals to have practiced in another state, federal territory, or Canadian province for 20 years. This bill changes the practice requirement to 12 years.

This bill would also transfer all investigators and medical consultants employed by the Medical Board of California (Board) and their support staff to the Department of Consumer Affairs' (DCA) Division of Investigation (DOI).

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 and were/are included in this bill:

- 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. This bill requires the Board to send out a confirmation email to all physicians on an annual basis to ensure the Board has the correct email address for each physician.**

- 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 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 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 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 – **The language that was previously in this bill that would have required the complete expert reviewer report to be provided and that would have required the expert testimony information to be provided within 90 days from the filing of a notice of defense, was amended out of the bill due to issues raised by the California Medical Association.**
- The Board recommended that the provision in existing law that requires the Board to approve non-ABMS specialty boards be deleted. The Board suggested that the law should continue to require physicians to advertise as board certified only if they have been certified by ABMS boards and the four additional boards currently approved by the Board – **The language that was previously in this bill that would have deleted 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 was amended out of the bill due to heavy opposition and concerns raised.**
- 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 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 specifies that a licensee's failure to comply with an order to compel a physical or mental examination constitutes grounds for issuance of an interim suspension order.**
- 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 transfers the Board's investigators, medical consultants, and their support staff to the Department of Consumer Affairs' (DCA) Division of Investigation (DOI) and would create a new Health Quality Investigation Unit (HQIU) (previous amendments to the bill would have transferred the investigators and their support staff to the Department of Justice). The bill specifies that the transfer includes all sworn peace officer and medical consultant positions and all support staff positions for those peace officer and medical consultant positions. This bill further specifies that all civil service employees transferred shall retain their positions, status, and rights. This bill does not allow DCA to charge the Board an hourly rate for the performance of investigations. The transfer of the investigators, medical consultants, and their staff will occur no later than July 1, 2014.

This bill does not allow DCA to charge the Board an hourly rate for the performance of investigations. However, the overall intention of this language is that the transition be cost neutral to the Board.

The transfer of investigative staff means that Board investigators and support staff will become employees of DCA. The Board will retain control of receipt and triage of all complaints. Once a determination is made to investigate the matter, it will be referred to the new HQIU of DCA (formerly the Board's investigative unit). The HQIU will work with the Attorney General's Office (AGO) via the vertical enforcement/ prosecution model to investigate the allegations in complaints. At the completion of the investigation, the HQIU and the AGO will determine the appropriate disposition of the investigation, e.g. closure, referral to the District Attorney's office, referral to the AGO for the filing of an Accusation, referral to citation and fine, referral the Board for a pre-accusation public letter of reprimand, etc.

In the past, the case would then just continue through one of the avenues identified above for disposition. However, with the transition, the investigation and outcome of the case must be forwarded to the Board for review and concurrence with the suggested disposition.

Board staff must review the case disposition and determine whether the action taken by the HQIU and the AGO are warranted. If questions/concerns arise, then staff will need to discuss the matter with the AGO and HQIU. If the Board staff agrees with the outcome, the Board assumes control of the case and will either issue a citation and fine, follow the case through the administrative process (including review of the matter by the Board members), issue the public letter of reprimand, etc.

There are some issues that are included in this bill that are not issues raised in the Board's Sunset Report. This bill requires the DCA director to approve the employment of the Board's selection of an Executive Director, if hired after January 1, 2014. This bill also amends existing law regarding international medical graduates who have attended a disapproved school. Existing law passed in 2012 required these individuals to have practiced in another state, federal territory, or Canadian province for 20 years. This bill changes the practice requirement to 12 years.

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. The Board supported all the provisions in this bill except transferring the Board's investigators and their staff to DOI.

FISCAL: The intent is that the transfer of investigative staff be cost neutral to the Board.

SUPPORT: Center for Public Interest Law
Medical Board of California (if amended)

OPPOSITION: None on File

IMPLEMENTATION:

- Newsletter Article
- Notify/Train Board Staff
- Notify interested parties
- Work closely with DCA on the implementation plan for the transfer of investigators, medical consultants, and their support staff (this will be discussed at the Enforcement Committee)
- Update Web site to reflect all new changes to law that are included in this bill
- Revise renewal form to require email addresses to be reported if a physician has one
- Develop a process/procedure to send out a confirmation email to all physicians on an annual basis to ensure the Board has the correct email address for each physician
- Develop a process/procedure to ensure that 801.01 reports are excluded from the requirements in existing law that require an upfront review by a medical expert; these reports should go directly to investigative staff
- Notify the AGO to seek ISOs when a licensee fails to comply with an order to compel a physical or mental examination constitutes, as this is now grounds for issuance of an interim suspension order

Senate Bill No. 304

CHAPTER 515

An act to amend Sections 159.5, 160.5, 2001, 2020, 2021, 2135.7, 2177, 2220.08, 2225.5, 2514, 2569, 4800, 4804.5, 4809.5, 4809.7, and 4809.8 of, to amend, repeal, and add Sections 160 and 4836.1 of, to amend and add Section 2006 of, and to add Sections 2216.3, 2216.4, 2403, 4836.2, 4836.3, and 4836.4 to, the Business and Professions Code, to amend Sections 11529, 12529.6, and 12529.7 of, and to amend and repeal Sections 12529 and 12529.5 of, the Government Code, to amend Section 1248.15 of the Health and Safety Code, and to amend, repeal, and add Section 830.3 of the Penal Code, relating to healing arts, and making an appropriation therefor.

[Approved by Governor October 3, 2013. Filed with Secretary of State October 3, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

SB 304, Lieu. Healing arts: boards.

(1) Existing law provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Existing law authorizes the board to employ an executive director. Existing law provides that those provisions will be repealed on January 1, 2014, and, upon repeal, the board is subject to review by the Joint Sunset Review Committee.

This bill would instead repeal those provisions on January 1, 2018, and subject the board to review by the appropriate policy committees of the Legislature. The bill would authorize the board to employ an executive director by, and with the approval of, the Director of Consumer Affairs.

Existing law authorizes the board to issue a physician and surgeon's license to an applicant who acquired all or part of his or her medical education at a foreign medical school that is not recognized by the board if, among other requirements, the applicant has held an unlimited and unrestricted license as a physician and surgeon in another state or federal territory and has continuously practiced for a minimum of 10 years prior to the date of application or to an applicant who acquired any part of his or her professional instruction at a foreign medical school that has previously been disapproved by the board if, among other requirements, the applicant has held an unlimited and unrestricted license as a physician and surgeon in another state or federal territory and has continuously practiced for a minimum of 20 years prior to the date of application. For the purposes of these provisions, the board may combine the period of time that the applicant has held an unlimited and unrestricted license, but requires each applicant to have a minimum of 5 years continuous licensure and practice in a single state or federal territory.

This bill would instead authorize the board to issue a physician and surgeon's license to an applicant who acquired any part of his or her medical education from an unrecognized medical school if, among other requirements, the applicant has held an unlimited and unrestricted license as a physician and surgeon in another state, a federal territory, or a Canadian province and has continuously practiced for a minimum of 10 years prior to the date of application, or from a disapproved medical school if, among other requirements, the applicant has held an unlimited and unrestricted license as a physician and surgeon in another state, a federal territory, or a Canadian province and has continuously practiced for a minimum of 12 years prior to the date of application. The bill would reduce the minimum number of years that each applicant must have continuous licensure and practice in a single state or federal territory to 2 years and permit the period of continuous licensure and practice to occur in a Canadian province.

Existing law authorizes the Medical Board of California, if it publishes a directory of its licensees, as specified, to require persons licensed, as specified, to furnish specified information to the board for purposes of compiling the directory.

This bill would require that an applicant and licensee who has an electronic mail address report to the board that electronic mail address no later than July 1, 2014. The bill would provide that the electronic mail address is to be considered confidential, as specified.

Existing law requires an applicant for a physician and surgeon's certificate to obtain a passing score on Step 3 of the United States Medical Licensing Examination with not more than 4 attempts, subject to an exception.

This bill would require an applicant to have obtained a passing score on all parts of that examination with not more than 4 attempts, subject to the exception.

Existing law requires that a complaint, with exceptions, received by the board determined to involve quality of care, before referral to a field office for further investigation, meet certain criteria.

This bill would expand the types of reports that are exempted from that requirement.

Existing law provides for a civil penalty of up to $1,000 per day, as specified, to be imposed on a health care facility that fails to comply with a patient's medical record request, as specified, within 30 days.

This bill would shorten the time limit for compliance to 15 days for those health care facilities that have electronic health records.

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 or doctors of podiatric medicine enrolled in approved residency postgraduate training programs or fellowship programs.

(2) Existing law, the Licensed Midwifery Practice Act of 1993, provides for the licensure and regulation of 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.

(3) 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.

(4) Existing law provides for the accreditation of outpatient settings, as defined, by the Medical Board of California, and requires outpatient settings to report adverse events, as defined, to the State Department of Public Health within specified time limits. Existing law provides for the imposition of a civil penalty in the event that an adverse event is not reported within the applicable time limit.

This bill would instead require those outpatient settings to report adverse events to the Medical Board of California within specified time limits and authorize the board to impose a civil penalty if an outpatient setting fails to timely report an adverse event.

(5) Existing law establishes the Medical Quality Hearing Panel, consisting of no fewer than 5 administrative law judges with certain medical training, within the Office of Administrative Hearings. Existing law authorizes those administrative law judges to issue interim orders suspending a license, or imposing drug testing, continuing education, supervision of procedures, or other license restrictions. Existing law requires that in all of those cases in which an interim order is issued, and an accusation is not filed and served within 15 days of the date in which the parties to the hearing have submitted the matter, the order be dissolved.

Under existing law, if a healing arts practitioner is unable to practice his or her profession safely due to mental or physical illness, his or her licensing agency may order the practitioner to be examined by specified professionals.

This bill would extend the time in which the accusation must be filed and served to 30 days from the date on which the parties to the hearing submitted the matter. The bill would also provide that a physician and surgeon's failure to comply with an order to be examined may constitute grounds for an administrative law judge of the Medical Quality Hearing Panel to issue an interim suspension order.

Existing law establishes the Health Quality Enforcement Section within the Department of Justice to investigate and prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, the Board of

Psychology, or any committee under the jurisdiction of the Medical Board of California. Existing law provides for the funding for the section, and for the appointment of a Senior Assistant Attorney General to the section to carry out specified duties. Existing law requires that all complaints or relevant information concerning licensees that are within the jurisdiction of the boards served by the Health Quality Enforcement Section be made available to the Health Quality Enforcement Section. Existing law establishes the procedures for processing the complaints, assisting the boards or committees in establishing training programs for their staff, and for determining whether to bring a disciplinary proceeding against a licensee of the boards. Existing law provides for the repeal of those provisions, as provided, on January 1, 2014.

This bill would extend the operation of those provisions indefinitely and make those provisions applicable to the Physical Therapy Board of California and licensees within its jurisdiction.

Existing law establishes, until January 1, 2014, a vertical enforcement and prosecution model for cases before the Medical Board of California and requires the board to report to the Governor and Legislature on that model by March 1, 2012.

This bill would extend the date that report is due to March 1, 2015.

Existing law creates the Division of Investigation within the Department of Consumer Affairs and requires investigators who have the authority of peace officers to be in the division, except that investigators of the Medical Board of California and the Dental Board of California who have that authority are not required to be in the division.

This bill would require, effective July 1, 2014, that investigators of the Medical Board of California who have the authority of a peace officer be in the division and would protect the positions, status, and rights of those employees who are subsequently transferred as a result of these provisions. The bill would also, effective July 1, 2014, create within the Division of Investigation the Health Quality Investigation Unit.

(6) Existing law, the Veterinary Medicine Practice Act, provides for the licensure and registration of veterinarians and registered veterinary technicians and the regulation of the practice of veterinary medicine by the Veterinary Medical Board. Existing law repeals the provisions establishing the board, and authorizing the board to appoint an executive officer, as of January 1, 2014. Under existing law, the board is subject to evaluation by the Joint Sunset Review Committee prior to its repeal.

This bill would provide that those provisions are instead repealed as of January 1, 2016. The bill, upon repeal of the board, would require that the board be subject to a specifically limited review by the appropriate policy committees of the Legislature.

Existing law authorizes the board, at any time, to inspect the premises in which veterinary medicine, veterinary dentistry, or veterinary surgery is being practiced and requires that those premises be registered with the board. Existing law requires the board to establish a regular inspection program that will provide for random, unannounced inspections.

This bill would require the board to make every effort to inspect at least 20% of veterinary premises on an annual basis and would exclude from inspection those premises that are not registered with the board.

Existing law requires the board to establish an advisory committee, the Veterinary Medicine Multidisciplinary Advisory Committee, to assist, advise, and make recommendations for the implementation of rules and regulations necessary to ensure proper administration and enforcement of specified provisions and to assist the board in its examination, licensure, and registration programs. Existing law requires the committee to consist of 7 members, with 4 licensed veterinarians, 2 registered veterinary technicians, and one public member.

This bill would expand the number of members on the committee to 9 by including one veterinarian member of the board, to be appointed by the board president, and the registered veterinary technician of the board, both of whom would serve concurrently with their terms of office on the board. The bill would additionally require that the committee serve only in an advisory capacity to the board, as specified. The bill would make other technical and conforming changes.

Existing law authorizes a registered veterinary technician or a veterinary assistant to administer a drug under the direct or indirect supervision of a licensed veterinarian when administered pursuant to the order, control, and full professional responsibility of a licensed veterinarian. Existing law limits access to controlled substances by veterinary assistants to persons who have undergone a background check and who, to the best of the licensee manager's knowledge, do not have any drug- or alcohol-related felony convictions. A violation of these provisions is a crime. Existing law repeals these provisions on January 1, 2015.

This bill would instead require, until the later of January 1, 2015, or the effective date of a specified legislative determination, a licensee manager to conduct a background check on a veterinary assistant prior to authorizing him or her to obtain or administer a controlled substance by the order of a supervising veterinarian and to prohibit the veterinary assistant from obtaining or administering controlled substances if the veterinary assistant has a drug- or alcohol-related felony conviction. Because a violation of these provisions would be a crime, this bill imposes a state-mandated local program.

This bill would require that, upon the later of January 1, 2015, or the effective date of a specified legislative determination, a veterinary assistant be designated by a licensed veterinarian and hold a valid veterinary assistant controlled substances permit from the board in order to obtain or administer controlled substances. The bill would, as part of the application for a permit, require an applicant to furnish a set of fingerprints to the Department of Justice for the purposes of conducting both a state and federal criminal history record check. The bill would require an applicant for a veterinary assistant controlled substances permit to apply for a renewal of his or her permit on or before the last day of the applicant's birthday month and to update his or her mailing or employer address with the board. The bill would

authorize the board to collect a filing fee, not to exceed $100, from applicants for a veterinary assistant controlled substances permit. Because that fee would be deposited in the Veterinary Medical Board Contingent Fund, which is a continuously appropriated fund, the bill would make an appropriation.

(7) This bill would incorporate additional changes to Section 11529 of the Government Code proposed by SB 670 that would become operative if this bill and SB 670 are enacted and this bill is chaptered last.

(8) 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.

Appropriation: yes.

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

SECTION 1. Section 159.5 of the Business and Professions Code is amended to read:

159.5. (a) (1) There is in the department the Division of Investigation. The division is in the charge of a person with the title of chief of the division.

(2) Except as provided in Section 160, investigators who have the authority of peace officers, as specified in subdivision (a) of Section 160 and in subdivision (a) of Section 830.3 of the Penal Code, shall be in the division and shall be appointed by the director.

(b) (1) There is in the Division of Investigation the Health Quality Investigation Unit. The primary responsibility of the unit is to investigate violations of law or regulation within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Psychology, the Osteopathic Medical Board of California, the Physician Assistant Board, or any entities under the jurisdiction of the Medical Board of California.

(2) The Medical Board of California shall not be charged an hourly rate for the performance of investigations by the unit.

(3) This subdivision shall become operative on July 1, 2014.

SEC. 2. Section 160 of the Business and Professions Code is amended to read:

160. (a) The chief and all investigators of the Division of Investigation of the department and all investigators of the Medical Board of California and the Dental Board of California have the authority of peace officers while engaged in exercising the powers granted or performing the duties imposed upon them or the division in investigating the laws administered by the various boards comprising the department or commencing directly or indirectly any criminal prosecution arising from any investigation conducted under these laws. All persons herein referred to shall be deemed to be acting

within the scope of employment with respect to all acts and matters set forth in this section.

(b) The Division of Investigation of the department, the Medical Board of California, and the Dental Board of California may employ individuals, who are not peace officers, to provide investigative services.

(c) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2015, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 3. Section 160 is added to the Business and Professions Code, to read:

160. (a) The chief and all investigators of the Division of Investigation of the department and all investigators of the Dental Board of California have the authority of peace officers while engaged in exercising the powers granted or performing the duties imposed upon them or the division in investigating the laws administered by the various boards comprising the department or commencing directly or indirectly any criminal prosecution arising from any investigation conducted under these laws. All persons herein referred to shall be deemed to be acting within the scope of employment with respect to all acts and matters set forth in this section.

(b) The Division of Investigation of the department and the Dental Board of California may employ individuals, who are not peace officers, to provide investigative services.

(c) This section shall become operative on July 1, 2014.

SEC. 4. Section 160.5 of the Business and Professions Code is amended to read:

160.5. (a) All civil service employees currently employed by the Board of Dental Examiners of the Department of Consumer Affairs, whose functions are transferred as a result of the act adding this section shall retain their positions, status, and rights pursuant to Section 19050.9 of the Government Code and the State Civil Service Act (Part 2 (commencing with Section 18500) of Division 5 of Title 2 of the Government Code). The transfer of employees as a result of the act adding this section shall occur no later than July 1, 1999.

(b) (1) All civil service employees currently employed by the Medical Board of California of the Department of Consumer Affairs, whose functions are transferred as a result of the act adding this subdivision shall retain their positions, status, and rights pursuant to Section 19050.9 of the Government Code and the State Civil Service Act (Part 2 (commencing with Section 18500) of Division 5 of Title 2 of the Government Code). The transfer of employees as a result of the act adding this subdivision shall occur no later than July 1, 2014.

(2) The transfer of employees pursuant to this subdivision shall include all peace officer and medical consultant positions and all staff support positions for those peace officer and medical consultant positions.

SEC. 5. Section 2001 of the Business and Professions Code is amended to read:

2001. (a) There is in the Department of Consumer Affairs a Medical Board of California that consists of 15 members, 7 of whom shall be public members.

(b) The Governor shall appoint 13 members to the board, subject to confirmation by the Senate, 5 of whom shall be public members. The Senate Committee on Rules and the Speaker of the Assembly shall each appoint a public member.

(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. 6. Section 2006 of the Business and Professions Code is amended to read:

2006. (a) Any reference in this chapter to an investigation by the board shall be deemed to refer to a joint investigation conducted by employees of the Department of Justice and the board under the vertical enforcement and prosecution model, as specified in Section 12529.6 of the Government Code.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2015, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 7. Section 2006 is added to the Business and Professions Code, to read:

2006. (a) Any reference in this chapter to an investigation by the board shall be deemed to refer to a joint investigation conducted by employees of the Department of Justice and the Health Quality Investigation Unit under the vertical enforcement and prosecution model, as specified in Section 12529.6 of the Government Code.

(b) This section shall become operative on July 1, 2014.

SEC. 8. Section 2020 of the Business and Professions Code is amended to read:

2020. (a) The board, by and with the approval of the director, may employ an executive director exempt from the provisions of the Civil Service Act and may also employ investigators, legal counsel, medical consultants, and other assistance as it may deem necessary to carry this chapter into effect. The board may fix the compensation to be paid for services subject to the provisions of applicable state laws and regulations and may incur other expenses as it may deem necessary. Investigators employed by the board shall be provided special training in investigating medical practice activities.

(b) The Attorney General shall act as legal counsel for the board for any judicial and administrative proceedings and his or her services shall be a charge against it.

(c) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.

SEC. 9. Section 2021 of the Business and Professions Code is amended to read:

2021. (a) If the board publishes a directory pursuant to Section 112, it may require persons licensed pursuant to this chapter to furnish any information as it may deem necessary to enable it to compile the directory.

(b) Each licensee shall report to the board each and every change of address within 30 days after each change, giving both the old and new address. If an address reported to the board at the time of application for licensure or subsequently is a post office box, the applicant shall also provide the board with a street address. If another address is the licensee's address of record, he or she may request that the second address not be disclosed to the public.

(c) Each licensee shall report to the board each and every change of name within 30 days after each change, giving both the old and new names.

(d) Each applicant and licensee who has an electronic mail address shall report to the board that electronic mail address no later than July 1, 2014. The electronic mail address shall be considered confidential and not subject to public disclosure.

(e) The board shall annually send an electronic notice to each applicant and licensee that requests confirmation from the applicant or licensee that his or her electronic mail address is current.

SEC. 10. Section 2135.7 of the Business and Professions Code is amended to read:

2135.7. (a) Upon review and recommendation, the board may determine that an applicant for a physician and surgeon's certificate who acquired his or her medical education or a portion thereof at a foreign medical school that is not recognized or has been previously disapproved by the board is eligible for a physician and surgeon's certificate if the applicant meets all of the following criteria:

(1) Has successfully completed a resident course of medical education leading to a degree of medical doctor equivalent to that specified in Sections 2089 to 2091.2, inclusive.

(2) (A) (i) For an applicant who acquired any part of his or her medical education from an unrecognized foreign medical school, he or she holds an unlimited and unrestricted license as a physician and surgeon in another state, a federal territory, or a Canadian province and has held that license and continuously practiced for a minimum of 10 years prior to the date of application.

(ii) For an applicant who acquired any part of his or her professional instruction from a foreign medical school that was disapproved by the board at the time he or she attended the school, he or she holds an unlimited and unrestricted license as a physician and surgeon in another state, a federal territory, or a Canadian province and has held that license and continuously practiced for a minimum of 12 years prior to the date of application.

(B) For the purposes of clauses (i) and (ii) of subparagraph (A), the board may combine the period of time that the applicant has held an unlimited and unrestricted license in other states, federal territories, or Canadian

provinces and continuously practiced therein, but each applicant under this section shall have a minimum of two years continuous licensure and practice in a single state, federal territory, or Canadian province. For purposes of this paragraph, continuous licensure and practice includes any postgraduate training after 24 months in a postgraduate training program that is accredited by the Accreditation Council for Graduate Medical Education (ACGME) or postgraduate training completed in Canada that is accredited by the Royal College of Physicians and Surgeons of Canada (RCPSC).

(3) Is certified by a specialty board that is a member board of the American Board of Medical Specialties.

(4) Has successfully taken and passed the examinations described in Article 9 (commencing with Section 2170).

(5) Has not been the subject of a disciplinary action by a medical licensing authority or of adverse judgments or settlements resulting from the practice of medicine that the board determines constitutes a pattern of negligence or incompetence.

(6) Has successfully completed three years of approved postgraduate training. The postgraduate training required by this paragraph shall have been obtained in a postgraduate training program accredited by the ACGME or postgraduate training completed in Canada that is accredited by the RCPSC.

(7) Is not subject to denial of licensure under Division 1.5 (commencing with Section 475) or Article 12 (commencing with Section 2220).

(8) Has not held a healing arts license and been the subject of disciplinary action by a healing arts board of this state or by another state, federal territory, or Canadian province.

(b) The board may adopt regulations to establish procedures for accepting transcripts, diplomas, and other supporting information and records when the originals are not available due to circumstances outside the applicant's control. The board may also adopt regulations authorizing the substitution of additional specialty board certifications for years of practice or licensure when considering the certification for a physician and surgeon pursuant to this section.

(c) This section shall not apply to a person seeking to participate in a program described in Sections 2072, 2073, 2111, 2112, 2113, 2115, or 2168, or seeking to engage in postgraduate training in this state.

SEC. 11. Section 2177 of the Business and Professions Code is amended to read:

2177. (a) A passing score is required for an entire examination or for each part of an examination, as established by resolution of the board.

(b) Applicants may elect to take the written examinations conducted or accepted by the board in separate parts.

(c) (1) An applicant shall have obtained a passing score on all parts of Step 3 of the United States Medical Licensing Examination within not more than four attempts in order to be eligible for a physician's and surgeon's certificate.

(2) Notwithstanding paragraph (1), an applicant who obtains a passing score on all parts of Step 3 of the United States Medical Licensing Examination in more than four attempts and who meets the requirements of Section 2135.5 shall be eligible to be considered for issuance of a physician's and surgeon's certificate.

SEC. 12. Section 2216.3 is added to the Business and Professions Code, to read:

2216.3. (a) An outpatient setting accredited pursuant to Section 1248.1 of the Health and Safety Code shall report an adverse event to the board no later than five days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected. Disclosure of individually identifiable patient information shall be consistent with applicable law.

(b) For the purposes of this section, "adverse event" has the same meaning as in subdivision (b) of Section 1279.1 of the Health and Safety Code.

SEC. 13. Section 2216.4 is added to the Business and Professions Code, to read:

2216.4. If an accredited outpatient setting fails to report an adverse event pursuant to Section 2216.3, the board may assess the accredited outpatient setting a civil penalty in an amount not to exceed one hundred dollars ($100) for each day that the adverse event is not reported following the initial five-day period or 24-hour period, as applicable. If the accredited outpatient setting disputes a determination by the board regarding an alleged failure to report an adverse event, the accredited outpatient setting may, within 10 days of notification of the board's determination, request a hearing, which shall be conducted pursuant to the administrative adjudication provisions of Chapter 4.5 (commencing with Section 11400) and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. Penalties shall be paid when appeals pursuant to those provisions have been exhausted.

SEC. 14. Section 2220.08 of the Business and Professions Code is amended to read:

2220.08. (a) Except for reports received by the board pursuant to Section 801.01 or 805 that may be treated as complaints by the board and new complaints relating to a physician and surgeon who is the subject of a pending accusation or investigation or who is on probation, any complaint determined to involve quality of care, before referral to a field office for further investigation, shall meet the following criteria:

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

(2) It shall include the review of the following, which shall be requested by the board:

(A) Relevant patient records.

(B) The statement or explanation of the care and treatment provided by the physician and surgeon.

(C) Any additional expert testimony or literature provided by the physician and surgeon.

(D) Any additional facts or information requested by the medical expert reviewers that may assist them in determining whether the care rendered constitutes a departure from the standard of care.

(b) If the board does not receive the information requested pursuant to paragraph (2) of subdivision (a) within 10 working days of requesting that information, the complaint may be reviewed by the medical experts and referred to a field office for investigation without the information.

(c) Nothing in this section shall impede the board's ability to seek and obtain an interim suspension order or other emergency relief.

SEC. 15. Section 2225.5 of the Business and Professions Code is amended to read:

2225.5. (a) (1) A licensee who fails or refuses to comply with a request for the certified medical records of a patient, that is accompanied by that patient's written authorization for release of records to the board, within 15 days of receiving the request and authorization, shall pay to the board a civil penalty of one thousand dollars ($1,000) per day for each day that the documents have not been produced after the 15th day, up to ten thousand dollars ($10,000), unless the licensee is unable to provide the documents within this time period for good cause.

(2) A health care facility shall comply with a request for the certified medical records of a patient that is accompanied by that patient's written authorization for release of records to the board together with a notice citing this section and describing the penalties for failure to comply with this section. Failure to provide the authorizing patient's certified medical records to the board within 30 days of receiving the request, authorization, and notice shall subject the health care facility to a civil penalty, payable to the board, of up to one thousand dollars ($1,000) per day for each day that the documents have not been produced after the 30th day, up to ten thousand dollars ($10,000), unless the health care facility is unable to provide the documents within this time period for good cause. For health care facilities that have electronic health records, failure to provide the authorizing patient's certified medical records to the board within 15 days of receiving the request, authorization, and notice shall subject the health care facility to a civil penalty, payable to the board, of up to one thousand dollars ($1,000) per day for each day that the documents have not been produced after the 15th day, up to ten thousand dollars ($10,000), unless the health care facility is unable to provide the documents within this time period for good cause. This paragraph shall not require health care facilities to assist the board in obtaining the patient's authorization. The board shall pay the reasonable costs of copying the certified medical records.

(b) (1) A licensee who fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the board shall pay to the board a civil penalty of one thousand dollars

($1,000) per day for each day that the documents have not been produced after the date by which the court order requires the documents to be produced, up to ten thousand dollars ($10,000), unless it is determined that the order is unlawful or invalid. Any statute of limitations applicable to the filing of an accusation by the board shall be tolled during the period the licensee is out of compliance with the court order and during any related appeals.

(2) Any licensee who fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the board is guilty of a misdemeanor punishable by a fine payable to the board not to exceed five thousand dollars ($5,000). The fine shall be added to the licensee's renewal fee if it is not paid by the next succeeding renewal date. Any statute of limitations applicable to the filing of an accusation by the board shall be tolled during the period the licensee is out of compliance with the court order and during any related appeals.

(3) A health care facility that fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of patient records to the board, that is accompanied by a notice citing this section and describing the penalties for failure to comply with this section, shall pay to the board a civil penalty of up to one thousand dollars ($1,000) per day for each day that the documents have not been produced, up to ten thousand dollars ($10,000), after the date by which the court order requires the documents to be produced, unless it is determined that the order is unlawful or invalid. Any statute of limitations applicable to the filing of an accusation by the board against a licensee shall be tolled during the period the health care facility is out of compliance with the court order and during any related appeals.

(4) Any health care facility that fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the board is guilty of a misdemeanor punishable by a fine payable to the board not to exceed five thousand dollars ($5,000). Any statute of limitations applicable to the filing of an accusation by the board against a licensee shall be tolled during the period the health care facility is out of compliance with the court order and during any related appeals.

(c) Multiple acts by a licensee in violation of subdivision (b) shall be punishable by a fine not to exceed five thousand dollars ($5,000) or by imprisonment in a county jail not exceeding six months, or by both that fine and imprisonment. Multiple acts by a health care facility in violation of subdivision (b) shall be punishable by a fine not to exceed five thousand dollars ($5,000) and shall be reported to the State Department of Public Health and shall be considered as grounds for disciplinary action with respect to licensure, including suspension or revocation of the license or certificate.

(d) A failure or refusal of a licensee to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the board constitutes unprofessional conduct and is grounds for suspension or revocation of his or her license.

(e) Imposition of the civil penalties authorized by this section shall be in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Division 3 of Title 2 of the Government Code).

(f) For purposes of this section, "certified medical records" means a copy of the patient's medical records authenticated by the licensee or health care facility, as appropriate, on a form prescribed by the board.

(g) For purposes of this section, a "health care facility" means a clinic or health facility licensed or exempt from licensure pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.

SEC. 16. 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 or doctors of podiatric medicine enrolled in approved residency postgraduate training programs or fellowship programs.

SEC. 17. 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. 18. 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. 19. Section 4800 of the Business and Professions Code is amended to read:

4800. (a) There is in the Department of Consumer Affairs a Veterinary Medical Board in which the administration of this chapter is vested. The board consists of the following members:

(1) Four licensed veterinarians.

(2) One registered veterinary technician.

(3) Three public members.

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

(c) Notwithstanding any other law, the repeal of this section renders the board subject to review by the appropriate policy committees of the Legislature. However, the review of the board shall be limited to those issues identified by the appropriate policy committees of the Legislature and shall not involve the preparation or submission of a sunset review document or evaluative questionnaire.

SEC. 20. Section 4804.5 of the Business and Professions Code is amended to read:

4804.5. 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.

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

SEC. 21. Section 4809.5 of the Business and Professions Code is amended to read:

4809.5. The board may at any time inspect the premises in which veterinary medicine, veterinary dentistry, or veterinary surgery is being practiced. The board's inspection authority does not extend to premises that are not registered with the board. Nothing in this section shall be construed to affect the board's ability to investigate alleged unlicensed activity or to inspect a premises for which registration has lapsed or is delinquent.

SEC. 22. Section 4809.7 of the Business and Professions Code is amended to read:

4809.7. The board shall establish a regular inspection program that will provide for random, unannounced inspections. The board shall make every effort to inspect at least 20 percent of veterinary premises on an annual basis.

SEC. 23. Section 4809.8 of the Business and Professions Code is amended to read:

4809.8. (a) The board shall establish an advisory committee to assist, advise, and make recommendations for the implementation of rules and regulations necessary to ensure proper administration and enforcement of this chapter and to assist the board in its examination, licensure, and registration programs. The committee shall serve only in an advisory capacity to the board and the objectives, duties, and actions of the committee shall not be a substitute for or conflict with any of the powers, duties, and responsibilities of the board. The committee shall be known as the Veterinary Medicine Multidisciplinary Advisory Committee. The multidisciplinary committee shall consist of nine members. The following members of the multidisciplinary committee shall be appointed by the board from lists of nominees solicited by the board: four licensed veterinarians, two registered veterinary technicians, and one public member. The committee shall also include one veterinarian member of the board, to be appointed by the board president, and the registered veterinary technician member of the board. Members of the multidisciplinary committee shall represent a sufficient

cross section of the interests in veterinary medicine in order to address the issues before it, as determined by the board, including veterinarians, registered veterinary technicians, and members of the public.

(b) Multidisciplinary committee members appointed by the board shall serve for a term of three years and appointments shall be staggered accordingly. A member may be reappointed, but no person shall serve as a member of the committee for more than two consecutive terms. Vacancies occurring shall be filled by appointment for the unexpired term, within 90 days after they occur. Board members of the multidisciplinary committee shall serve concurrently with their terms of office on the board.

(c) The multidisciplinary committee shall be subject to the requirements of Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code.

(d) Multidisciplinary committee members shall receive a per diem as provided in Section 103 and shall be compensated for their actual travel expenses in accordance with the rules and regulations adopted by the Department of Human Resources.

(e) The board may remove a member of the multidisciplinary committee appointed by the board for continued neglect of a duty required by this chapter, for incompetency, or for unprofessional conduct.

(f) It is the intent of the Legislature that the multidisciplinary committee, in implementing this section, give appropriate consideration to issues pertaining to the practice of registered veterinarian technicians.

SEC. 24. Section 4836.1 of the Business and Professions Code is amended to read:

4836.1. (a) Notwithstanding any other provision of law, a registered veterinary technician or a veterinary assistant may administer a drug, including, but not limited to, a drug that is a controlled substance, under the direct or indirect supervision of a licensed veterinarian when done pursuant to the order, control, and full professional responsibility of a licensed veterinarian. However, no person, other than a licensed veterinarian, may induce anesthesia unless authorized by regulation of the board.

(b) Prior to authorizing a veterinary assistant to obtain or administer a controlled substance by the order of a supervising veterinarian, the licensee manager in a veterinary practice shall conduct a background check on that veterinary assistant. A veterinary assistant who has a drug- or alcohol-related felony conviction, as indicated in the background check, shall be prohibited from obtaining or administering controlled substances.

(c) Notwithstanding subdivision (b), if the Veterinary Medical Board, in consultation with the Board of Pharmacy, identifies a dangerous drug, as defined in Section 4022, as a drug that has an established pattern of being diverted, the Veterinary Medical Board may restrict access to that drug by veterinary assistants.

(d) For purposes of this section, the following definitions apply:

(1) "Controlled substance" has the same meaning as that term is defined in Section 11007 of the Health and Safety Code.

(2) "Direct supervision" has the same meaning as that term is defined in subdivision (e) of Section 2034 of Title 16 of the California Code of Regulations.

(3) "Drug" has the same meaning as that term is defined in Section 11014 of the Health and Safety Code.

(4) "Indirect supervision" has the same meaning as that term is defined in subdivision (f) of Section 2034 of Title 16 of the California Code of Regulations.

(e) This section shall become inoperative on the later of January 1, 2015, or the date Section 4836.2 becomes operative, and, as of January 1 next following that date, is repealed, unless a later enacted statute, that becomes operative on or before that date, deletes or extends the dates on which it becomes inoperative is repealed.

SEC. 25. Section 4836.1 is added to the Business and Professions Code, to read:

4836.1. (a) Notwithstanding any other law, a registered veterinary technician or a veterinary assistant may administer a drug, including, but not limited to, a drug that is a controlled substance, under the direct or indirect supervision of a licensed veterinarian when done pursuant to the order, control, and full professional responsibility of a licensed veterinarian. However, no person, other than a licensed veterinarian, may induce anesthesia unless authorized by regulation of the board.

(b) A veterinary assistant may obtain or administer a controlled substance pursuant to the order, control, and full professional responsibility of a licensed veterinarian, only if he or she meets both of the following conditions:

(1) Is designated by a licensed veterinarian to obtain or administer controlled substances.

(2) Holds a valid veterinary assistant controlled substance permit issued pursuant to Section 4836.2.

(c) Notwithstanding subdivision (b), if the Veterinary Medical Board, in consultation with the Board of Pharmacy, identifies a dangerous drug, as defined in Section 4022, as a drug that has an established pattern of being diverted, the Veterinary Medical Board may restrict access to that drug by veterinary assistants.

(d) For purposes of this section, the following definitions apply:

(1) "Controlled substance" has the same meaning as that term is defined in Section 11007 of the Health and Safety Code.

(2) "Direct supervision" has the same meaning as that term is defined in subdivision (e) of Section 2034 of Title 16 of the California Code of Regulations.

(3) "Drug" has the same meaning as that term is defined in Section 11014 of the Health and Safety Code.

(4) "Indirect supervision" has the same meaning as that term is defined in subdivision (f) of Section 2034 of Title 16 of the California Code of Regulations.

(e) This section shall become operative on the date Section 4836.2 becomes operative.

SEC. 26. Section 4836.2 is added to the Business and Professions Code, to read:

4836.2. (a) Applications for a veterinary assistant controlled substance permit shall be upon a form furnished by the board.

(b) The fee for filing an application for a veterinary assistant controlled substance permit shall be set by the board in an amount the board determines is reasonably necessary to provide sufficient funds to carry out the purposes of this section, not to exceed one hundred dollars ($100).

(c) The board may deny, suspend, or revoke the controlled substance permit of a veterinary assistant after notice and hearing for any cause provided in this subdivision. The proceedings under this section shall be conducted in accordance with the provisions for administrative adjudication in Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the board shall have all the powers granted therein. The board may revoke or suspend a veterinary assistant controlled substance permit for any of the following reasons:

(1) The employment of fraud, misrepresentation, or deception in obtaining a veterinary assistant controlled substance permit.

(2) Chronic inebriety or habitual use of controlled substances.

(3) Violating or attempts to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter, or of the regulations adopted under this chapter.

(d) The board shall not issue a veterinary assistant controlled substance permit to any applicant with a state or federal felony controlled substance conviction.

(e) The board shall revoke a veterinary assistant controlled substance permit upon notification that the veterinary assistant to whom the license is issued has been convicted of a state or federal felony controlled substance violation.

(f) (1) As part of the application for a veterinary assistant controlled substance permit, the applicant shall submit to the Department of Justice fingerprint images and related information, as required by the Department of Justice for all veterinary assistant applicants, for the purposes of obtaining information as to the existence and content of a record of state or federal convictions and state or federal arrests and information as to the existence and content of a record of state or federal arrests for which the Department of Justice establishes that the person is free on bail or on his or her own recognizance pending trial or appeal.

(2) When received, the Department of Justice shall forward to the Federal Bureau of Investigation requests for federal summary criminal history information that it receives pursuant to this section. The Department of Justice shall review any information returned to it from the Federal Bureau of Investigation and compile and disseminate a response to the board summarizing that information.

(3) The Department of Justice shall provide a state or federal level response to the board pursuant to paragraph (1) of subdivision (p) of Section 11105 of the Penal Code.

(4) The Department of Justice shall charge a reasonable fee sufficient to cover the cost of processing the request described in this subdivision.

(g) The board shall request from the Department of Justice subsequent notification service, as provided pursuant to Section 11105.2 of the Penal Code, for persons described in paragraph (1) of subdivision (f).

(h) This section shall become operative upon the later of January 1, 2015, or the effective date of the statute in which the Legislature makes a determination that the board has sufficient staffing to implement this section.

SEC. 27. Section 4836.3 is added to the Business and Professions Code, to read:

4836.3. (a) Each person who has been issued a veterinary assistant controlled substance permit by the board pursuant to Section 4836.2 shall biennially apply for renewal of his or her permit on or before the last day of the applicant's birthday month. The application shall be made on a form provided by the board.

(b) The application shall contain a statement to the effect that the applicant has not been convicted of a felony, has not been the subject of professional disciplinary action taken by any public agency in California or any other state or territory, and has not violated any of the provisions of this chapter. If the applicant is unable to make that statement, the application shall contain a statement of the conviction, professional discipline, or violation.

(c) The board may, as part of the renewal process, make necessary inquiries of the applicant and conduct an investigation in order to determine if cause for disciplinary action exists.

(d) The fee for filing an application for a renewal of a veterinary assistant controlled substance permit shall be set by the board in an amount the board determines is reasonably necessary to provide sufficient funds to carry out the purposes of this section, not to exceed fifty dollars ($50).

(e) This section shall become operative on the date Section 4836.2 becomes operative.

SEC. 28. Section 4836.4 is added to the Business and Professions Code, to read:

4836.4. (a) Every person who has been issued a veterinary assistant controlled substance permit by the board pursuant to Section 4836.2 who changes his or her mailing or employer address shall notify the board of his or her new mailing or employer address within 30 days of the change. The board shall not renew the permit of any person who fails to comply with this section unless the person pays the penalty fee prescribed in Section 4842.5. An applicant for the renewal of a permit shall specify in his or her application whether he or she has changed his or her mailing or employer address and the board may accept that statement as evidence of the fact.

(b) This section shall become operative on the date Section 4836.2 becomes operative.

SEC. 29. Section 11529 of the Government Code is amended to read:

11529. (a) The administrative law judge of the Medical Quality Hearing Panel established pursuant to Section 11371 may issue an interim order suspending a license, or imposing drug testing, continuing education, supervision of procedures, or other license restrictions. Interim orders may be issued only if the affidavits in support of the petition show that the licensee has engaged in, or is about to engage in, acts or omissions constituting a violation of the Medical Practice Act or the appropriate practice act governing each allied health profession, or is unable to practice safely due to a mental or physical condition, and that permitting the licensee to continue to engage in the profession for which the license was issued will endanger the public health, safety, or welfare. The failure to comply with an order issued pursuant to Section 820 of the Business and Professions Code may constitute grounds to issue an interim suspension order under this section.

(b) All orders authorized by this section shall be issued only after a hearing conducted pursuant to subdivision (d), unless it appears from the facts shown by affidavit that serious injury would result to the public before the matter can be heard on notice. Except as provided in subdivision (c), the licensee shall receive at least 15 days' prior notice of the hearing, which notice shall include affidavits and all other information in support of the order.

(c) If an interim order is issued without notice, the administrative law judge who issued the order without notice shall cause the licensee to be notified of the order, including affidavits and all other information in support of the order by a 24-hour delivery service. That notice shall also include the date of the hearing on the order, which shall be conducted in accordance with the requirement of subdivision (d), not later than 20 days from the date of issuance. The order shall be dissolved unless the requirements of subdivision (a) are satisfied.

(d) For the purposes of the hearing conducted pursuant to this section, the licentiate shall, at a minimum, have the following rights:

(1) To be represented by counsel.

(2) To have a record made of the proceedings, copies of which may be obtained by the licentiate upon payment of any reasonable charges associated with the record.

(3) To present written evidence in the form of relevant declarations, affidavits, and documents.

The discretion of the administrative law judge to permit testimony at the hearing conducted pursuant to this section shall be identical to the discretion of a superior court judge to permit testimony at a hearing conducted pursuant to Section 527 of the Code of Civil Procedure.

(4) To present oral argument.

(e) Consistent with the burden and standards of proof applicable to a preliminary injunction entered under Section 527 of the Code of Civil Procedure, the administrative law judge shall grant the interim order where, in the exercise of discretion, the administrative law judge concludes that:

(1) There is a reasonable probability that the petitioner will prevail in the underlying action.

(2) The likelihood of injury to the public in not issuing the order outweighs the likelihood of injury to the licensee in issuing the order.

(f) In all cases in which 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 on which the parties to the hearing on the interim order have submitted the matter, the order shall be dissolved.

Upon service of the accusation the licensee shall have, in addition to the rights granted by this section, all of the rights and privileges available as specified in this chapter. If the licensee requests a hearing on the accusation, the board shall provide the licensee with a hearing within 30 days of the request, unless the licensee stipulates to a later hearing, and a decision within 15 days of the date the decision is received from the administrative law judge, or the board shall nullify the interim order previously issued, unless good cause can be shown by the Division of Medical Quality for a delay.

(g) If an interim order is issued, a written decision shall be prepared within 15 days of the hearing, by the administrative law judge, including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached.

(h) Notwithstanding the fact that interim orders issued pursuant to this section are not issued after a hearing as otherwise required by this chapter, interim orders so issued shall be subject to judicial review pursuant to Section 1094.5 of the Code of Civil Procedure. The relief that may be ordered shall be limited to a stay of the interim order. Interim orders issued pursuant to this section are final interim orders and, if not dissolved pursuant to subdivision (c) or (f), may only be challenged administratively at the hearing on the accusation.

(i) The interim order provided for by this section shall be:

(1) In addition to, and not a limitation on, the authority to seek injunctive relief provided for in the Business and Professions Code.

(2) A limitation on the emergency decision procedure provided in Article 13 (commencing with Section 11460.10) of Chapter 4.5.

SEC. 29.5. Section 11529 of the Government Code is amended to read:

11529. (a) The administrative law judge of the Medical Quality Hearing Panel established pursuant to Section 11371 may issue an interim order suspending a license, imposing drug testing, continuing education, supervision of procedures, limitations on the authority to prescribe, furnish, administer, or dispense controlled substances, or other license restrictions. Interim orders may be issued only if the affidavits in support of the petition show that the licensee has engaged in, or is about to engage in, acts or omissions constituting a violation of the Medical Practice Act or the appropriate practice act governing each allied health profession, or is unable to practice safely due to a mental or physical condition, and that permitting the licensee to continue to engage in the profession for which the license was issued will endanger the public health, safety, or welfare. The failure to comply with an order issued pursuant to Section 820 of the Business and

Professions Code may constitute grounds to issue an interim suspension order under this section.

(b) All orders authorized by this section shall be issued only after a hearing conducted pursuant to subdivision (d), unless it appears from the facts shown by affidavit that serious injury would result to the public before the matter can be heard on notice. Except as provided in subdivision (c), the licensee shall receive at least 15 days' prior notice of the hearing, which notice shall include affidavits and all other information in support of the order.

(c) If an interim order is issued without notice, the administrative law judge who issued the order without notice shall cause the licensee to be notified of the order, including affidavits and all other information in support of the order by a 24-hour delivery service. That notice shall also include the date of the hearing on the order, which shall be conducted in accordance with the requirement of subdivision (d), not later than 20 days from the date of issuance. The order shall be dissolved unless the requirements of subdivision (a) are satisfied.

(d) For the purposes of the hearing conducted pursuant to this section, the licentiate shall, at a minimum, have the following rights:

(1) To be represented by counsel.

(2) To have a record made of the proceedings, copies of which may be obtained by the licentiate upon payment of any reasonable charges associated with the record.

(3) To present written evidence in the form of relevant declarations, affidavits, and documents.

The discretion of the administrative law judge to permit testimony at the hearing conducted pursuant to this section shall be identical to the discretion of a superior court judge to permit testimony at a hearing conducted pursuant to Section 527 of the Code of Civil Procedure.

(4) To present oral argument.

(e) Consistent with the burden and standards of proof applicable to a preliminary injunction entered under Section 527 of the Code of Civil Procedure, the administrative law judge shall grant the interim order 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 30 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.

(g) If an interim order is issued, a written decision shall be prepared within 15 days of the hearing, by the administrative law judge, including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached.

(h) Notwithstanding the fact that interim orders issued pursuant to this section are not issued after a hearing as otherwise required by this chapter, interim orders so issued shall be subject to judicial review pursuant to Section 1094.5 of the Code of Civil Procedure. The relief that may be ordered shall be limited to a stay of the interim order. Interim orders issued pursuant to this section are final interim orders and, if not dissolved pursuant to subdivision (c) or (f), may only be challenged administratively at the hearing on the accusation.

(i) The interim order provided for by this section shall be:

(1) In addition to, and not a limitation on, the authority to seek injunctive relief provided for in the Business and Professions Code.

(2) A limitation on the emergency decision procedure provided in Article 13 (commencing with Section 11460.10) of Chapter 4.5.

SEC. 30. Section 12529 of the Government Code, as amended by Section 112 of Chapter 332 of the Statutes of 2012, is amended to read:

12529. (a) There is in the Department of Justice the Health Quality Enforcement Section. The primary responsibility of the section is to investigate and prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Psychology, the Physical Therapy Board of California, or any committee under the jurisdiction of the Medical Board of California.

(b) The Attorney General shall appoint a Senior Assistant Attorney General of the Health Quality Enforcement Section. The Senior Assistant Attorney General of the Health Quality Enforcement Section shall be an attorney in good standing licensed to practice in the State of California, experienced in prosecutorial or administrative disciplinary proceedings and competent in the management and supervision of attorneys performing those functions.

(c) The Attorney General shall ensure that the Health Quality Enforcement Section is staffed with a sufficient number of experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions against the licensees of the boards.

(d) Funding for the Health Quality Enforcement Section shall be budgeted in consultation with the Attorney General from the special funds financing the operations of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Psychology, the Physical Therapy Board of California, 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. 31. Section 12529 of the Government Code, as amended by Section 113 of Chapter 332 of the Statutes of 2012, is repealed.

SEC. 32. 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, the Board of Psychology, or the Physical Therapy Board of California 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 (a) 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 in designing and providing initial and in-service training programs for staff of the boards, 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 as appropriate in consultation with the senior assistant.

SEC. 33. Section 12529.5 of the Government Code, as amended by Section 115 of Chapter 332 of the Statutes of 2012, is repealed.

SEC. 34. Section 12529.6 of the Government Code is amended to read:

12529.6. (a) The Legislature finds and declares that the Medical Board of California, by ensuring the quality and safety of medical care, performs one of the most critical functions of state government. Because of the critical importance of the board's public health and safety function, the complexity of cases involving alleged misconduct by physicians and surgeons, and the evidentiary burden in the board's disciplinary cases, the Legislature finds and declares that using a vertical enforcement and prosecution model for those investigations is in the best interests of the people of California.

(b) Notwithstanding any other provision of law, as of January 1, 2006, each complaint that is referred to a district office of the board for investigation shall be simultaneously and jointly assigned to an investigator and to the deputy attorney general in the Health Quality Enforcement Section responsible for prosecuting the case if the investigation results in the filing of an accusation. The joint assignment of the investigator and the deputy attorney general shall exist for the duration of the disciplinary matter. During the assignment, the investigator so assigned shall, under the direction but not the supervision of the deputy attorney general, be responsible for obtaining the evidence required to permit the Attorney General to advise the board on legal matters such as whether the board should file a formal accusation, dismiss the complaint for a lack of evidence required to meet the applicable burden of proof, or take other appropriate legal action.

(c) The Medical Board of California, the Department of Consumer Affairs, and the Office of the Attorney General shall, if necessary, enter into an interagency agreement to implement this section.

(d) This section does not affect the requirements of Section 12529.5 as applied to the Medical Board of California where complaints that have not been assigned to a field office for investigation are concerned.

(e) It is the intent of the Legislature to enhance the vertical enforcement and prosecution model as set forth in subdivision (a). The Medical Board of California shall do all of the following:

(1) Increase its computer capabilities and compatibilities with the Health Quality Enforcement Section in order to share case information.

(2) Establish and implement a plan to locate its enforcement staff and the staff of the Health Quality Enforcement Section in the same offices, as appropriate, in order to carry out the intent of the vertical enforcement and prosecution model.

(3) Establish and implement a plan to assist in team building between its enforcement staff and the staff of the Health Quality Enforcement Section in order to ensure a common and consistent knowledge base.

SEC. 35. 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. 36. Section 1248.15 of the Health and Safety Code is amended to read:

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

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

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

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

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

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

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

written transfer agreement with licensees who have admitting privileges at local accredited or licensed acute care hospitals.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) As part of the accreditation process, the accrediting agency shall conduct a reasonable investigation of the prior history of the outpatient setting, including all licensed physicians and surgeons who have an

ownership interest therein, to determine whether there have been any adverse accreditation decisions rendered against them. For the purposes of this section, "conducting a reasonable investigation" means querying the Medical Board of California and the Osteopathic Medical Board of California to ascertain if either the outpatient setting has, or, if its owners are licensed physicians and surgeons, if those physicians and surgeons have, been subject to an adverse accreditation decision.

SEC. 37. Section 830.3 of the Penal Code is amended to read:

830.3. The following persons are peace officers whose authority extends to any place in the state for the purpose of performing their primary duty or when making an arrest pursuant to Section 836 as to any public offense with respect to which there is immediate danger to person or property, or of the escape of the perpetrator of that offense, or pursuant to Section 8597 or 8598 of the Government Code. These peace officers may carry firearms only if authorized and under those terms and conditions as specified by their employing agencies:

(a) Persons employed by the Division of Investigation of the Department of Consumer Affairs and investigators of the Medical Board of California and the Board of Dental Examiners, who are designated by the Director of Consumer Affairs, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 160 of the Business and Professions Code.

(b) Voluntary fire wardens designated by the Director of Forestry and Fire Protection pursuant to Section 4156 of the Public Resources Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 4156 of that code.

(c) Employees of the Department of Motor Vehicles designated in Section 1655 of the Vehicle Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 1655 of that code.

(d) Investigators of the California Horse Racing Board designated by the board, provided that the primary duty of these peace officers shall be the enforcement of Chapter 4 (commencing with Section 19400) of Division 8 of the Business and Professions Code and Chapter 10 (commencing with Section 330) of Title 9 of Part 1 of this code.

(e) The State Fire Marshal and assistant or deputy state fire marshals appointed pursuant to Section 13103 of the Health and Safety Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 13104 of that code.

(f) Inspectors of the food and drug section designated by the chief pursuant to subdivision (a) of Section 106500 of the Health and Safety Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 106500 of that code.

(g) All investigators of the Division of Labor Standards Enforcement designated by the Labor Commissioner, provided that the primary duty of

these peace officers shall be the enforcement of the law as prescribed in Section 95 of the Labor Code.

(h) All investigators of the State Departments of Health Care Services, Public Health, Social Services, Mental Health, and Alcohol and Drug Programs, the Department of Toxic Substances Control, the Office of Statewide Health Planning and Development, and the Public Employees' Retirement System, provided that the primary duty of these peace officers shall be the enforcement of the law relating to the duties of his or her department or office. Notwithstanding any other provision of law, investigators of the Public Employees' Retirement System shall not carry firearms.

(i) The Chief of the Bureau of Fraudulent Claims of the Department of Insurance and those investigators designated by the chief, provided that the primary duty of those investigators shall be the enforcement of Section 550.

(j) Employees of the Department of Housing and Community Development designated under Section 18023 of the Health and Safety Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 18023 of that code.

(k) Investigators of the office of the Controller, provided that the primary duty of these investigators shall be the enforcement of the law relating to the duties of that office. Notwithstanding any other law, except as authorized by the Controller, the peace officers designated pursuant to this subdivision shall not carry firearms.

(*l*) Investigators of the Department of Business Oversight designated by the Commissioner of Business Oversight, provided that the primary duty of these investigators shall be the enforcement of the provisions of law administered by the Department of Business Oversight. Notwithstanding any other provision of law, the peace officers designated pursuant to this subdivision shall not carry firearms.

(m) Persons employed by the Contractors State License Board designated by the Director of Consumer Affairs pursuant to Section 7011.5 of the Business and Professions Code, provided that the primary duty of these persons shall be the enforcement of the law as that duty is set forth in Section 7011.5, and in Chapter 9 (commencing with Section 7000) of Division 3, of that code. The Director of Consumer Affairs may designate as peace officers not more than 12 persons who shall at the time of their designation be assigned to the special investigations unit of the board. Notwithstanding any other provision of law, the persons designated pursuant to this subdivision shall not carry firearms.

(n) The Chief and coordinators of the Law Enforcement Branch of the Office of Emergency Services.

(o) Investigators of the office of the Secretary of State designated by the Secretary of State, provided that the primary duty of these peace officers shall be the enforcement of the law as prescribed in Chapter 3 (commencing with Section 8200) of Division 1 of Title 2 of, and Section 12172.5 of, the

Government Code. Notwithstanding any other provision of law, the peace officers designated pursuant to this subdivision shall not carry firearms.

(p) The Deputy Director for Security designated by Section 8880.38 of the Government Code, and all lottery security personnel assigned to the California State Lottery and designated by the director, provided that the primary duty of any of those peace officers shall be the enforcement of the laws related to assuring the integrity, honesty, and fairness of the operation and administration of the California State Lottery.

(q) Investigators employed by the Investigation Division of the Employment Development Department designated by the director of the department, provided that the primary duty of those peace officers shall be the enforcement of the law as that duty is set forth in Section 317 of the Unemployment Insurance Code.

Notwithstanding any other provision of law, the peace officers designated pursuant to this subdivision shall not carry firearms.

(r) The chief and assistant chief of museum security and safety of the California Science Center, as designated by the executive director pursuant to Section 4108 of the Food and Agricultural Code, provided that the primary duty of those peace officers shall be the enforcement of the law as that duty is set forth in Section 4108 of the Food and Agricultural Code.

(s) Employees of the Franchise Tax Board designated by the board, provided that the primary duty of these peace officers shall be the enforcement of the law as set forth in Chapter 9 (commencing with Section 19701) of Part 10.2 of Division 2 of the Revenue and Taxation Code.

(t) Notwithstanding any other provision of this section, a peace officer authorized by this section shall not be authorized to carry firearms by his or her employing agency until that agency has adopted a policy on the use of deadly force by those peace officers, and until those peace officers have been instructed in the employing agency's policy on the use of deadly force.

Every peace officer authorized pursuant to this section to carry firearms by his or her employing agency shall qualify in the use of the firearms at least every six months.

(u) Investigators of the Department of Managed Health Care designated by the Director of the Department of Managed Health Care, provided that the primary duty of these investigators shall be the enforcement of the provisions of laws administered by the Director of the Department of Managed Health Care. Notwithstanding any other provision of law, the peace officers designated pursuant to this subdivision shall not carry firearms.

(v) The Chief, Deputy Chief, supervising investigators, and investigators of the Office of Protective Services of the State Department of Developmental Services, provided that the primary duty of each of those persons shall be the enforcement of the law relating to the duties of his or her department or office.

(w) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2015, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 38. Section 830.3 is added to the Penal Code, to read:

830.3. The following persons are peace officers whose authority extends to any place in the state for the purpose of performing their primary duty or when making an arrest pursuant to Section 836 as to any public offense with respect to which there is immediate danger to person or property, or of the escape of the perpetrator of that offense, or pursuant to Section 8597 or 8598 of the Government Code. These peace officers may carry firearms only if authorized and under those terms and conditions as specified by their employing agencies:

(a) Persons employed by the Division of Investigation of the Department of Consumer Affairs and investigators of the Board of Dental Examiners, who are designated by the Director of Consumer Affairs, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 160 of the Business and Professions Code.

(b) Voluntary fire wardens designated by the Director of Forestry and Fire Protection pursuant to Section 4156 of the Public Resources Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 4156 of that code.

(c) Employees of the Department of Motor Vehicles designated in Section 1655 of the Vehicle Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 1655 of that code.

(d) Investigators of the California Horse Racing Board designated by the board, provided that the primary duty of these peace officers shall be the enforcement of Chapter 4 (commencing with Section 19400) of Division 8 of the Business and Professions Code and Chapter 10 (commencing with Section 330) of Title 9 of Part 1 of this code.

(e) The State Fire Marshal and assistant or deputy state fire marshals appointed pursuant to Section 13103 of the Health and Safety Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 13104 of that code.

(f) Inspectors of the food and drug section designated by the chief pursuant to subdivision (a) of Section 106500 of the Health and Safety Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 106500 of that code.

(g) All investigators of the Division of Labor Standards Enforcement designated by the Labor Commissioner, provided that the primary duty of these peace officers shall be the enforcement of the law as prescribed in Section 95 of the Labor Code.

(h) All investigators of the State Departments of Health Care Services, Public Health, Social Services, Mental Health, and Alcohol and Drug Programs, the Department of Toxic Substances Control, the Office of Statewide Health Planning and Development, and the Public Employees' Retirement System, provided that the primary duty of these peace officers shall be the enforcement of the law relating to the duties of his or her department or office. Notwithstanding any other provision of law,

investigators of the Public Employees' Retirement System shall not carry firearms.

(i) The Chief of the Bureau of Fraudulent Claims of the Department of Insurance and those investigators designated by the chief, provided that the primary duty of those investigators shall be the enforcement of Section 550.

(j) Employees of the Department of Housing and Community Development designated under Section 18023 of the Health and Safety Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 18023 of that code.

(k) Investigators of the office of the Controller, provided that the primary duty of these investigators shall be the enforcement of the law relating to the duties of that office. Notwithstanding any other law, except as authorized by the Controller, the peace officers designated pursuant to this subdivision shall not carry firearms.

(*l*) Investigators of the Department of Business Oversight designated by the Commissioner of Business Oversight, provided that the primary duty of these investigators shall be the enforcement of the provisions of law administered by the Department of Business Oversight. Notwithstanding any other provision of law, the peace officers designated pursuant to this subdivision shall not carry firearms.

(m) Persons employed by the Contractors State License Board designated by the Director of Consumer Affairs pursuant to Section 7011.5 of the Business and Professions Code, provided that the primary duty of these persons shall be the enforcement of the law as that duty is set forth in Section 7011.5, and in Chapter 9 (commencing with Section 7000) of Division 3, of that code. The Director of Consumer Affairs may designate as peace officers not more than 12 persons who shall at the time of their designation be assigned to the special investigations unit of the board. Notwithstanding any other provision of law, the persons designated pursuant to this subdivision shall not carry firearms.

(n) The Chief and coordinators of the Law Enforcement Branch of the Office of Emergency Services.

(o) Investigators of the office of the Secretary of State designated by the Secretary of State, provided that the primary duty of these peace officers shall be the enforcement of the law as prescribed in Chapter 3 (commencing with Section 8200) of Division 1 of Title 2 of, and Section 12172.5 of, the Government Code. Notwithstanding any other provision of law, the peace officers designated pursuant to this subdivision shall not carry firearms.

(p) The Deputy Director for Security designated by Section 8880.38 of the Government Code, and all lottery security personnel assigned to the California State Lottery and designated by the director, provided that the primary duty of any of those peace officers shall be the enforcement of the laws related to assuring the integrity, honesty, and fairness of the operation and administration of the California State Lottery.

(q) Investigators employed by the Investigation Division of the Employment Development Department designated by the director of the

department, provided that the primary duty of those peace officers shall be the enforcement of the law as that duty is set forth in Section 317 of the Unemployment Insurance Code.

Notwithstanding any other provision of law, the peace officers designated pursuant to this subdivision shall not carry firearms.

(r) The chief and assistant chief of museum security and safety of the California Science Center, as designated by the executive director pursuant to Section 4108 of the Food and Agricultural Code, provided that the primary duty of those peace officers shall be the enforcement of the law as that duty is set forth in Section 4108 of the Food and Agricultural Code.

(s) Employees of the Franchise Tax Board designated by the board, provided that the primary duty of these peace officers shall be the enforcement of the law as set forth in Chapter 9 (commencing with Section 19701) of Part 10.2 of Division 2 of the Revenue and Taxation Code.

(t) Notwithstanding any other provision of this section, a peace officer authorized by this section shall not be authorized to carry firearms by his or her employing agency until that agency has adopted a policy on the use of deadly force by those peace officers, and until those peace officers have been instructed in the employing agency's policy on the use of deadly force.

Every peace officer authorized pursuant to this section to carry firearms by his or her employing agency shall qualify in the use of the firearms at least every six months.

(u) Investigators of the Department of Managed Health Care designated by the Director of the Department of Managed Health Care, provided that the primary duty of these investigators shall be the enforcement of the provisions of laws administered by the Director of the Department of Managed Health Care. Notwithstanding any other provision of law, the peace officers designated pursuant to this subdivision shall not carry firearms.

(v) The Chief, Deputy Chief, supervising investigators, and investigators of the Office of Protective Services of the State Department of Developmental Services, provided that the primary duty of each of those persons shall be the enforcement of the law relating to the duties of his or her department or office.

(w) This section shall become operative July 1, 2014.

SEC. 39. Section 29.5 of this bill incorporates amendments to Section 11529 of the Government Code proposed by both this bill and Senate Bill 670. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2014, (2) each bill amends Section 11529 of the Government Code, and (3) this bill is enacted after Senate Bill 670, in which case Section 29 of this bill shall not become operative.

SEC. 40. 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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SIBES

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 305
Author: Lieu
Chapter: 516
Bill Date: September 6, 2013, Amended
Subject: Healing Arts: Boards
Sponsor: Author
Position: Support provisions related to records of arrests and convictions for applicants and licensees

DESCRIPTION OF CURRENT LEGISLATION:

Among other provisions, this bill allows 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 specifies 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 clarifies 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 are sometimes questions on what documents can be shared from agency to agency, and this bill clarifies 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: Association of Regulatory Boards of Optometry; 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; SEIU; and Western University of Health Sciences

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter Article
- Notify/Train Board enforcement staff

Senate Bill No. 305

CHAPTER 516

An act to amend Sections 1000, 2450, 2450.3, 2530.2, 2531, 2531.06, 2531.75, 2532.6, 2533, 2570.19, 3010.5, 3014.6, 3046, 3056, 3057, 3110, 3685, 3686, 3710, 3716, and 3765 of, and to add Sections 144.5 and 3090.5 to, the Business and Professions Code, relating to healing arts.

[Approved by Governor October 3, 2013. Filed with Secretary of State October 3, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

SB 305, Lieu. Healing arts: boards.

(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.

(2) The Chiropractic Act, enacted by an initiative measure, provides for the licensure and regulation of chiropractors in this state by the State Board of Chiropractic Examiners. Existing law specifies that the law governing chiropractors is found in the act.

This bill would require that the powers and duties of the board, as provided, be subject to review by the appropriate policy committees of the Legislature as if these provisions were scheduled to be repealed on January 1, 2018. This bill would also make nonsubstantive changes to conform with the Governor's Reorganization Plan No. 2.

(3) Existing law, the Osteopathic Act, provides for the licensure and regulation of osteopathic physicians and surgeons by the Osteopathic Medical Board of California.

This bill would require that the powers and duties of the board, as provided, be subject to review by the appropriate policy committees of the Legislature. The bill would require that the review be performed as if these provisions were scheduled to be repealed as of January 1, 2018.

(4) Existing law, the Speech-Language Pathologists and Audiologists and Hearing Aid Dispensers Licensure Act, provides for the licensure and regulation of speech-language pathologists, audiologists, and hearing aid dispensers by the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board. The act authorizes the board to appoint an executive

officer. Existing law repeals these 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.

The Speech-Language Pathologists and Audiologists and Hearing Aid Dispensers Licensure Act also authorizes the board to refuse to issue, or issue subject to terms and conditions, a license on specified grounds, including, among others, securing a license by fraud or deceit.

This bill would additionally authorize the board to refuse to issue, or issue subject to terms and conditions, a license for a violation of a term or condition of a probationary order of a license or a term or condition of a conditional license issued by the board, as provided. The bill would also delete an obsolete provision and make other technical changes.

(5) Existing law, the Occupational Therapy Practice Act, provides for the licensure and regulation of occupational therapists, as defined, 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.

(6) 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.

(7) 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.

(8) The Optometry Practice Act prescribes license eligibility requirements, including, but not limited to, not having been convicted of a crime, as specified. The act defines unprofessional conduct to include, committing or soliciting an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of an optometrist. Under the act, the board may take action against a licensee who is charged with unprofessional conduct, and may deny an application

for a license if the applicant has committed an act of unprofessional conduct. Under existing law, commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action against any healing arts licensee, subject to a specified exception for a physician and surgeon.

This bill would add to the license eligibility requirements under the act that the applicant is not currently required to register as a sex offender, as specified. The bill would make conviction of a crime that currently requires a licensee to register as a sex offender unprofessional conduct and would expressly specify that commission of an act of sexual abuse or misconduct, as specified, constitutes unprofessional conduct, subject to an exception for an optometrist treating his or her spouse or person in an equivalent domestic relationship. The bill would also state that those acts of unprofessional conduct shall be considered crimes substantially related to the qualifications, functions, or duties of a licensee. The bill would also expressly specify that the board may revoke a license if the licensee has been found, in an administrative proceeding, as specified, to have been convicted of sexual misconduct or convicted of a crime that currently requires the licensee to register as a sex offender.

(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 acts, including, among others, the performance of respiratory care services in case of an emergency or self-care by a patient.

This bill would additionally authorize the performance of pulmonary function testing by persons who are currently employed by Los Angeles County hospitals and have performed pulmonary function testing for at least 15 years.

This bill would make legislative findings and declarations as to the necessity of a special statute for the persons described above.

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

SECTION 1. Section 144.5 is added to the Business and Professions Code, to read:

144.5. Notwithstanding any other law, a board described in Section 144 may request, and is authorized to 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. A local or state agency may provide those records to the board upon request.

SEC. 2. Section 1000 of the Business and Professions Code is amended to read:

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, unless a later enacted statute that is enacted before January 1, 2018, deletes or extends that date. Notwithstanding any other provision of law, the repeal of this section renders the Naturopathic Medicine Committee subject to review by the appropriate policy committees of the Legislature.

SEC. 5. Section 2530.2 of the Business and Professions Code is amended to read:

2530.2. As used in this chapter, unless the context otherwise requires:

(a) "Board" means the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board.

(b) "Person" means any individual, partnership, corporation, limited liability company, or other organization or combination thereof, except that only individuals can be licensed under this chapter.

(c) A "speech-language pathologist" is a person who practices speech-language pathology.

(d) The practice of speech-language pathology means all of the following:

(1) The application of principles, methods, instrumental procedures, and noninstrumental procedures for measurement, testing, screening, evaluation, identification, prediction, and counseling related to the development and disorders of speech, voice, language, or swallowing.

(2) The application of principles and methods for preventing, planning, directing, conducting, and supervising programs for habilitating, rehabilitating, ameliorating, managing, or modifying disorders of speech, voice, language, or swallowing in individuals or groups of individuals.

(3) Conducting hearing screenings.

(4) Performing suctioning in connection with the scope of practice described in paragraphs (1) and (2), after compliance with a medical facility's training protocols on suctioning procedures.

(e) (1) Instrumental procedures referred to in subdivision (d) are the use of rigid and flexible endoscopes to observe the pharyngeal and laryngeal areas of the throat in order to observe, collect data, and measure the parameters of communication and swallowing as well as to guide communication and swallowing assessment and therapy.

(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 fiber optic 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 fiber optic 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 fiber optic 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 requirements. For purposes of this paragraph, a "clear" credential is a credential that is not issued pursuant to a waiver or emergency permit and is as otherwise defined by the Commission on Teacher Credentialing. Nothing in this section referring to credentialed supervising speech-language pathologists expands existing exemptions from licensing pursuant to Section 2530.5.

(j) An "audiologist" is one who practices audiology.

(k) "The practice of audiology" means the application of principles, methods, and procedures of measurement, testing, appraisal, prediction, consultation, counseling, instruction related to auditory, vestibular, and related functions and the modification of communicative disorders involving speech, language, auditory behavior or other aberrant behavior resulting from auditory dysfunction; and the planning, directing, conducting, supervising, or participating in programs of identification of auditory disorders, hearing conservation, cerumen removal, aural habilitation, and rehabilitation, including, hearing aid recommendation and evaluation procedures including, but not limited to, specifying amplification requirements and evaluation of the results thereof, auditory training, and speech reading, and the selling of hearing aids.

(l) A "dispensing audiologist" is a person who is authorized to sell hearing aids pursuant to his or her audiology license.

(m) "Audiology aide" means any person meeting the minimum requirements established by the board. An audiology aid may not perform any function that constitutes the practice of audiology unless he or she is under the supervision of an audiologist. The board may by regulation exempt certain functions performed by an industrial audiology aide from supervision provided that his or her employer has established a set of procedures or protocols that the aide shall follow in performing these functions.

(n) "Medical board" means the Medical Board of California.

(o) A "hearing screening" performed by a speech-language pathologist means a binary puretone screening at a preset intensity level for the purpose of determining if the screened individuals are in need of further medical or audiological evaluation.

(p) "Cerumen removal" means the nonroutine removal of cerumen within the cartilaginous ear canal necessary for access in performance of audiological procedures that shall occur under physician and surgeon supervision. Cerumen removal, as provided 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 2531.06 of the Business and Professions Code is amended to read:

2531.06. (a) The board is vested with the duties, powers, purposes, responsibilities, and jurisdiction over the licensing and regulation of hearing aid dispensers as provided under Article 8 (commencing with Section 2538.10).

(b) In the performance of the duties and the exercise of the powers vested in the board under this chapter, the board may consult with hearing aid dispenser industry representatives.

(c) For the performance of the duties and the exercise of the powers vested in the board under this chapter, the board shall have possession and control of all records, papers, offices, equipment, supplies, or other property, real or personal, held for the benefit or use by the former Hearing Aid Dispensers Bureau.

(d) All regulations in Division 13.3 (commencing with Section 1399.100) of Title 16 of the California Code of Regulations are continued in existence under the administration of the board until repealed by regulation.

SEC. 8. 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.

(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. 9. Section 2532.6 of the Business and Professions Code is amended to read:

2532.6. (a) The Legislature recognizes that the education and experience requirements of this chapter constitute only minimal requirements to assure the public of professional competence. The Legislature encourages all professionals licensed and registered by the board under this chapter to regularly engage in continuing professional development and learning that is related and relevant to the professions of speech-language pathology and audiology.

(b) The board shall not renew any license or registration pursuant to this chapter unless the applicant certifies to the board that he or she has completed in the preceding two years not less than the minimum number of continuing professional development hours established by the board pursuant to subdivision (c) for the professional practice authorized by his or her license or registration.

(c) (1) The board shall prescribe the forms utilized for and the number of hours of required continuing professional development for persons licensed or registered under this chapter.

(2) The board shall have the right to audit the records of any applicant to verify the completion of the continuing professional development requirements.

(3) Applicants shall maintain records of completion of required continuing professional development coursework for a minimum of two years and shall make these records available to the board for auditing purposes upon request.

(d) The board shall establish exceptions from the continuing professional development requirements of this section for good cause as defined by the board.

(e) (1) The continuing professional development services shall be obtained from accredited institutions of higher learning, organizations approved as continuing education providers by either the American Speech-Language Hearing Association or the American Academy of Audiology, the California Medical Association's Institute for Medical Quality Continuing Medical Education Program, or other entities or organizations approved as continuing professional development providers by the board, in its discretion.

(2) No hours shall be credited for any course enrolled in by a licensee that has not first been approved and certified by the board, if the board has sufficient funding and staff resources to implement the approval and certification process.

(3) The continuing professional development services offered by these entities may, but are not required to, utilize pretesting and posttesting or

other evaluation techniques to measure and demonstrate improved professional learning and competency.

(4) An accredited institution of higher learning, an organization approved as continuing education providers by either the American Speech-Language Hearing Association or the American Academy of Audiology, and the California Medical Association's Institute for Medical Quality Continuing Education Program shall be exempt from any application or registration fees that the board may charge for continuing education providers.

(5) Unless a course offered by entities listed in paragraph (4) meets the requirements established by the board, the course may not be credited towards the continuing professional development requirements for license renewal.

(6) The licensee shall be responsible for obtaining the required course completion documents for courses offered by entities specified in paragraph (1).

(f) The board, by regulation, shall fund the administration of this section through professional development services provider and licensing fees to be deposited in the Speech-Language Pathology and Audiology Board Fund. The fees related to the administration of this section shall be sufficient to meet, but shall not exceed, the costs of administering the corresponding provisions of this section.

(g) The continuing professional development requirements adopted by the board shall comply with any guidelines for mandatory continuing education established by the Department of Consumer Affairs.

SEC. 10. Section 2533 of the Business and Professions Code is amended to read:

2533. The board may refuse to issue, or issue subject to terms and conditions, a license on the grounds specified in Section 480, or may suspend, revoke, or impose terms and conditions upon the license of any licensee for any of the following:

(a) Conviction of a crime substantially related to the qualifications, functions, and duties of a speech-language pathologist or audiologist or hearing aid dispenser, as the case may be. The record of the conviction shall be conclusive evidence thereof.

(b) Securing a license by fraud or deceit.

(c) (1) The use or administering to himself or herself of any controlled substance.

(2) The use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent or in a manner as to be dangerous or injurious to the licensee, to any other person, or to the public, or to the extent that the use impairs the ability of the licensee to practice speech-language pathology or audiology safely.

(3) More than one misdemeanor or any felony involving the use, consumption, or self-administration of any of the substances referred to in this section.

(4) Any combination of paragraph (1), (2), or (3).

The record of the conviction shall be conclusive evidence of unprofessional conduct.

(d) Advertising in violation of Section 17500. Advertising an academic degree that was not validly awarded or earned under the laws of this state or the applicable jurisdiction in which it was issued is deemed to constitute a violation of Section 17500.

(e) Committing a dishonest or fraudulent act that is substantially related to the qualifications, functions, or duties of a licensee.

(f) Incompetence, gross negligence, or repeated negligent acts.

(g) Other acts that have endangered or are likely to endanger the health, welfare, and safety of the public.

(h) Use by a hearing aid dispenser of the term "doctor" or "physician" or "clinic" or "audiologist," or any derivation thereof, except as authorized by law.

(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.

(m) Violation of a term or condition of a conditional license issued by the board pursuant to this section.

SEC. 11. 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 occupational therapy assistant, and may not have had, within two years of the appointment, a substantial financial interest in a person regulated by the board.

(f) The Governor shall appoint two board members for a term of one year, two board members for a term of two years, and one board member for a term of three years. Appointments made thereafter shall be for four-year terms, but no person shall be appointed to serve more than two consecutive terms. Terms shall begin on the first day of the calendar year and end on the last day of the calendar year or until successors are appointed, except for the first appointed members who shall serve through the last calendar day of the year in which they are appointed, before commencing the terms prescribed by this section. Vacancies shall be filled by appointment for the unexpired term. The board shall annually elect one of its members as president.

(g) The board shall meet and hold at least one regular meeting annually in the Cities of Sacramento, Los Angeles, and San Francisco. The board may convene from time to time until its business is concluded. Special meetings of the board may be held at any time and place designated by the board.

(h) Notice of each meeting of the board shall be given in accordance with the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code).

(i) Members of the board shall receive no compensation for their services, but shall be entitled to reasonable travel and other expenses incurred in the execution of their powers and duties in accordance with Section 103.

(j) The appointing power shall have the power to remove any member of the board from office for neglect of any duty imposed by state law, for incompetency, or for unprofessional or dishonorable conduct.

(k) 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. 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 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. 14. Section 3046 of the Business and Professions Code is amended to read:

3046. In order to obtain a license to practice optometry in California, an applicant shall have graduated from an accredited school of optometry, passed the required examinations for licensure, not have met any of the grounds for denial established in Section 480, and not be currently required to register as a sex offender pursuant to Section 290 of the Penal Code. The proceedings under this section shall be in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 15. Section 3056 of the Business and Professions Code is amended to read:

3056. (a) The board may issue a license to practice optometry to a person who meets all of the following qualifications:

(1) Has a degree as a doctor of optometry issued by an accredited school or college of optometry.

(2) Is currently licensed in another state.

(3) Is currently a full-time faculty member of an accredited California school or college of optometry and has served in that capacity for a period of at least five continuous years.

(4) Has attained, at an accredited California school or college of optometry, the academic rank of professor, associate professor, or clinical professor, except that the status of adjunct or affiliated faculty member shall not be deemed sufficient.

(5) Has successfully passed the board's jurisprudence examination.

(6) Is in good standing, with no past or pending malpractice awards or judicial or administrative actions.

(7) Has met the minimum continuing education requirements set forth in Section 3059 for the current and preceding year.

(8) Has met the requirements of Section 3041.3 regarding the use of therapeutic pharmaceutical agents under subdivision (e) of Section 3041.

(9) Has never had his or her license to practice optometry revoked or suspended.

(10) (A) Is not subject to denial based on any of the grounds listed in Section 480.

(B) Is not currently required to register as a sex offender pursuant to Section 290 of the Penal Code.

(11) Pays an application fee in an amount equal to the application fee prescribed by the board pursuant to Section 3152.

(12) Files an application on a form prescribed by the board.

(b) Any license issued pursuant to this section shall expire as provided in Section 3146, and may be renewed as provided in this chapter, subject to the same conditions as other licenses issued under this chapter.

(c) The term "in good standing," as used in this section, means that a person under this section:

(1) Is not currently under investigation nor has been charged with an offense for any act substantially related to the practice of optometry by any public agency, nor entered into any consent agreement or subject to an administrative decision that contains conditions placed by an agency upon a person's professional conduct or practice, including any voluntary surrender of license, nor been the subject of an adverse judgment resulting from the practice of optometry that the board determines constitutes evidence of a pattern of incompetence or negligence.

(2) Has no physical or mental impairment related to drugs or alcohol, and has not been found mentally incompetent by a physician so that the person is unable to undertake the practice of optometry in a manner consistent with the safety of a patient or the public.

SEC. 16. Section 3057 of the Business and Professions Code is amended to read:

3057. (a) The board may issue a license to practice optometry to a person who meets all of the following requirements:

(1) Has a degree as a doctor of optometry issued by an accredited school or college of optometry.

(2) Has successfully passed the licensing examination for an optometric license in another state.

(3) Submits proof that he or she is licensed in good standing as of the date of application in every state where he or she holds a license, including compliance with continuing education requirements.

(4) Submits proof that he or she has been in active practice in a state in which he or she is licensed for a total of at least 5,000 hours in five of the seven consecutive years immediately preceding the date of his or her application under this section.

(5) Is not subject to disciplinary action as set forth in subdivision (h) of Section 3110. If the person has been subject to disciplinary action, the board shall review that action to determine if it presents sufficient evidence of a

violation of this chapter to warrant the submission of additional information from the person or the denial of the application for licensure.

(6) Has furnished a signed release allowing the disclosure of information from the Healthcare Integrity and Protection Data Bank and, if applicable, the verification of registration status with the federal Drug Enforcement Administration. The board shall review this information to determine if it presents sufficient evidence of a violation of this chapter to warrant the submission of additional information from the person or the denial of the application for licensure.

(7) Has never had his or her license to practice optometry revoked or suspended.

(8) (A) Is not subject to denial of an application for licensure based on any of the grounds listed in Section 480.

(B) Is not currently required to register as a sex offender pursuant to Section 290 of the Penal Code.

(9) Has met the minimum continuing education requirements set forth in Section 3059 for the current and preceding year.

(10) Has met the certification requirements of Section 3041.3 to use therapeutic pharmaceutical agents under subdivision (e) of Section 3041.

(11) Submits any other information as specified by the board to the extent it is required for licensure by examination under this chapter.

(12) Files an application on a form prescribed by the board, with an acknowledgment by the person executed under penalty of perjury and automatic forfeiture of license, of the following:

(A) That the information provided by the person to the board is true and correct, to the best of his or her knowledge and belief.

(B) That the person has not been convicted of an offense involving conduct that would violate Section 810.

(13) Pays an application fee in an amount equal to the application fee prescribed pursuant to subdivision (a) of Section 3152.

(14) Has successfully passed the board's jurisprudence examination.

(b) If the board finds that the competency of a candidate for licensure pursuant to this section is in question, the board may require the passage of a written, practical, or clinical exam or completion of additional continuing education or coursework.

(c) In cases where the person establishes, to the board's satisfaction, that he or she has been displaced by a federally declared emergency and cannot relocate to his or her state of practice within a reasonable time without economic hardship, the board is authorized to do both of the following:

(1) Approve an application where the person's time in active practice is less than that specified in paragraph (4) of subdivision (a), if a sufficient period in active practice can be verified by the board and all other requirements of subdivision (a) are satisfied by the person.

(2) Reduce or waive the fees required by paragraph (13) of subdivision (a).

(d) Any license issued pursuant to this section shall expire as provided in Section 3146, and may be renewed as provided in this chapter, subject to the same conditions as other licenses issued under this chapter.

(e) The term "in good standing," as used in this section, means that a person under this section:

(1) Is not currently under investigation nor has been charged with an offense for any act substantially related to the practice of optometry by any public agency, nor entered into any consent agreement or subject to an administrative decision that contains conditions placed by an agency upon a person's professional conduct or practice, including any voluntary surrender of license, nor been the subject of an adverse judgment resulting from the practice of optometry that the board determines constitutes evidence of a pattern of incompetence or negligence.

(2) Has no physical or mental impairment related to drugs or alcohol, and has not been found mentally incompetent by a physician so that the person is unable to undertake the practice of optometry in a manner consistent with the safety of a patient or the public.

SEC. 17. Section 3090.5 is added to the Business and Professions Code, to read:

3090.5. The board may revoke a license issued to a licensee upon a decision, made in a proceeding as provided in Section 3092, that contains a finding of fact of either of the following:

(a) The licensee has engaged in an act of sexual abuse, misconduct, or relations with a patient, as described in paragraph (2) of subdivision (m) of Section 3110.

(b) The licensee has been convicted of a crime described in paragraph (3) of subdivision (m) of Section 3110.

SEC. 18. Section 3110 of the Business and Professions Code is amended to read:

3110. The board may take action against any licensee who is charged with unprofessional conduct, and may deny an application for a license if the applicant has committed 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 or any of the rules and regulations adopted by the board pursuant to this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions.

(d) Incompetence.

(e) The commission of fraud, misrepresentation, or any act involving dishonesty or corruption, that is substantially related to the qualifications, functions, or duties of an optometrist.

(f) Any action or conduct that would have warranted the denial of a license.

(g) The use of advertising relating to optometry that violates Section 651 or 17500.

(h) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license by another state or territory of the United States, by any other governmental agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.

(i) Procuring his or her license by fraud, misrepresentation, or mistake.

(j) Making or giving any false statement or information in connection with the application for issuance of a license.

(k) Conviction of a felony or of any offense substantially related to the qualifications, functions, and duties of an optometrist, in which event the record of the conviction shall be conclusive evidence thereof.

(*l*) Administering to himself or herself any controlled substance or using any of the dangerous drugs specified in Section 4022, or using alcoholic beverages to the extent, or in a manner, as to be dangerous or injurious to the person applying for a license or holding a license under this chapter, or to any other person, or to the public, or, to the extent that the use impairs the ability of the person applying for or holding a license to conduct with safety to the public the practice authorized by the license, or the conviction of a misdemeanor or felony involving the use, consumption, or self administration of any of the substances referred to in this subdivision, or any combination thereof.

(m) (1) Committing or soliciting an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of an optometrist.

(2) Committing any act of sexual abuse, misconduct, or relations with a patient. The commission of and conviction for any act of sexual abuse, sexual misconduct, or attempted sexual misconduct, whether or not with a patient, shall be considered a crime substantially related to the qualifications, functions, or duties of a licensee. This paragraph shall not apply to sexual contact between any person licensed under this chapter and his or her spouse or person in an equivalent domestic relationship when that licensee provides optometry treatment to his or her spouse or person in an equivalent domestic relationship.

(3) Conviction of a crime that currently requires the person to register as a sex offender pursuant to Section 290 of the Penal Code. A conviction within the meaning of this paragraph means a plea or verdict of guilty or a conviction following a plea of nolo contendere. A conviction described in this paragraph shall be considered a crime substantially related to the qualifications, functions, or duties of a licensee.

(n) Repeated acts of excessive prescribing, furnishing or administering of controlled substances or dangerous drugs specified in Section 4022, or repeated acts of excessive treatment.

(o) Repeated acts of excessive use of diagnostic or therapeutic procedures, or repeated acts of excessive use of diagnostic or treatment facilities.

(p) The prescribing, furnishing, or administering of controlled substances or drugs specified in Section 4022, or treatment without a good faith prior examination of the patient and optometric reason.

(q) The failure to maintain adequate and accurate records relating to the provision of services to his or her patients.

(r) Performing, or holding oneself out as being able to perform, or offering to perform, any professional services beyond the scope of the license authorized by this chapter.

(s) The practice of optometry without a valid, unrevoked, unexpired license.

(t) The employing, directly or indirectly, of any suspended or unlicensed optometrist to perform any work for which an optometry license is required.

(u) Permitting another person to use the licensee's optometry license for any purpose.

(v) Altering with fraudulent intent a license issued by the board, or using a fraudulently altered license, permit certification or any registration issued by the board.

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

(x) Failure or refusal to comply with a request for the clinical 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, unless the licensee is unable to provide the documents within this time period for good cause.

(y) Failure to refer a patient to an appropriate physician in either of the following circumstances:

(1) Where an examination of the eyes indicates a substantial likelihood of any pathology that requires the attention of that physician.

(2) As required by subdivision (c) of Section 3041.

SEC. 19. Section 3685 of the Business and Professions Code is amended to read:

3685. Notwithstanding any other law, the repeal of this chapter renders the committee subject to review by the appropriate policy committees of the Legislature.

SEC. 20. Section 3686 of the Business and Professions Code is amended to read:

3686. This chapter shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.

SEC. 21. Section 3710 of the Business and Professions Code is amended to read:

3710. (a) The Respiratory Care Board of California, hereafter referred to as the board, shall enforce and administer this chapter.

(b) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date. Notwithstanding any other law, the repeal of this section renders the board subject to review by the appropriate policy committees of the Legislature.

SEC. 22. Section 3716 of the Business and Professions Code is amended to read:

3716. The board may employ an executive officer exempt from civil service and, subject to the provisions of law relating to civil service, clerical assistants and, except as provided in Section 159.5, other employees as it may deem necessary to carry out its powers and duties.

This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.

SEC. 23. Section 3765 of the Business and Professions Code is amended to read:

3765. This act does not prohibit any of the following activities:

(a) The performance of respiratory care that is an integral part of the program of study by students enrolled in approved respiratory therapy training programs.

(b) Self-care by the patient or the gratuitous care by a friend or member of the family who does not represent or hold himself or herself out to be a respiratory care practitioner licensed under the provisions of this chapter.

(c) The respiratory care practitioner from performing advances in the art and techniques of respiratory care learned through formal or specialized training.

(d) The performance of respiratory care in an emergency situation by paramedical personnel who have been formally trained in these modalities and are duly licensed under the provisions of an act pertaining to their specialty.

(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. 24. 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
Chapter:	286
Bill Date:	June 19, 2013, Amended
Subject:	Medical Assistants: Supervision
Sponsor:	California Academy of Physician Assistants (CAPA) & California Association of Physician Groups
Position:	Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill allows physician assistants (PAs), nurse practitioners (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 CNMs 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 CNM were to allow the MA to perform tasks that are not in the approved scope of responsibility, that the PA, NP, or CNM 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 is supportive of this bill.

FISCAL: None

SUPPORT: CAPA (co-sponsor); California Association of Physician Groups (co-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; and United Nurses Associations of California/Union of Health Care Professionals

OPPOSITION: Board of Registered Nursing
California Nurses Association
National Nurses United

IMPLEMENTATION:

- Newsletter Article
- Update information on medical assistant Web site page
- Notify/Train Board Staff

Senate Bill No. 352

CHAPTER 286

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

[Approved by Governor September 9, 2013. Filed with Secretary of State September 9, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

SB 352, 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 delete several obsolete references and make other clarifying, conforming, technical, and nonsubstantive changes.

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

SECTION 1. Section 2069 of the Business and Professions Code is amended to read:

2069. (a) (1) Notwithstanding any other law, a medical assistant may administer medication only by intradermal, subcutaneous, or intramuscular injections and perform skin tests and additional technical supportive services upon the specific authorization and supervision of a licensed physician and surgeon or a licensed podiatrist. A medical assistant may also perform all these tasks and services upon the specific authorization of a physician assistant, a nurse practitioner, or a certified nurse-midwife.

(2) The supervising physician and surgeon may, at his or her discretion, in consultation with the nurse practitioner, certified nurse-midwife, or physician assistant, provide written instructions to be followed by a medical assistant in the performance of tasks or supportive services. These written instructions may provide that the supervisory function for the medical assistant for these tasks or supportive services may be delegated to the nurse practitioner, certified nurse-midwife, or physician assistant within the standardized procedures or protocol, and that tasks may be performed when the supervising physician and surgeon is not onsite, if either of the following apply:

(A) The nurse practitioner or certified nurse-midwife is functioning pursuant to standardized procedures, as defined by Section 2725, or protocol. The standardized procedures or protocol, including instructions for specific authorizations, shall be developed and approved by the supervising physician and surgeon and the nurse practitioner or certified nurse-midwife.

(B) The physician assistant is functioning pursuant to regulated services defined in Section 3502, including instructions for specific authorizations, and is approved to do so by the supervising physician and surgeon.

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

(1) "Medical assistant" means a person who may be unlicensed, who performs basic administrative, clerical, and technical supportive services in compliance with this section and Section 2070 for a licensed physician and surgeon or a licensed podiatrist, or group thereof, for a medical or podiatry corporation, for a physician assistant, a nurse practitioner, or a 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 medical assistant who has limited training and who functions under the supervision of a licensed physician and surgeon or a licensed podiatrist, or a physician assistant, a nurse practitioner, or a certified nurse-midwife as provided in subdivision (a).

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

(1) The licensure of medical assistants.

(2) The administration of local anesthetic agents by a medical assistant.

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

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

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

(d) A nurse practitioner, certified nurse-midwife, or physician assistant shall not authorize a medical assistant to perform any clinical laboratory test or examination for which the medical assistant is not authorized by Chapter 3 (commencing with Section 1200). A violation of this subdivision constitutes unprofessional conduct.

(e) Notwithstanding any other law, a medical assistant shall not be employed for inpatient care in a licensed general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code.

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SB 463

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 493
Author: Hernandez
Chapter: 469
Bill Date: September 6, 2013, Amended
Subject: Pharmacy Practice
Sponsor: Author
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill allows pharmacists to furnish medication, order and interpret tests, furnish self-administered hormonal contraceptives, furnish prescription medications not requiring a diagnosis recommended by the Centers for Disease Control and Prevention for individuals traveling outside the United States, independently initiate and administer vaccines, and furnish prescription nicotine replacement products and smoking cessation services. This bill requires the Board of Pharmacy (BOP) and the Medical Board of California (Board) to develop standardized procedures or protocols for the furnishing of self-administered hormonal contraceptives and nicotine replacement products. This bill also establishes an Advanced Practice Pharmacist (APP) recognition. This bill also contains language regarding prescription labeling requirements.

ANALYSIS:

This bill expands the scope of a pharmacist by allowing a pharmacist to do the following:

- Provide consultation, 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 self-administered hormonal contraceptives in accordance with standardized procedures or protocols developed and approved by the BOP and the Board.
- Furnish prescription nicotine replacement products in accordance with standardized procedures and protocols developed and approved by the BOP and the Board and provide smoking cessation services. The pharmacist must maintain records of drugs and devices furnished for three years, notify the patient's primary care provider, be certified in smoking cessation therapy, and complete one hour of continuing education focused on smoking cessation therapy biennially.
- Furnish prescription medications not requiring a diagnosis that are recommended by the federal Centers for Disease Control and Prevention for individuals traveling outside of

the United States.

- Order and interpret tests for the purpose of monitoring and managing the efficacy and toxicity of drug therapies – A pharmacist must ensure that the ordering of those tests is done in coordination with the patient's primary care provider or diagnosing prescriber.
- 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 a pharmacist to notify the patient's primary care provider of any drugs or devices furnished to the patient, or enter the appropriate information in a patient record system shared with the primary care provider. If the patient does not have a primary care provider, the pharmacist must provide the patient with a written record and advise the patient to consult a physician of the patient's choice.

This bill would require the BOP and the Board to develop standardized procedures or protocols for self-administered hormonal contraceptives and nicotine replacement products. 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 the 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 has been amended and now only allows this under existing law, pursuant to a specific written order or authorization made by the individual patient's treating prescriber. 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.
- 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 also includes language to avoid chaptering out issues with SB 205 (Corbett), related to prescription drug labeling requirements.

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 nicotine replacement products and provide smoking cessation services, is in line with their scope. Allowing pharmacists to initiate and administer routine vaccines seems appropriate. This bill will help to further the Board's mission of promoting access to care and the Board has a support position on this bill.

FISCAL: Minimal and absorbable workload to help develop standardized procedures or protocols for furnishing of self-administered hormonal contraceptives and nicotine replacement products.

SUPPORT: Adventist Health; American Society of Health-System Pharmacists; Bay Area Council; Blue Shield of California; California Association for Nurse Practitioners; California Association of Physician Groups; 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 Primary Care Association; California Retailers Association; California Society of Health-System Pharmacists; California State Board of Pharmacy; Californians for Patient Care; Cedars-Sinai Medical Center; Dignity Health; Indian Pharmacists Association of California; Kaiser Permanente; Medical Board of California; National Asian American Coalition; Pharmacy Choice and Access Now; Private Essential Access Community Hospitals; Safeway; St. Elizabeth Community Hospital; St. Francis Memorial Hospital; St. Joseph's Behavioral Health Center; Tuoro University-California School of Pharmacy; Union of Health Care Professionals; United Nurses Association of California/Union of Health Care Professionals; University of California; and Western University of Health Sciences

OPPOSITION: Blind Children's Center; California Academy of Eye Physicians and Surgeons; California Right to Life Committee, Inc; California Society of Plastic Surgeons; Canvasback Missions, Inc.; Diabetes Coalition of

California; Let's Face It Together; Lighthouse for Christ Mission and Eye Center; The Dream Machine Foundation; Time for Change Foundation; and Ventura County American Chinese Medical Dental Association

IMPLEMENTATION:

- Newsletter Article
- Notify/Train Board Staff
- Work with BOP and interested parties to develop standardized procedures or protocols for furnishing of self-administered hormonal contraceptives and nicotine replacement products

Senate Bill No. 493

CHAPTER 469

An act to amend Sections 733, 4040, 4050, 4051, 4052, 4052.3, 4060, 4076, 4111, and 4174 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.

[Approved by Governor October 1, 2013. Filed with Secretary of State October 1, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

SB 493, 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 authorize pharmacists to perform other functions, including, among other things, to furnish self-administered hormonal contraceptives, nicotine replacement products, and prescription medications not requiring a diagnosis that are recommended for international travelers, as specified. Additionally, the bill would authorize pharmacists to order and interpret tests for the purpose of monitoring and managing the efficacy and toxicity of drug therapies, and to independently initiate and administer routine vaccinations, as specified. This bill also would establish board recognition for an advanced practice pharmacist, as defined, would specify the criteria for that recognition, and would specify additional functions that may be performed by an advanced practice pharmacist, including, among other things, performing patient assessments, and certain other functions, as specified. The bill would authorize the board, by regulation, to set the fee for the issuance and renewal of advanced practice pharmacist recognition at the reasonable cost of regulating advanced practice pharmacists pursuant to these provisions, not to exceed $300.

Because a violation of these provisions would be a crime, the bill would impose a state-mandated local program.

The bill would make other conforming and technical changes.

This bill would incorporate additional changes in Section 4076 of the Business and Professions Code proposed by SB 205, that would become

operative only if SB 205 and this bill are both chaptered and become effective on or before January 1, 2014, and this bill is chaptered last.

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.

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

SECTION 1. Section 733 of the Business and Professions Code is amended to read:

733. (a) A licentiate shall not obstruct a patient in obtaining a prescription drug or device that has been legally prescribed or ordered for that patient. A violation of this section constitutes unprofessional conduct by the licentiate and shall subject the licentiate to disciplinary or administrative action by his or her licensing agency.

(b) Notwithstanding any other law, a licentiate shall dispense drugs and devices, as described in subdivision (a) of Section 4024, pursuant to a lawful order or prescription unless one of the following circumstances exists:

(1) Based solely on the licentiate's professional training and judgment, dispensing pursuant to the order or the prescription is contrary to law, or the licentiate determines that the prescribed drug or device would cause a harmful drug interaction or would otherwise adversely affect the patient's medical condition.

(2) The prescription drug or device is not in stock. If an order, other than an order described in Section 4019, or prescription cannot be dispensed because the drug or device is not in stock, the licentiate shall take one of the following actions:

(A) Immediately notify the patient and arrange for the drug or device to be delivered to the site or directly to the patient in a timely manner.

(B) Promptly transfer the prescription to another pharmacy known to stock the prescription drug or device that is near enough to the site from which the prescription or order is transferred, to ensure the patient has timely access to the drug or device.

(C) Return the prescription to the patient and refer the patient. The licentiate shall make a reasonable effort to refer the patient to a pharmacy that stocks the prescription drug or device that is near enough to the referring site to ensure that the patient has timely access to the drug or device.

(3) The licentiate refuses on ethical, moral, or religious grounds to dispense a drug or device pursuant to an order or prescription. A licentiate may decline to dispense a prescription drug or device on this basis only if the licentiate has previously notified his or her employer, in writing, of the drug or class of drugs to which he or she objects, and the licentiate's employer can, without creating undue hardship, provide a reasonable accommodation of the licentiate's objection. The licentiate's employer shall

establish protocols that ensure that the patient has timely access to the prescribed drug or device despite the licentiate's refusal to dispense the prescription or order. For purposes of this section, "reasonable accommodation" and "undue hardship" shall have the same meaning as applied to those terms pursuant to subdivision (*l*) of Section 12940 of the Government Code.

(c) For the purposes of this section, "prescription drug or device" has the same meaning as the definition in Section 4022.

(d) This section applies to emergency contraception drug therapy and self-administered hormonal contraceptives described in Section 4052.3.

(e) This section imposes no duty on a licentiate to dispense a drug or device pursuant to a prescription or order without payment for the drug or device, including payment directly by the patient or through a third-party payer accepted by the licentiate or payment of any required copayment by the patient.

(f) The notice to consumers required by Section 4122 shall include a statement that describes patients' rights relative to the requirements of this section.

SEC. 2. Section 4016.5 is added to the Business and Professions Code, to read:

4016.5. "Advanced practice pharmacist" means a licensed pharmacist who has been recognized as an advanced practice pharmacist by the board, pursuant to Section 4210. A board-recognized advanced practice pharmacist is entitled to practice advanced practice pharmacy, as described in Section 4052.6, within or outside of a licensed pharmacy as authorized by this chapter.

SEC. 3. Section 4040 of the Business and Professions Code is amended to read:

4040. (a) "Prescription" means an oral, written, or electronic transmission order that is both of the following:

(1) Given individually for the person or persons for whom ordered that includes all of the following:

(A) The name or names and address of the patient or patients.

(B) The name and quantity of the drug or device prescribed and the directions for use.

(C) The date of issue.

(D) Either rubber stamped, typed, or printed by hand or typeset, the name, address, and telephone number of the prescriber, his or her license classification, and his or her federal registry number, if a controlled substance is prescribed.

(E) A legible, clear notice of the condition or purpose for which the drug is being prescribed, if requested by the patient or patients.

(F) If in writing, signed by the prescriber issuing the order, or the certified nurse-midwife, nurse practitioner, physician assistant, or naturopathic doctor who issues a drug order pursuant to Section 2746.51, 2836.1, 3502.1, or 3640.5, respectively, or the pharmacist who issues a drug order pursuant to Section 4052.1, 4052.2, or 4052.6.

(2) Issued by a physician, dentist, optometrist, podiatrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7 or, if a drug order is issued pursuant to Section 2746.51, 2836.1, 3502.1, or 3460.5, by a certified nurse-midwife, nurse practitioner, physician assistant, or naturopathic doctor licensed in this state, or pursuant to Section 4052.1, 4052.2, or 4052.6 by a pharmacist licensed in this state.

(b) Notwithstanding subdivision (a), a written order of the prescriber for a dangerous drug, except for any Schedule II controlled substance, that contains at least the name and signature of the prescriber, the name and address of the patient in a manner consistent with paragraph (2) of subdivision (a) of Section 11164 of the Health and Safety Code, the name and quantity of the drug prescribed, directions for use, and the date of issue may be treated as a prescription by the dispensing pharmacist as long as any additional information required by subdivision (a) is readily retrievable in the pharmacy. In the event of a conflict between this subdivision and Section 11164 of the Health and Safety Code, Section 11164 of the Health and Safety Code shall prevail.

(c) "Electronic transmission prescription" includes both image and data prescriptions. "Electronic image transmission prescription" means any prescription order for which a facsimile of the order is received by a pharmacy from a licensed prescriber. "Electronic data transmission prescription" means any prescription order, other than an electronic image transmission prescription, that is electronically transmitted from a licensed prescriber to a pharmacy.

(d) The use of commonly used abbreviations shall not invalidate an otherwise valid prescription.

(e) Nothing in the amendments made to this section (formerly Section 4036) at the 1969 Regular Session of the Legislature shall be construed as expanding or limiting the right that a chiropractor, while acting within the scope of his or her license, may have to prescribe a device.

SEC. 4. Section 4050 of the Business and Professions Code is amended to read:

4050. (a) In recognition of and consistent with the decisions of the appellate courts of this state, the Legislature hereby declares the practice of pharmacy to be a profession.

(b) Pharmacy practice is a dynamic, patient-oriented health service that applies a scientific body of knowledge to improve and promote patient health by means of appropriate drug use, drug-related therapy, and communication for clinical and consultative purposes. Pharmacy practice is continually evolving to include more sophisticated and comprehensive patient care activities.

(c) The Legislature further declares that pharmacists are health care providers who have the authority to provide health care services.

SEC. 5. Section 4051 of the Business and Professions Code is amended to read:

4051. (a) Except as otherwise provided in this chapter, it is unlawful for any person to manufacture, compound, furnish, sell, or dispense a

dangerous drug or dangerous device, or to dispense or compound a prescription pursuant to Section 4040 of a prescriber unless he or she is a pharmacist under this chapter.

(b) Notwithstanding any other law, a pharmacist may authorize the initiation of a prescription, pursuant to Section 4052.1, 4052.2, 4052.3, or 4052.6, and otherwise provide clinical advice, services, 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. 6. 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 medications described in subparagraph (A) in accordance with subparagraph (B):

(A) (1) Emergency contraception drug therapy and self-administered hormonal contraceptives, as authorized by Section 4052.3.

(2) Nicotine replacement products, as authorized by Section 4052.9.

(3) 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.

(B) The pharmacist shall notify the patient's primary care provider of any drugs or devices furnished to the patient, or enter the appropriate information in a patient record system shared with the primary care provider, as permitted by that primary care provider. If the patient does not have a primary care provider, the pharmacist shall provide the patient with a written record of the drugs or devices furnished and advise the patient to consult a physician of the patient's choice.

(11) Administer immunizations pursuant to a protocol with a prescriber.

(12) Order and interpret tests for the purpose of monitoring and managing the efficacy and toxicity of drug therapies. A pharmacist who orders and interprets tests pursuant to this paragraph shall ensure that the ordering of those tests is done in coordination with the patient's primary care provider or diagnosing prescriber, as appropriate, including promptly transmitting written notification to the patient's diagnosing prescriber or entering the appropriate information in a patient record system shared with the prescriber, when available and as permitted by that prescriber.

(b) A pharmacist who is authorized to issue an order to initiate or adjust a controlled substance therapy pursuant to this section shall personally register with the federal Drug Enforcement Administration.

(c) This section does not affect the applicable requirements of law relating to either of the following:

(1) Maintaining the confidentiality of medical records.

(2) The licensing of a health care facility.

SEC. 7. Section 4052.3 of the Business and Professions Code is amended to read:

4052.3. (a) (1) Notwithstanding any other law, a pharmacist may furnish self-administered hormonal contraceptives in accordance with standardized procedures or protocols developed and approved by both the board and the Medical Board of California in consultation with the American Congress of Obstetricians and Gynecologists, the California Pharmacists Association, and other appropriate entities. The standardized procedure or protocol shall require that the patient use a self-screening tool that will identify patient risk factors for use of self-administered hormonal contraceptives, based on the current United States Medical Eligibility Criteria (USMEC) for Contraceptive Use developed by the federal Centers for Disease Control and Prevention, and that the pharmacist refer the patient to the patient's primary care provider or, if the patient does not have a primary care provider, to nearby clinics, upon furnishing a self-administered hormonal contraceptive pursuant to this subdivision, or if it is determined that use of a self-administered hormonal contraceptive is not recommended.

(2) The board and the Medical Board of California are both authorized to ensure compliance with this subdivision, and each board is specifically charged with the enforcement of this subdivision with respect to its respective

licensees. This subdivision does not expand the authority of a pharmacist to prescribe any prescription medication.

(b) (1) Notwithstanding any other 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. This paragraph shall become inoperative for dedicated emergency contraception drugs if these drugs are reclassified as over-the-counter products by the federal Food and Drug Administration.

(4) A pharmacist shall not require a patient to provide individually identifiable medical information that is not specified in Section 1707.1 of Title 16 of the California Code of Regulations before initiating emergency contraception drug therapy pursuant to this subdivision.

(c) For each emergency contraception drug therapy or self-administered hormonal contraception initiated pursuant to this section, the pharmacist shall provide the recipient of the drug with a standardized factsheet that

includes, but is not limited to, the indications and contraindications for use of the drug, the appropriate method for using the drug, the need for medical followup, and other appropriate information. The board shall develop this form in consultation with the State Department of Public Health, the American Congress of Obstetricians and Gynecologists, the California Pharmacists Association, and other health care organizations. This section does not preclude the use of existing publications developed by nationally recognized medical organizations.

SEC. 8. Section 4052.6 is added to the Business and Professions Code, to read:

4052.6. (a) A pharmacist recognized by the board as an advanced practice pharmacist may do all of the following:

(1) Perform patient assessments.

(2) Order and interpret drug therapy-related tests.

(3) Refer patients to other health care providers.

(4) Participate in the evaluation and management of diseases and health conditions in collaboration with other health care providers.

(5) Initiate, adjust, or discontinue drug therapy in the manner specified in paragraph (4) of subdivision (a) of Section 4052.2.

(b) A pharmacist who adjusts or discontinues drug therapy shall promptly transmit written notification to the patient's diagnosing prescriber or enter the appropriate information in a patient record system shared with the prescriber, as permitted by that prescriber. A pharmacist who initiates drug therapy shall promptly transmit written notification to, or enter the appropriate information into, a patient record system shared with the patient's primary care provider or diagnosing provider, as permitted by that provider.

(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.

(e) A pharmacist who orders and interprets tests pursuant to paragraph (2) of subdivision (a) shall ensure that the ordering of those tests is done in coordination with the patient's primary care provider or diagnosing prescriber, as appropriate, including promptly transmitting written notification to the patient's diagnosing prescriber or entering the appropriate information in a patient record system shared with the prescriber, when available and as permitted by that prescriber.

SEC. 9. Section 4052.8 is added to the Business and Professions Code, to read:

4052.8. (a) In addition to the authority provided in paragraph (11) 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 (11) 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. 10. Section 4052.9 is added to the Business and Professions Code, to read:

4052.9. (a) A pharmacist may furnish nicotine replacement products approved by the federal Food and Drug Administration for use by prescription only in accordance with standardized procedures and protocols developed and approved by both the board and the Medical Board of California in consultation with other appropriate entities and provide smoking cessation services if all of the following conditions are met:

(1) The pharmacist maintains records of all prescription drugs and devices furnished for a period of at least three years for purposes of notifying other health care providers and monitoring the patient.

(2) The pharmacist notifies the patient's primary care provider of any drugs or devices furnished to the patient, or enters the appropriate information in a patient record system shared with the primary care provider, as permitted by that primary care provider. If the patient does not have a primary care provider, the pharmacist provides the patient with a written record of the drugs or devices furnished and advises the patient to consult a physician of the patient's choice.

(3) The pharmacist is certified in smoking cessation therapy by an organization recognized by the board.

(4) The pharmacist completes one hour of continuing education focused on smoking cessation therapy biennially.

(b) The board and the Medical Board of California are both authorized to ensure compliance with this section, and each board is specifically charged with the enforcement of this section with respect to their respective licensees. Nothing in this section shall be construed to expand the authority of a pharmacist to prescribe any other prescription medication.

SEC. 11. Section 4060 of the Business and Professions Code is amended to read:

4060. A person shall not possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to Section 4052.1, 4052.2, or 4052.6. This section does not apply to the possession of any controlled substance by a manufacturer, wholesaler, pharmacy, pharmacist, physician, podiatrist, dentist, optometrist, veterinarian, naturopathic doctor, certified nurse-midwife, nurse practitioner, or physician assistant, if in stock in containers correctly labeled with the name and address of the supplier or producer.

This section does not authorize a certified nurse-midwife, a nurse practitioner, a physician assistant, or a naturopathic doctor, to order his or her own stock of dangerous drugs and devices.

SEC. 12. Section 4076 of the Business and Professions Code is amended to read:

4076. (a) A pharmacist shall not dispense any prescription except in a container that meets the requirements of state and federal law and is correctly labeled with all of the following:

(1) Except when the prescriber or the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6 orders otherwise, either the manufacturer's trade name of the drug or the generic name and the name of the manufacturer. Commonly used abbreviations may be used. Preparations containing two or more active ingredients may be identified by the manufacturer's trade name or the commonly used name or the principal active ingredients.

(2) The directions for the use of the drug.

(3) The name of the patient or patients.

(4) The name of the prescriber or, if applicable, the name of the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6.

(5) The date of issue.

(6) The name and address of the pharmacy, and prescription number or other means of identifying the prescription.

(7) The strength of the drug or drugs dispensed.

(8) The quantity of the drug or drugs dispensed.

(9) The expiration date of the effectiveness of the drug dispensed.

(10) The condition or purpose for which the drug was prescribed if the condition or purpose is indicated on the prescription.

(11) (A) Commencing January 1, 2006, the physical description of the dispensed medication, including its color, shape, and any identification code that appears on the tablets or capsules, except as follows:

(i) Prescriptions dispensed by a veterinarian.

(ii) An exemption from the requirements of this paragraph shall be granted to a new drug for the first 120 days that the drug is on the market and for the 90 days during which the national reference file has no description on file.

(iii) Dispensed medications for which no physical description exists in any commercially available database.

(B) This paragraph applies to outpatient pharmacies only.

(C) The information required by this paragraph may be printed on an auxiliary label that is affixed to the prescription container.

(D) This paragraph shall not become operative if the board, prior to January 1, 2006, adopts regulations that mandate the same labeling requirements set forth in this paragraph.

(b) If a pharmacist dispenses a prescribed drug by means of a unit dose medication system, as defined by administrative regulation, for a patient in a skilled nursing, intermediate care, or other health care facility, the requirements of this section will be satisfied if the unit dose medication system contains the aforementioned information or the information is otherwise readily available at the time of drug administration.

(c) If a pharmacist dispenses a dangerous drug or device in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include on individual unit dose containers for a specific patient, the name of the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6.

(d) If a pharmacist dispenses a prescription drug for use in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include the information required in paragraph (11) of subdivision (a) when the prescription drug is administered to a patient by a person licensed under the Medical Practice Act (Chapter 5 (commencing with Section 2000)), the Nursing Practice Act (Chapter 6 (commencing with Section 2700)), or the Vocational Nursing Practice Act (Chapter 6.5

(commencing with Section 2840)), who is acting within his or her scope of practice.

SEC. 12.5. Section 4076 of the Business and Professions Code is amended to read:

4076. (a) A pharmacist shall not dispense any prescription except in a container that meets the requirements of state and federal law and is correctly labeled with all of the following:

(1) Except when the prescriber or the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6 orders otherwise, either the manufacturer's trade name of the drug or the generic name and the name of the manufacturer. Commonly used abbreviations may be used. Preparations containing two or more active ingredients may be identified by the manufacturer's trade name or the commonly used name or the principal active ingredients.

(2) The directions for the use of the drug.

(3) The name of the patient or patients.

(4) The name of the prescriber or, if applicable, the name of the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6.

(5) The date of issue.

(6) The name and address of the pharmacy, and prescription number or other means of identifying the prescription.

(7) The strength of the drug or drugs dispensed.

(8) The quantity of the drug or drugs dispensed.

(9) The expiration date of the effectiveness of the drug dispensed.

(10) The condition or purpose for which the drug was prescribed if the condition or purpose is indicated on the prescription.

(11) (A) Commencing January 1, 2006, the physical description of the dispensed medication, including its color, shape, and any identification code that appears on the tablets or capsules, except as follows:

(i) Prescriptions dispensed by a veterinarian.

(ii) An exemption from the requirements of this paragraph shall be granted to a new drug for the first 120 days that the drug is on the market and for the 90 days during which the national reference file has no description on file.

(iii) Dispensed medications for which no physical description exists in any commercially available database.

(B) This paragraph applies to outpatient pharmacies only.

(C) The information required by this paragraph may be printed on an auxiliary label that is affixed to the prescription container.

(D) This paragraph shall not become operative if the board, prior to January 1, 2006, adopts regulations that mandate the same labeling requirements set forth in this paragraph.

(b) If a pharmacist dispenses a prescribed drug by means of a unit dose medication system, as defined by administrative regulation, for a patient in a skilled nursing, intermediate care, or other health care facility, the requirements of this section will be satisfied if the unit dose medication system contains the aforementioned information or the information is otherwise readily available at the time of drug administration.

(c) If a pharmacist dispenses a dangerous drug or device in a health facility, as defined in Section 1250 of the Health and Safety Code, it is not necessary to include on individual unit dose containers for a specific patient, the name of the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6.

(d) If a pharmacist dispenses a prescription drug for use in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include the information required in paragraph (11) of subdivision (a) when the prescription drug is administered to a patient by a person licensed under the Medical Practice Act (Chapter 5 (commencing with Section 2000)), the Nursing Practice Act (Chapter 6 (commencing with Section 2700)), or the Vocational Nursing Practice Act (Chapter 6.5 (commencing with Section 2840)), who is acting within his or her scope of practice.

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

SEC. 12.7. Section 4076 is added to the Business and Professions Code, to read:

4076. (a) A pharmacist shall not dispense any prescription except in a container that meets the requirements of state and federal law and is correctly labeled with all of the following:

(1) Except when the prescriber or the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor

who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6 orders otherwise, either the manufacturer's trade name of the drug or the generic name and the name of the manufacturer. Commonly used abbreviations may be used. Preparations containing two or more active ingredients may be identified by the manufacturer's trade name or the commonly used name or the principal active ingredients.

(2) The directions for the use of the drug.

(3) The name of the patient or patients.

(4) The name of the prescriber or, if applicable, the name of the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6.

(5) The date of issue.

(6) The name and address of the pharmacy, and prescription number or other means of identifying the prescription.

(7) The strength of the drug or drugs dispensed.

(8) The quantity of the drug or drugs dispensed.

(9) The expiration date of the effectiveness of the drug dispensed.

(10) The condition or purpose for which the drug was prescribed if the condition or purpose is indicated on the prescription.

(11) (A) Commencing January 1, 2006, the physical description of the dispensed medication, including its color, shape, and any identification code that appears on the tablets or capsules, except as follows:

(i) Prescriptions dispensed by a veterinarian.

(ii) An exemption from the requirements of this paragraph shall be granted to a new drug for the first 120 days that the drug is on the market and for the 90 days during which the national reference file has no description on file.

(iii) Dispensed medications for which no physical description exists in any commercially available database.

(B) This paragraph applies to outpatient pharmacies only.

(C) The information required by this paragraph may be printed on an auxiliary label that is affixed to the prescription container.

(D) This paragraph shall not become operative if the board, prior to January 1, 2006, adopts regulations that mandate the same labeling requirements set forth in this paragraph.

(b) The information required by paragraphs (1), (2), (3), (7), and (10) of subdivision (a) shall be printed in at least a 12-point typeface.

(c) If a pharmacist dispenses a prescribed drug by means of a unit dose medication system, as defined by administrative regulation, for a patient in

a skilled nursing, intermediate care, or other health care facility, the requirements of this section will be satisfied if the unit dose medication system contains the aforementioned information or the information is otherwise readily available at the time of drug administration.

(d) If a pharmacist dispenses a dangerous drug or device in a health facility, as defined in Section 1250 of the Health and Safety Code, it is not necessary to include on individual unit dose containers for a specific patient, the name of the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6.

(e) If a pharmacist dispenses a prescription drug for use in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include the information required in paragraph (11) of subdivision (a) when the prescription drug is administered to a patient by a person licensed under the Medical Practice Act (Chapter 5 (commencing with Section 2000)), the Nursing Practice Act (Chapter 6 (commencing with Section 2700)), or the Vocational Nursing Practice Act (Chapter 6.5 (commencing with Section 2840)), who is acting within his or her scope of practice.

(f) This section shall become operative on January 1, 2016.

SEC. 13. Section 4111 of the Business and Professions Code is amended to read:

4111. (a) Except as otherwise provided in subdivision (b), (d), or (e), the board shall not issue or renew a license to conduct a pharmacy to any of the following:

(1) A person or persons authorized to prescribe or write a prescription, as specified in Section 4040, in the State of California.

(2) A person or persons with whom a person or persons specified in paragraph (1) shares a community or other financial interest in the permit sought.

(3) Any corporation that is controlled by, or in which 10 percent or more of the stock is owned by a person or persons prohibited from pharmacy ownership by paragraph (1) or (2).

(b) Subdivision (a) shall not preclude the issuance of a permit for an inpatient hospital pharmacy to the owner of the hospital in which it is located.

(c) The board may require any information the board deems is reasonably necessary for the enforcement of this section.

(d) Subdivision (a) shall not preclude the issuance of a new or renewal license for a pharmacy to be owned or owned and operated by a person licensed on or before August 1, 1981, under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) and qualified on or before August

1, 1981, under subsection (d) of Section 1310 of Title XIII of the federal Public Health Service Act, as amended, whose ownership includes persons defined pursuant to paragraphs (1) and (2) of subdivision (a).

(e) Subdivision (a) shall not preclude the issuance of a new or renewal license for a pharmacy to be owned or owned and operated by a pharmacist authorized to issue a drug order pursuant to Section 4052.1, 4052.2, or 4052.6.

SEC. 14. Section 4174 of the Business and Professions Code is amended to read:

4174. Notwithstanding any other law, a pharmacist may dispense drugs or devices upon the drug order of a nurse practitioner functioning pursuant to Section 2836.1 or a certified nurse-midwife functioning pursuant to Section 2746.51, a drug order of a physician assistant functioning pursuant to Section 3502.1 or a naturopathic doctor functioning pursuant to Section 3640.5, or the order of a pharmacist acting under Section 4052.1, 4052.2, 4052.3, or 4052.6.

SEC. 15. 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, geriatric pharmacy, 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 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 provided clinical services to 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. 16. Section 4233 is added to the Business and Professions Code, to read:

4233. A pharmacist who is recognized as an advanced practice pharmacist shall complete 10 hours of continuing education each renewal cycle in addition to the requirements of Section 4231. The subject matter shall be in one or more areas of practice relevant to the pharmacist's clinical practice.

SEC. 17. Sections 12.5 and 12.7 of this bill incorporate amendments to Section 4076 of the Business and Professions Code proposed by both this bill and Senate Bill 205. They shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2014, (2) each bill amends Section 4076 of the Business and Professions Code, and (3) this bill is enacted after Senate Bill 205, in which case Section 12 of this bill shall not become operative.

SEC. 18. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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SB 670

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 670
Author: Steinberg
Chapter: 399
Bill Date: September 11, 2013, Amended
Subject: Physicians and surgeons: investigations
Sponsor: Author
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill authorizes the Medical Board of California (Board) to inspect the medical records of a patient who is deceased without the consent of the patient's next of kin or a court order in any case that involves the death of a patient. This bill also revises the definition of unprofessional conduct, for a licensee who is under investigation, if the licensee repeatedly fails to attend and participate in an interview of the Board.

This bill would have allowed 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 "probable cause" that the physician prescribed, furnished, administered, or dispensed controlled substances in violation of the Medical Practice Act; however, this provision was amended out of the bill.

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 has deviated from the standard of care. If the Board cannot obtain written authorization to release the medical records, it has obtain a subpoena and it must be proven that there is a compelling state need in order to obtain those records through a subpoena.

This bill allows 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. The Board must include a declaration in the written request to the physician requesting the patient's records that the Board has been unsuccessful in locating or contacting the deceased patient's beneficiary or personal representative after reasonable efforts. If the Board does contact the deceased patient's beneficiary or personal representative and consent to the Board is refused for obtaining records, then the Board must obtain the records

through a court order. This bill specifies 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 revises the definition of unprofessional conduct, for a licensee who is under investigation, if the licensee repeatedly fails to attend and participate in an interview of the Board. Removing the "mutual agreement" language may help to resolve the issue of physicians failing to agree to any interview with the Board, and may help to reduce enforcement timelines.

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 have allowed 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 probable cause to believe that the physician has prescribed, furnished, administered, or dispensed controlled substances in violation of the Medical Practice Act; however, this provision was removed from the bill at the end of the legislative session in order to address concerns raised by the opposition.

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 taken a support position on this bill, as the due process concern is no longer valid.

FISCAL: Minimal and absorbable

SUPPORT: Center for Public Interest Law
California Academy of Family Physicians
Medical Board of California
Osteopathic Physicians and Surgeons of California
California Medical Association

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter Article
- Notify attorneys who represent physicians
- Notify/Train Board Staff
- Revise existing processes and procedures regarding obtaining records for deceased patients
- Develop declaration to include with the written request for a deceased patient's records
- Revise existing processes and procedures for scheduling physician interviews – mutual agreement is no longer required

Senate Bill No. 670

CHAPTER 399

An act to amend Sections 2225 and 2234 of the Business and Professions Code, and to amend Section 11529 of the Government Code, relating to healing arts.

[Approved by Governor September 27, 2013. Filed with Secretary of State September 27, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

SB 670, 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, in any investigation that involves the death of a patient, to inspect and copy the medical records of the deceased patient without the authorization of the beneficiary or personal representative of the deceased patient or a court order solely to determine the extent to which the death was the result of the physician and surgeon's violation of the Medical Practice Act, if the board provides a written request to the physician and surgeon that includes a declaration that the board has been unsuccessful in locating or contacting the deceased patient's beneficiary or personal representative after reasonable efforts.

(2) Existing law requires the board to take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct is defined for this purpose to include, among other things, the repeated failure by a licensee who is the subject of a board investigation, in the absence of good cause, to attend and participate in an interview scheduled by the mutual agreement of the licensee and the board.

This bill would revise that definition of unprofessional conduct to include the repeated failure by a licensee who is the subject of a board investigation, in the absence of good cause, to attend and participate in an interview by the board.

(3) Existing law, the Administrative Procedure Act, authorizes the administrative law judge of the Medical Quality Hearing Panel to issue an interim order suspending a license, or imposing drug testing, continuing education, supervision of procedures, or other licensee restrictions.

This bill would further authorize the administrative law judge to issue an interim order limiting the authority to prescribe, furnish, administer, or dispense controlled substances.

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

SECTION 1. 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, and may inspect documents relevant to those investigations in accordance with the following procedures:

(1) Any document relevant to an investigation may be inspected, and copies may be obtained, where patient consent is given.

(2) Any document relevant to the business operations of a licensee, and not involving medical records attributable to identifiable patients, may be inspected and copied if relevant to an investigation of a licensee.

(c) (1) Notwithstanding subdivision (b) or any other law, in any investigation that involves the death of a patient, the board may inspect and copy the medical records of the deceased patient without the authorization of the beneficiary or personal representative of the deceased patient or a court order solely for the purpose of determining the extent to which the death was the result of the physician and surgeon's conduct in violation of the Medical Practice Act, if the board provides a written request to the physician and surgeon that includes a declaration that the board has been unsuccessful in locating or contacting the deceased patient's beneficiary or personal representative after reasonable efforts. Nothing in this subdivision shall be construed to allow the board to inspect and copy the medical records of a deceased patient without a court order when the beneficiary or personal representative of the deceased patient has been located and contacted but has refused to consent to the board inspecting and copying the medical records of the deceased patient.

(2) The Legislature finds and declares that the authority created in the board pursuant to this section, and a physician and surgeon's compliance with this section, are consistent with the public interest and benefit activities of the federal Health Insurance Portability and Accountability Act (HIPAA).

(d) In all cases in which documents are inspected or copies of those documents are received, their acquisition or review shall be arranged so as not to unnecessarily disrupt the medical and business operations of the licensee or of the facility where the records are kept or used.

(e) If documents are lawfully requested from licensees in accordance with this section by the Attorney General or his or her agents or deputies, or investigators of the board or the California Board of Podiatric Medicine, the documents shall be provided within 15 business days of receipt of the request, unless the licensee is unable to provide the documents within this time period for good cause, including, but not limited to, physical inability to access the records in the time allowed due to illness or travel. Failure to produce requested documents or copies thereof, after being informed of the required deadline, shall constitute unprofessional conduct. The board may use its authority to cite and fine a physician and surgeon for any violation of this section. This remedy is in addition to any other authority of the board to sanction a licensee for a delay in producing requested records.

(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. 2. 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 the implementation of the proposed registration program described in Section 2052.5.

(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

SEC. 3. 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, limitations on the authority to prescribe, furnish, administer, or dispense controlled substances, or other license restrictions. Interim orders may be issued only if the affidavits in support of the petition show that the licensee has engaged in, or is about to engage in, acts or omissions constituting a violation of the Medical Practice Act or the appropriate practice act governing each allied health profession, or is unable to practice safely due to a mental or physical condition, and that permitting the licensee to continue to engage in the profession for which the license was issued will endanger the public health, safety, or welfare.

(b) All orders authorized by this section shall be issued only after a hearing conducted pursuant to subdivision (d), unless it appears from the facts shown by affidavit that serious injury would result to the public before the matter can be heard on notice. Except as provided in subdivision (c), the licensee shall receive at least 15 days' prior notice of the hearing, which

notice shall include affidavits and all other information in support of the order.

(c) If an interim order is issued without notice, the administrative law judge who issued the order without notice shall cause the licensee to be notified of the order, including affidavits and all other information in support of the order by a 24-hour delivery service. That notice shall also include the date of the hearing on the order, which shall be conducted in accordance with the requirement of subdivision (d), not later than 20 days from the date of issuance. The order shall be dissolved unless the requirements of subdivision (a) are satisfied.

(d) For the purposes of the hearing conducted pursuant to this section, the licentiate shall, at a minimum, have the following rights:

(1) To be represented by counsel.

(2) To have a record made of the proceedings, copies of which may be obtained by the licentiate upon payment of any reasonable charges associated with the record.

(3) To present written evidence in the form of relevant declarations, affidavits, and documents.

The discretion of the administrative law judge to permit testimony at the hearing conducted pursuant to this section shall be identical to the discretion of a superior court judge to permit testimony at a hearing conducted pursuant to Section 527 of the Code of Civil Procedure.

(4) To present oral argument.

(e) Consistent with the burden and standards of proof applicable to a preliminary injunction entered under Section 527 of the Code of Civil Procedure, the administrative law judge shall grant the interim order 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.

(g) If an interim order is issued, a written decision shall be prepared within 15 days of the hearing, by the administrative law judge, including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached.

(h) Notwithstanding the fact that interim orders issued pursuant to this section are not issued after a hearing as otherwise required by this chapter, interim orders so issued shall be subject to judicial review pursuant to Section 1094.5 of the Code of Civil Procedure. The relief that may be ordered shall be limited to a stay of the interim order. Interim orders issued pursuant to this section are final interim orders and, if not dissolved pursuant to subdivision (c) or (f), may only be challenged administratively at the hearing on the accusation.

(i) The interim order provided for by this section shall be:

(1) In addition to, and not a limitation on, the authority to seek injunctive relief provided for in the Business and Professions Code.

(2) A limitation on the emergency decision procedure provided in Article 13 (commencing with Section 11460.10) of Chapter 4.5.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 809
Author: DeSaulnier and Steinberg
Chapter: 400
Bill Date: September 3, 2013, Amended
Subject: Controlled Substances: Reporting
Sponsor: California Attorney General Kamala Harris
Position: Support if Amended

DESCRIPTION OF CURRENT LEGISLATION:

This bill makes findings and declarations regarding the Controlled Substance Utilization Review and Evaluation System (CURES) and establishes the Fund that would be administered by the Department of Justice (DOJ), and would consist of funds collected from boards that license prescribers and dispensers, for purposes of funding and upgrading the CURES system.

This bill requires DOJ, the Department of Consumer Affairs (DCA) and the regulatory boards to identify and implement a streamlined application and approval process to provide access to CURES, and to make efforts to incorporate the CURES application at the time of license application or renewal. DOJ, DCA and the regulatory boards must also identify necessary procedures to enable prescribers and dispensers to delegate their authority to order CURES reports, and develop a procedure to enable health care practitioners, who do not have a federal Drug Enforcement Administration (DEA) number, to opt out of applying for access to CURES.

This bill requires 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).

This bill requires prescribers and dispensers, before January 1, 2016, or upon receipt of a federal DEA number, to submit an application to DOJ to obtain approval to access information online regarding the controlled substance history of a patient from CURES.

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 makes findings and declarations related to the importance of CURES. This bill establishes the CURES Fund that would be funded, beginning April 1, 2014, by an annual $6 flat fee 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; 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 makes 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 specifies that the fee increase shall be due at time of renewal and shall not exceed the reasonable costs associated with maintaining CURES.

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 Board, this will be $1.638 million. The Budget Bill states the legislative intent that the CURES system be jointly developed by DOJ and 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 allows DOJ to seek private funds from qualified manufacturers, insurers, and health care service plans for the purpose of supporting CURES. This bill requires DOJ to annually report to the Legislature and make available to the public the amount and source of funds it receives for support of CURES.

This bill requires DOJ to establish policies, procedures, and regulations regarding the use, access, evaluation, management, implementation, storage, disclosure, and security of the information within CURES. This bill also allows 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 requires DOJ to consult with prescribers, regulatory boards, and other stakeholders to identify desirable capabilities and upgrades to the CURES system.

This bill requires 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 (DHCS) and DOJ in developing the materials.

This bill requires DOJ, DCA and the regulatory boards to identify and implement a streamlined application and approval process to provide access to CURES and to make efforts to incorporate the CURES application at the time of license application or renewal. DOJ, DCA and the regulatory boards must also identify necessary procedures to enable prescribers and dispensers to delegate their authority to order CURES reports, and develop a procedure to enable health care practitioners who do not have a federal DEA number to opt out of applying for access to CURES.

This bill requires prescribers and dispensers, before January 1, 2016, or upon receipt of a federal DEA number, to submit an application to DOJ to obtain approval to access information online regarding the controlled substance history of a patient from CURES.

The Board believes CURES is a very important enforcement tool and an effective aid for physicians to use to prevent "doctor shopping". The Board continues to support CURES being fully funded and upgraded, as it is imperative that California have an effective reporting system that is at optimum operating capacity. This bill has been amended to address the Board's previous implementation concerns. Although the Board also believes that the cost for funding and maintaining cures should be a shared contribution by prescribers, dispensers, pharmaceutical manufacturers, insurers, and the

public, having CURES funded and upgraded is of utmost importance in order to ensure consumer protection and to help aid physicians, as well as all regulatory boards.

FISCAL: This bill would result in an annual $6 flat fee increase for physicians, which equates to a $12 increase for renewals. 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); ALPHA Fund; American Cancer Society Cancer Action Network; American Medical Association; Association of California Healthcare Districts; Association of California Insurance Companies; Association of California Life and Health Insurance Companies; Association of Northern California Oncologists; Behind the Orange Curtain, the Documentary; American College of Emergency Physicians, California Chapter; California Academy of Physician Assistants; California Association for Nurse Practitioners; California Association of Joint Powers Authority; California Association of Oral and Maxillofacial Surgeons; California Coalition on Workers' Compensation; California Department of Insurance; California Hospital Association; California Joint Powers Insurance Authority; California Labor Federation; California Medical Association; California Narcotic Officers Association; California Pharmacists Association; California Primary Care Association; California Police Chiefs Association; California Professional Association of Specialty Contractors; California Retailers Association; California Self-Insurers Association; California Society of Health-System Pharmacists; California Special Districts Association; California State Association of Counties; California State Board of Pharmacy; California State Sheriff's Association; Center for Public Interest Law; City and County of San Francisco; CompPharma; County Alcohol and Drug Program Administrators Association of California; County of San Diego; CSAC Excess Insurance Authority; Deputy Sheriffs' Association of San Diego County; Employers Group; Gallagher Bassett Services, Inc.; Golden Oak Cooperative Corporation; Grimmway Farms; Healthcare Distribution Management Association; Health Officers Association of California; Independent Insurance Agents and Brokers of California; Los Angeles County District Attorney's Office; Kaiser Permanente; Medical Board of California (if amended); Medical Oncology Association of Southern California, Inc; Metro Risk Management; Michael Sullivan and Associates; National Association of Chain Drug Stores; National Coalition Against Prescription Drug Abuse; Nordstrom; Safeway; Schools Insurance Authority; Schools Insurance Group; Sedgwick Claims Management Services; Shaw, Jacobsmeyer, Crain, and Claffey;

South Orange County Coalition; Troy and Alana Pack Foundation; Western Occupational and Environmental Medical Association; University of California; and Western Propane Gas Association

OPPOSITION: None

IMPLEMENTATION:

- Newsletter Article
- Post information on the Board's Web site regarding the fee increase and email physicians
- Notify/Train Board Staff
- Revise the renewal application form to reflect the new fee and revise the renewal letter to reflect the new fee
- Make necessary changes to the computer system to reflect the fee increase
- Work with DCA, DOJ and other regulatory boards on a streamlined application process for CURES and provide recommendations on how this application could be integrated as part of the license and renewal process
- Work with DCA, DOJ and other regulatory boards to develop a procedure to enable health care practitioners to delegate their authority to order CURES reports, and to develop an opt-out procedure for those practitioners who do not have a DEA number
- Provide input to DOJ and DCA on desirable capabilities of the new CURES system for the Board's enforcement program
- Work with DOJ and DHCS to identify educational materials related to assessing a patient's risk of abusing or diverting controlled substances and information on CURES; these educational materials must be disseminated to each licensed physician and GACH

Senate Bill No. 809

CHAPTER 400

An act to add Sections 208, 209, and 2196.8 to the Business and Professions Code, and to amend Sections 11164.1, 11165, and 11165.1 of, and to add Section 11165.5 to, the Health and Safety Code, relating to controlled substances.

[Approved by Governor September 27, 2013. Filed with Secretary of State September 27, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

SB 809, DeSaulnier. Controlled substances: reporting.

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

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

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

This bill would, beginning April 1, 2014, require an annual fee of $6 to be assessed on specified licensees, including licensees authorized to prescribe, order, administer, furnish, or dispense controlled substances, and require the regulating agency of each of those licensees to bill and collect that fee at the time of license renewal. The bill would authorize the Department of Consumer Affairs to reduce, by regulation, that fee to the reasonable cost of operating and maintaining CURES for the purpose of regulating those licensees, if the reasonable regulatory cost is less than $6 per licensee. The bill would require the proceeds of the fee to be deposited into the CURES Fund for the support of CURES, as specified. The bill would also permit specified insurers, health care service plans, qualified manufacturers, and other donors to voluntarily contribute to the CURES Fund, as described.

(2) Existing law requires the Medical Board of California to periodically develop and disseminate information and educational materials regarding various subjects, including pain management techniques, to each licensed physician and surgeon and to each general acute care hospital in California.

This bill would additionally require the board to periodically develop and disseminate to each licensed physician and surgeon and to each general acute care hospital in California information and educational materials relating to the assessment of a patient's risk of abusing or diverting controlled substances and information relating to CURES.

(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, by January 1, 2016, or upon receipt of a federal Drug Enforcement Administration registration, whichever occurs later, health care practitioners authorized to prescribe, order, administer, furnish, or dispense controlled substances, 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 their care. The bill would require the Department of Justice, in conjunction with the Department of Consumer Affairs and certain licensing boards, to, among other things, develop a streamlined application and approval process to provide access to the CURES database for licensed health care practitioners and pharmacists. The bill would make other related and conforming changes.

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

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

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

(b) Each year CURES responds to more than 800,000 requests from practitioners and pharmacists regarding all of the following:

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

(2) Helping practitioners make prescribing decisions.

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

(c) Schedule II, Schedule III, and Schedule IV controlled substances have had deleterious effects on private and public interests, including the misuse, abuse, and trafficking in dangerous prescription medications resulting in injury and death. It is the intent of the Legislature to work with stakeholders to fully fund the operation of CURES which seeks to mitigate those deleterious effects and serve as a tool for ensuring safe patient care, and which has proven to be a cost-effective tool to help reduce the misuse, abuse, and trafficking of those drugs.

(d) The following goals are critical to increase the effectiveness and functionality of CURES:

(1) Upgrading the CURES PDMP so that it is capable of accepting real-time updates and is accessible in real-time, 24 hours a day, seven days a week.

(2) Upgrading the CURES PDMP in California so that it is capable of operating in conjunction with all national prescription drug monitoring programs.

(3) Providing subscribers to prescription drug monitoring programs access to information relating to controlled substances dispensed in California, including those dispensed through the United States Department of Veterans Affairs, the Indian Health Service, the Department of Defense, and any other entity with authority to dispense controlled substances in California.

(4) Upgrading the CURES PDMP so that it is capable of accepting the reporting of electronic prescription data, thereby enabling more reliable, complete, and timely prescription monitoring.

SEC. 2. Section 208 is added to the Business and Professions Code, to read:

208. (a) Beginning April 1, 2014, a CURES fee of six dollars ($6) shall be assessed annually on each of the licensees specified in subdivision (b) to pay the reasonable costs associated with operating and maintaining CURES for the purpose of regulating those licensees. The fee assessed pursuant to this subdivision shall be billed and collected by the regulating agency of each licensee at the time of the licensee's license renewal. If the reasonable regulatory cost of operating and maintaining CURES is less than six dollars ($6) per licensee, the Department of Consumer Affairs may, by regulation, reduce the fee established by this section to the reasonable regulatory cost.

(b) (1) Licensees 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 or pharmacists licensed pursuant to Chapter 9 (commencing with Section 4000) of Division 2.

(2) Wholesalers and nonresident wholesalers of dangerous drugs licensed pursuant to Article 11 (commencing with Section 4160) of Chapter 9 of Division 2.

(3) Nongovernmental clinics licensed pursuant to Article 13 (commencing with Section 4180) and Article 14 (commencing with Section 4190) of Chapter 9 of Division 2.

(4) Nongovernmental pharmacies licensed pursuant to Article 7 (commencing with Section 4110) of Chapter 9 of Division 2.

(c) The funds collected pursuant to subdivision (a) shall be deposited in the CURES Fund, which is hereby created within the State Treasury. Moneys in the CURES Fund shall, upon appropriation by the Legislature, be available to the Department of Consumer Affairs to reimburse the Department of Justice for costs to operate and maintain CURES for the purposes of regulating the licensees specified in subdivision (b).

(d) The Department of Consumer Affairs shall contract with the Department of Justice on behalf of the Medical Board of California, the Dental Board of California, the California State Board of Pharmacy, the Veterinary Medical Board, the Board of Registered Nursing, the Physician Assistant Board of the Medical Board of California, the Osteopathic Medical Board of California, the Naturopathic Medicine Committee of the Osteopathic Medical Board, the State Board of Optometry, and the California Board of Podiatric Medicine to operate and maintain CURES for the purposes of regulating the licensees specified in subdivision (b).

SEC. 3. Section 209 is added to the Business and Professions Code, to read:

209. The Department of Justice, in conjunction with the Department of Consumer Affairs and the boards and committees identified in subdivision (d) of Section 208, shall do all of the following:

(a) Identify and implement a streamlined application and approval process to provide access to the CURES Prescription Drug Monitoring Program (PDMP) database for licensed health care practitioners eligible to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances and for pharmacists. Every reasonable effort shall be made to implement a streamlined application and approval process that a licensed health care practitioner or pharmacist can complete at the time that he or she is applying for licensure or renewing his or her license.

(b) Identify necessary procedures to enable licensed health care practitioners and pharmacists with access to the CURES PDMP to delegate their authority to order reports from the CURES PDMP.

(c) Develop a procedure to enable health care practitioners who do not have a federal Drug Enforcement Administration (DEA) number to opt out of applying for access to the CURES PDMP.

SEC. 4. Section 2196.8 is added to the Business and Professions Code, to read:

2196.8. The board shall periodically develop and disseminate information and educational material regarding assessing a patient's risk of abusing or diverting controlled substances and information relating to the Controlled Substance Utilization Review and Evaluation System (CURES), described in Section 11165 of the Health and Safety Code, to each licensed physician and surgeon and to each general acute care hospital in this state. The board shall consult with the State Department of Public Health, the boards and committees specified in subdivision (d) of Section 208, and the Department

of Justice in developing the materials to be distributed pursuant to this section.

SEC. 5. Section 11164.1 of the Health and Safety Code is amended to read:

11164.1. (a) (1) Notwithstanding any other provision of law, a prescription for a controlled substance issued by a prescriber in another state for delivery to a patient in another state may be dispensed by a California pharmacy, if the prescription conforms with the requirements for controlled substance prescriptions in the state in which the controlled substance was prescribed.

(2) All prescriptions for Schedule II, Schedule III, and Schedule IV controlled substances dispensed pursuant to this subdivision shall be reported by the dispensing pharmacy to the Department of Justice in the manner prescribed by subdivision (d) of Section 11165.

(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.

SEC. 6. 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 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 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.

(c) (1) The operation of CURES shall comply with all applicable federal and state privacy and security laws and regulations.

(2) CURES shall operate under existing provisions of law to safeguard the privacy and confidentiality of patients. Data obtained from CURES shall only be provided to appropriate state, local, and federal public agencies for disciplinary, civil, or criminal purposes and to other agencies or entities, as determined by the Department of Justice, for the purpose of educating practitioners and others in lieu of disciplinary, civil, or criminal actions. Data may be provided to public or private entities, as approved by the Department of Justice, for educational, peer review, statistical, or research purposes, provided that patient information, including any information that

may identify the patient, is not compromised. Further, data disclosed to any individual or agency as described in this subdivision shall not be disclosed, sold, or transferred to any third party. The Department of Justice shall establish policies, procedures, and regulations regarding the use, access, evaluation, management, implementation, operation, storage, disclosure, and security of the information within CURES, consistent with this subdivision.

(d) For each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance, as defined in the controlled substances schedules in federal law and regulations, specifically Sections 1308.12, 1308.13, and 1308.14, respectively, of Title 21 of the Code of Federal Regulations, the dispensing pharmacy, clinic, or other dispenser shall report the following information to the Department of Justice as soon as reasonably possible, but not more than seven days after the date a controlled substance is dispensed, in a format specified by the Department of Justice:

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

(2) The prescriber's category of licensure, license number, national provider identifier (NPI) number, if applicable, 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, NPI 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.

(e) 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 and dispenser invitees shall be licensed by one of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, in active practice in California, and a regular user of CURES.

(f) The Department of Justice shall, prior to upgrading CURES, consult with prescribers licensed by one of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, one or more of the boards or committees identified in subdivision (d) of Section

208 of the Business and Professions Code, and any other stakeholder identified by the department, for the purpose of identifying desirable capabilities and upgrades to the CURES Prescription Drug Monitoring Program (PDMP).

(g) The Department of Justice may establish a process to educate authorized subscribers of the CURES PDMP on how to access and use the CURES PDMP.

SEC. 7. Section 11165.1 of the Health and Safety Code is amended to read:

11165.1. (a) (1) (A) (i) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 shall, before January 1, 2016, or upon receipt of a federal Drug Enforcement Administration (DEA) registration, whichever occurs later, submit an application developed by the Department of Justice to obtain approval to access information online regarding the controlled substance history of a patient that is stored on the Internet and maintained within the Department of Justice, and, upon approval, the department shall release to that practitioner the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES Prescription Drug Monitoring Program (PDMP).

(ii) A pharmacist shall, before January 1, 2016, or upon licensure, whichever occurs later, submit an application developed by the Department of Justice to obtain approval to access information online regarding the controlled substance history of a patient that is stored on the Internet and maintained within the Department of Justice, and, upon approval, the department shall release to that pharmacist the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES PDMP.

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

(i) Materially falsifying an application for a subscriber.

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

(iii) Suspended or revoked federal DEA registration.

(iv) Any subscriber who is arrested for a violation of law governing controlled substances or any other law for which the possession or use of a controlled substance is an element of the crime.

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

(C) Any authorized subscriber shall notify the Department of Justice within 30 days of any changes to the subscriber account.

(2) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 or a pharmacist shall be deemed to have complied with paragraph (1) if the licensed health care practitioner or pharmacist has been approved to access the CURES database through the

process developed pursuant to subdivision (a) of Section 209 of the Business and Professions Code.

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

(c) In 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.

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

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

SEC. 8. Section 11165.5 is added to the Health and Safety Code, to read:

11165.5. (a) The Department of Justice may seek voluntarily contributed private funds from insurers, health care service plans, qualified manufacturers, and other donors for the purpose of supporting CURES. Insurers, health care service plans, qualified manufacturers, and other donors may contribute by submitting their payment to the Controller for deposit into the CURES Fund established pursuant to subdivision (c) of Section 208 of the Business and Professions Code. The department shall make information about the amount and the source of all private funds it receives for support of CURES available to the public. Contributions to the CURES Fund pursuant to this subdivision shall be nondeductible for state tax purposes.

(b) For purposes of this section, the following definitions apply:

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

(2) "Health care service plan" means an entity licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(3) "Insurer" means an admitted insurer writing health insurance, as defined in Section 106 of the Insurance Code, and an admitted insurer writing workers' compensation insurance, as defined in Section 109 of the Insurance Code.

(4) "Qualified manufacturer" means a manufacturer of a controlled substance, but does not mean a wholesaler or nonresident wholesaler of

dangerous drugs, regulated pursuant to Article 11 (commencing with Section 4160) of Chapter 9 of Division 2 of the Business and Professions Code, a veterinary food-animal drug retailer, regulated pursuant to Article 15 (commencing with Section 4196) of Chapter 9 of Division 2 of the Business and Professions Code, or an individual regulated by the Medical Board of California, the Dental Board of California, the California State Board of Pharmacy, the Veterinary Medical Board, the Board of Registered Nursing, the Physician Assistant Committee of the Medical Board of California, the Osteopathic Medical Board of California, the State Board of Optometry, or the California Board of Podiatric Medicine.

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SCR 8

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SCR 8
Author: DeSaulnier
Chapter: 26
Bill Date: April 18, 2013, Amended
Subject: Prescription Drug Abuse Awareness Month
Sponsor: Author
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This concurrent resolution proclaims the month of March, each year, as Prescription Drug Abuse Awareness Month and encourages all citizens to participate in prevention programs and activities and to pledge to "Spread the Word....One Pill Can Kill."

ANALYSIS:

This resolution makes declarations regarding prescription drugs. In 2008, 20,044 deaths were from prescription drug overdoses; in 2009, 1.2 million emergency department visits were related to misuse or abuse of pharmaceuticals; in 2010, 2 million people reported using prescription painkillers non-medically for the first time within the last year; and as many as 70 percent of people who abuse prescription drugs get them from a relative or friend instead of a doctor. This resolution also states that the National Coalition Against Prescription Drug Abuse, in cooperation with local law enforcement agencies and other community organizations, coordinate Prescription Drug Abuse Awareness Month activities. Lastly, this resolution states that community organizations, local government, practitioners, pharmacists, and the general public will demonstrate their commitment to the prevention of prescription medication abuse by participating in activities to highlight local efforts in March.

The epidemic of prescription drug abuse and overdoses is plaguing the nation, as well as California. This resolution will help to increase awareness of the prescription drug abuse problem in California and would encourage participation in prescription medication abuse prevention programs. The Board has taken a support position on this resolution.

FISCAL: None

SUPPORT: National Coalition Against Prescription Drug Abuse
The Board

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter Article
- Develop/identify outreach materials for dissemination in March 2014

Senate Concurrent Resolution No. 8

RESOLUTION CHAPTER 26

Senate Concurrent Resolution No. 8—Relative to Prescription Drug Abuse Awareness Month.

[Filed with Secretary of State May 8, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

SCR 8, DeSaulnier. Prescription Drug Abuse Awareness Month.

This measure would proclaim the month of March, each year, as Prescription Drug Abuse Awareness Month and encourage all citizens to participate in prevention programs and activities and to pledge to "Spread the Word ... One Pill Can Kill."

WHEREAS, In 2008, drug overdoses in the United States caused 36,450 deaths and 20,044 of these were from prescription drug overdoses; and

WHEREAS, Overdose deaths involving opioid pain relievers (OPR) have increased and now exceed deaths involving heroin and cocaine combined; and

WHEREAS, In 2009, 1.2 million emergency department visits were related to misuse or abuse of pharmaceuticals (an increase of 98.4 percent since 2004); and

WHEREAS, Nonmedical use of OPR costs insurance companies up to $72.5 billion annually in health care costs; and

WHEREAS, By 2010, enough prescription painkillers were sold to medicate every American adult with a typical dose of five milligrams of hydrocodone every four hours for one month; and

WHEREAS, In 2010, 2 million people reported using prescription painkillers nonmedically for the first time within the last year—nearly 5,500 a day; and

WHEREAS, As many as 70 percent of people who abuse prescription drugs get them from a relative or friend instead of a doctor; and

WHEREAS, The National Coalition Against Prescription Drug Abuse, in cooperation with law enforcement agencies, community-based organizations, alcohol and other drug service providers, and civic and business leaders, coordinates Prescription Drug Abuse Awareness Month activities to offer our citizens the opportunity to demonstrate their commitment to campaigns and education aimed at raising awareness about the abuse and misuse of prescription drugs, promoting safe storage and disposal of prescription drugs, and using medications only as prescribed; and

WHEREAS, Families, schools, businesses, faith-based communities, law enforcement, medical professionals, county and local governments, health

care practitioners, pharmacists, and the general public throughout the state will demonstrate their commitment to the prevention of prescription medication abuse by participating in activities intended to highlight local efforts during the month of March; now, therefore, be it

Resolved by the Senate of the State of California, the Assembly thereof concurring, That the month of March, each year, is hereby proclaimed to be Prescription Drug Abuse Awareness Month and that all citizens are encouraged to participate in prevention programs and activities and to pledge to "Spread the Word ... One Pill Can Kill"; and be it further

Resolved, That the Secretary of the Senate transmit copies of this resolution to the author for appropriate distribution.

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MBC TRACKER II BILLS
10/16/2013

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 5	Ammiano	Homelessness	2-year	04/30/13
AB 12	Cooley	Standardized Regulatory Impact Analysis	Vetoed	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	Chaptered, #547	04/02/13
AB 213	Logue	Healing Arts: Licensing Requirements: Military	2-year	04/18/13
AB 219	Perea	Health Care Coverage: Cancer Treatment	Chaptered, #661	09/04/13
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	2-year	07/10/13
AB 396	Fox	Prescriptions	2-year	
AB 411	Pan	Medi-Cal: Performance Measures	Vetoed	09/11/13
AB 446	Mitchell	HIV Testing	Chaptered, #589	09/06/13
AB 473	Ammiano	Medical Marijuana: State Regulation and Enforcement	2-year	05/24/13
AB 506	Mitchell	HIV Testing: Infants	Chaptered, #153	07/02/13
AB 555	Salas	Social Security Numbers	Chaptered, #103	04/30/13
AB 576	Perez, V.	Revenue Recovery and Collaborative Enforcement Team	Chaptered, #614	09/06/13
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	Chaptered, #674	09/05/13
AB 623	Lowenthal	Inmates: Psychiatric Medication: Informed Consent	2-year	

MBC TRACKER II BILLS
10/16/2013

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 633	Salas	Emergency Medical Services: Civil Liability	Chaptered, #591	08/26/13
AB 657	Nazarian	Women's Health	2-year	
AB 658	Calderon, I.	Personal Information: Disclosure	Chaptered, #296	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	2-year	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	Chaptered, #160	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	2-year	05/02/13
AB 894	Mansoor	Consumer Affairs	2-year	
AB 912	Quirk-Silva	Health Care Coverage: Fertility Preservation	Vetoed	09/03/13
AB 926	Bonilla	Reproductive Health and Research	Vetoed	04/23/13
AB 975	Wieckowski & Bonta	Health Facilities: Community Benefits	2-year	05/24/13
AB 980	Pan	Primary Care Clinics: Abortion	Chaptered, #663	09/12/13
AB 1013	Gomez	Consumer Affairs	2-year	
AB 1045	Quirk-Silva	Sterile Compounding and Nonresident Pharmacies	Chaptered, #302	06/19/13
AB 1057	Medina	Professions & Vocations: Licenses: Military Service	Chaptered, #693	06/03/13
AB 1136	Levine	Pharmacists: Drug Disclosures	Chaptered, #304	04/15/13

MBC TRACKER II BILLS
10/16/2013

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 1139	Lowenthal	Prescriptions: Biosimilar Products	2-year	
AB 1153	Eggman	Master Esthetician: License	2-year	09/11/13
AB 1180	Pan	Health Care Coverage: Federally Eligible Defined Individuals	Chaptered, #441	09/03/13
AB 1208	Pan	Medical Homes	Vetoed	09/06/13
AB 1231	Perez, V.	Regional Centers: Telehealth	Vetoed	09/05/13
AB 1263	Perez, J.	Medi-Cal: Communical	Vetoed	07/10/13
AB 1297	Perez, J.	Coroners: Organ Donation	Chaptered, #341	08/19/13
AB 1310	Brown	Medi-Cal: Pediatric Subacute Care	2-year	05/24/13
AB 1372	Bonilla	Health Insurance: Pervasive Developmental Disorder or Autism	2-year	
ABX1 2	Pan	Health Care Coverage	Chaptered, #1	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	Chaptered, #54	
SB 18	Hernandez	California Health Benefits Review Program	2-year	04/17/13
SB 22	Beall	Health Care Coverage: Mental Health Parity	2-year	07/02/13
SB 28	Hernandez	California Health Benefit Exchange	Chaptered, #442	09/06/13
SB 44	Yee	State Internet Web sties: online voter registration	Chaptered, #277	
SB 126	Steinberg	Health Care Coverage: pervasive developmental disorder/autism	Chaptered, #680	08/08/13
SB 138	Hernandez	Confidentiality of Medical Information	Chaptered, #444	09/03/13
SB 158	Correa	Autism Services: Demonstration Program	Vetoed	05/28/13
SB 176	Galgiani	Administrative Procedures	2-year	08/07/13
SB 189	Monning	Health Care Coverage: Wellness Programs	2-year	05/08/13
SB 198	Lieu	Physical Therapy Board of California	Chaptered, #389	09/06/13
SB 204	Corbett	Prescription Drugs: Labeling	2-year	06/27/13
SB 205	Corbett	Prescription Drugs: Labeling	Vetoed	09/06/13

MBC TRACKER II BILLS
10/16/2013

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 218	Yee	Healing Arts	2-year	08/05/13
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	2-year	
SB 294	Emmerson	Sterile Drug Products	Chaptered, #565	09/03/13
SB 306	Torres	Pharmacy: Dangerous Drugs and Devices	2-year	06/20/13
SB 351	Hernandez	Health Care Coverage: Hospital Billing	2-year	04/23/13
SB 353	Lieu	Health Care Coverage: Language Assistance	Chaptered, #447	09/04/13
SB 357	Correa	Elective Percutaneous Coronary Intervention Pilot Program	Chaptered, #202	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 460	Pavley	Prenatal Testing Program: Education	Chaptered, #667	09/03/13
SB 494	Monning	Health Care Providers	Chaptered, #684	09/06/13
SB 495	Yee	Postsecondary Education Employees: Physicians	2-year	05/21/13
SB 528	Yee	Dependents: Care and Treatment	Chaptered, #338	09/03/13
SB 532	De Leon	Professions and Vocations: Military Spouses: Temporary Licenses	2-year	
SB 534	Hernandez	Health and Care Facilities	Chaptered, #722	09/04/13
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	Vetoed	08/06/13
SB 631	Beall	Health Care Facilities: Observation	2-year	04/08/13
SB 639	Hernandez	Health Care Coverage	Chaptered, #316	09/06/13
SB 643	Price	Pharmacists: Identity	2-year	
SB 666	Steinberg	Employment: Retaliation	Chaptered, #577	09/04/13

MBC TRACKER II BILLS
10/16/2013

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 669	Huff	Emergency Medical Care: Epinephrine Auto Injectors	Chaptered, #725	09/03/13
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	Chaptered, #448	09/03/13
SBX1 2	Hernandez	Health Care Coverage	Chaptered, #2	04/01/13
SBX1 3	Hernandez	Health Care Coverage: Bridge Plan	Chaptered, #5	06/19/13

LEGISLATIVE PROPOSALS 2014

Sunset Review Proposals

The Board included new issues in its 2012 Sunset Review Report to the Legislature and in its 2013 Supplemental Report. These reports were 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. Some of the new issues that were included in the Board's Sunset Review Report that would require legislation were not included in the Board's Sunset Bill, SB 304. Board staff has identified the following proposals to move forward in 2014 (issues that the Legislature directed the Board to take some other action before proposing new legislation are not included):

- The Board recommended that, in the interest of consumer protection, legislation be written to require that regulations be adopted for physician availability in all clinical settings and for the Board to establish, by regulation, the knowledge, training, and ability a physician must possess in order to supervise other health care providers.

- The Board recommended 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 was contained in SB 62 (Lieu), which the Board supported, but was vetoed by the Governor for fiscal reasons. Board staff would like to continue to work with Senate Business, Professions, and Economic Development Committee on this important consumer protection 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, SB 304 did 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. SB 304 did include language that would have required the complete expert reviewer report to be provided 90 calendar days prior to the commencement of the hearing. However, after many meetings with the California Medical Association (CMA) and the Legislature on amendments to address CMA's concerns, the language was pulled from SB 304.

- 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 SB 304. This is a potential omnibus candidate.

Outpatient Settings Legislative Proposals

- Per existing law, Health and Safety Code Section 1216, clinics licensed by the California Department of Public Health (CDPH), including surgical clinics, are required to report aggregate data to the Office of Statewide Health Planning and Development (OSHPD). This data includes number of patients served and descriptive background, number of patient visits by type of service, patient charges, and any additional information required by CDPH and OSHPD. Before *Capen v. Shewry*, this data was being collected for the majority of outpatient settings, as they were licensed as surgical clinics. However, when physician-owned outpatient settings fell under the jurisdiction of the Board, this reporting was no longer required, which resulted in a serious deficiency of outpatient settings data. Board staff is suggesting that the data collection requirements be put into place for accredited outpatient settings; the data required for reporting would be very similar to the data that surgical clinics are required to report to OSHPD. The Board would work closely with OSHPD on this proposal.

- Existing law (Business and Professions Code Section 2240 (a)) requires a physician who performs a scheduled medical procedure outside of a general acute care hospital, that results in a death, to report the occurrence to the Board within 15 days. The Board would like to ensure all deaths in outpatient settings are reported to the Board, not just those that resulted from a scheduled medical procedure. Board staff suggests striking "scheduled" from existing law. This is a potential omnibus candidate.

- The Outpatient Settings Task Force will also be bringing some legislative proposals to the Board.

MEDICAL BOARD OF CALIFORNIA
Status of Pending Regulations

Subject	Current Status	Date Approved by Board	Date Notice Published by OAL	Date of Public Hearing	Date of Final Adoption by Board	Date to DCA (and other control agencies) for Final Review *	Date to OAL for Review **	Date to Sec. of State***
Implementation of SB 1441	Hearing set for 10/25/13	7/19/13	9/06/13	10/25/13		8/30/13 DCA for review and approval		

Prepared by Chris Valine
Updated October 11, 2013
For questions, call (916) 263-2466

DCA is allowed 30 calendar days for review.
OAL is allowed 30 working days for review.
Rulemakings become effective on a quarterly basis, unless otherwise specified.